Rehabilitation after traumatic injury

Consultation on draft guideline - Stakeholder comments table
27/07/21 – 08/09/21

Stakeholder	Document	Page No	Line No	Comments	Developer's response
Anglia Ruskin University - Cambridge Institute for Music Therapy Research	Guideline	General	General	Physical interventions and cognition There is further evidence from music intervention trials that rhythmic auditory stimulation can improve gait parameters (velocity, cadence and stride length), as well indicating cognitive gains. Offering patients something beyond what is established multidisciplinary team usual care (physiotherapy, occupational therapy, speech therapy and psychology) and that includes music-based exercises (there is significantly more evidence for music than for the other arts therapies) is worthy of investigation, as it can offer less daunting and potentially less fatigue inducing (see Stroke study: Grau-Sanchez et al, 2018, Music-supported therapy in the rehabilitation of subacute stroke patients: a randomized controlled trial, doi: 10.1111/nyas.13590) opportunities to achieve the required massed practice	Thank you for your comment. Unfortunately, NICE guidelines cannot cover every aspect of an area. The scope of this guideline was already very large, and music therapy was not identified as a high priority during scoping. As such, 'music therapy' was not included specifically in the search strategies for the systematic reviews. However, due to the breadth of the scope, search strategies were designed to be as inclusive of the rehabilitation after traumatic injury population as possible. If any studies had been identified during the initial sift or during full-text review that examined the effectiveness of music therapy and otherwise met the inclusion criteria of this review (i.e. population, comparison and outcomes), they would have been included by the systematic review team. This is because they could have been classified as 'psychological therapies for adjustment and engagement' and 'therapy for advanced activities of

				to induce neural reorganisation and functional gains. This review is a good start (for gait): Mishra et al, 2021 Role of Music Therapy in Traumatic Brain Injury: A Systematic Review and Meta-analysis. World Neurosurg. (2021) 146:197-204. https://doi.org/10.1016/j.wneu.2020.10.130 Rhythmic Auditory Stimulation is a standardised intervention that can be delivered by any healthcare professional trained and experienced in neurorehabilitation. Clinicians do not need musical skills and knowledge. Therefore, the intervention could be rolled out into existing services with some basic training. Other music-based interventions, including music listening for mood and cognition-which has been trialled with stroke survivors (Sarkamo et al, 2008, Music listening enhances cognitive recovery and mood after middle cerebral artery stroke, doi: 10.1093/brain/awn013), could also be	daily living'. Additional areas covered in the children protocols would be '(early specialist) play therapy' and 'interventions for adaptive dysfunction and behavioural disturbance'. No such studies were identified. Similarly, after reviewing your references, we are unable to include them in the evidence reviews as they did not meet the protocol inclusion criteria for the following reasons: Grau-Sanchez et al. (2018) Music-supported therapy in the rehabilitation of subacute stroke patients: a randomized controlled trial • Population not in protocols – Stroke patients Mishra et al. (2021) Role of Music Therapy in Traumatic Brain Injury: A Systematic Review and Meta-analysis. • Population not in protocols – Traumatic brain injury Sarkamo et al (2008) Music listening enhances cognitive recovery and mood after middle cerebral artery stroke. • Population not in protocols – Stroke patients

				delivered by existing multidisciplinary team members with minimal training.	Music therapy is not a routinely provided intervention after trauma, so any recommendations on its availability would cause a resource impact for certain settings. This, combined with the lack of evidence identified, meant that the committee did not issue any guidance for music therapy.
Anglia Ruskin University - Cambridge Institute for Music Therapy Research	Guideline	025	033 - 036	Physiological and psychosocial We are concerned that music-based interventions have not been considered in the review, some of which indicate promising outcomes for TBI patients. Whilst we acknowledge that more music intervention clinical trials are needed, there are some that should be considered to support music-based interventions for emotional recovery, for example Siponkoski et al, 2021 Effects of neurological music therapy on behavioural and emotional recovery after traumatic brain injury: A randomized controlled cross-over trial. https://doi.org/10.1080/09602011.2021.1890138 We suggest a search of literature, including music therapy, neurologic,	Thank you for your comment. Unfortunately, NICE guidelines cannot cover every aspect of an area. The scope of this guideline was already very large, and music therapy was not identified as a high priority during scoping. As such, 'music therapy' was not included specifically in the search strategies for the systematic reviews. However, due to the breadth of the scope, search strategies were designed to be as inclusive of the rehabilitation after traumatic injury population as possible. If any studies had been identified during the initial sift or during full-text review that examined the effectiveness of music therapy and otherwise met the inclusion criteria of this review (i.e. population, comparison and outcomes), they would

				TBI, emotional, psychological, psychosocial	have been included by the systematic review team. This is because they could have been classified as 'psychological therapies for adjustment and engagement' and 'therapy for advanced activities of daily living'. Additional areas covered in the children protocols would be '(early specialist) play therapy' and 'interventions for adaptive dysfunction and behavioural disturbance'. No such studies were identified. Music therapy is not a routinely provided intervention after trauma, so any recommendations on its availability would cause a resource impact for certain settings. This, combined with the lack of evidence identified, meant that the committee did not issue any guidance for music therapy. After reviewing Siponkoski et al. (2021), unfortunately it cannot be included in our systematic reviews as traumatic brain injury is excluded as per the protocol.
Association of Chartered Physiotherapists Interested in	Guideline	General	General	As BPPV is a common presentation of vestibular dysfunction following trauma (Pisani, V. et al 2015) (Szczupak, M et al 2016) we would recommend the BMJ	Thank you for your comment. We have removed the reference to CG161 NICE guidance on falls in this recommendation. Between guideline organisations, there are

Vestibular Rehabilitation				guidance on BPPV be utilized until CG 161 can be updated with appropriate resources for managing BPPV	differences in development methodology (for example, quality of included evidence) that mean NICE do not usually refer to non-NICE guidance within recommendations.
Association of Chartered Physiotherapists Interested in Vestibular Rehabilitation	Guideline	014	015 - 017	We applaud the inclusion of assessing neuro-vestibular symptoms and BPPV as this is too often overlooked in trauma injury	Thank you for your comment.
Association of Chartered Physiotherapists Interested in Vestibular Rehabilitation	Guideline	015	007 – 010	Assessing for neuro-vestibular disorders is appropriate here; however the link to CG 161 on Fall Prevention does not mention dizziness, vestibular or vertigo at all. We are aware that this is up for review, but for the next 2 years this link will not be helpful in this respect.	Thank you for your comment. This reference to the NICE guideline on Falls Management has been removed.
Association of Chartered Physiotherapists Interested in Vestibular Rehabilitation	Guideline	046	019	We applaud the inclusion of assessing the oft overlooked role of Vestibular function	Thank you for your comment.
Association of Chartered	Guideline	076	011	Please consider replacing the phrase "…of the inner ear and brain…" with the	Thank you for your comment. We have amended the text as suggested.

Physiotherapists Interested in Vestibular Rehabilitation				more accurate "…inner ear and/or brain…."	
Association of Chartered Physiotherapists Interested in Vestibular Rehabilitation	Evidence	082	006	The link to CG 161 on fall prevention will not provide any insight or guidance on vestibular issues or management. It is not mentioned anywhere in that Clinical Guidance.	Thank you for your comment. This reference to the NICE guideline on Falls Management has been removed.
Association of Trauma and Orthopaedic Chartered Physiotherapists	Guideline	General	General	General comment about inclusion of wheelchair accessibility	Thank you for your comment. Although not always specified, wheelchairs are included throughout the guideline. The 'Initial assessment and early interventions for people with complex rehabilitation needs' section recommends involving occupational therapy to advise on referrals for aids and equipment to retain independence as much as possible and to encourage movement. Wheelchairs would be included in this consideration. The committee made additional recommendations regarding supporting people with equipment for after discharge.
Association of Trauma and Orthopaedic	Guideline	General	General	General comment about inclusion of lifestyle/drug & alcohol services for patient support and education –	Thank you for your comment. This has been covered in the 'Multidisciplinary team rehabilitation needs assessment' section,

Chartered Physiotherapists				optimising moments to influence change	which includes a recommendation to 'assess the person's rehabilitation needs as soon as possible after the traumatic injury, when measures are being taken to optimise their ability to engage in the assessment process'. One of the measures listed is having drug or alcohol dependence withdrawal management in place.
Association of Trauma and Orthopaedic Chartered Physiotherapists	Guideline	049 - 050		General comment that there does not appear to be any mention of shoulder or elbow splitting and rehab / functional implications	Thank you for your comment. These guidelines only include recommendations which the committee felt were important to communicate to practitioners because of current inconsistencies in practice. NICE guidelines can not be a textbook regarding all the methods of rehabilitation used for every possible injury. For this reason there were inevitably aspects of rehabilitation and injury which the committee chose not to refer to in the recommendations and instead prioritised other areas as being more important for this guideline.
Association of Trauma and Orthopaedic	Guideline	010	027	We agree with the statement regarding including AHPs in the MDT, however, feel that this would read better with	Thank you for your comment. The examples given in this list are only examples of allied healthcare practitioners. It is not meant to be an exhaustive list.

Chartered Physiotherapists				greater inclusion of the wide range of AHPs not routinely recognised.	However, the committee have added several more examples to this list in order for it to be more inclusive.
Association of Trauma and Orthopaedic Chartered Physiotherapists	Guideline	012	009	1.2.9 ‘ Discussing rehab needs and sharing of information…’ We feel consent needs to be mentioned here, or at the beginning of the guidelines as a generalise statement for consideration throughout.	Thank you for your comment. Specific mention is made of consent in recommendation 1.4.1 about documenting ‘who the rehabilitation plan should be shared with (with the person’s consent) and details about any information that the person wants to remain confidential’ . Similarly, patient consent is stressed when sharing information about a person’s rehabilitation plan between healthcare settings or involving additional people in the transition process. The committee discussed the issue of communication with family etc. about rehabilitation and the importance of the input from family and carers at that point, but given that circumstances vary the committee included the phrase "as appropriate" to indicate that there are options here about who is and isn’t involved in those discussions.
Association of Trauma and	Guideline	014	003	1.2.12 ‘…… assessment after traumatic injury, including a Physio with	Thank you for your comment. We have amended the recommendation stem to

Orthopaedic Chartered Physiotherapists				appropriate skills…..' replace Physio for 'rehabilitation therapist' as this could any one of the AHPs.	read 'As part of the rehabilitation needs assessment after a traumatic injury, the multidisciplinary team with appropriate skills and competencies, should assess the person's pre-injury and current physical functioning, which should include:...'.
Association of Trauma and Orthopaedic Chartered Physiotherapists	Guideline	018	006 - 008	1.3.1 Do we need to specify the goals are to be SMART?	Thank you for your comment. The committee explained that using SMART goals is implied in the recommendation, and that the descriptive wording is more useful to an individual and therapist. However, we have now included a definition of a "strengths-based approach" in the glossary.
Association of Trauma and Orthopaedic Chartered Physiotherapists	Guideline	020	015 - 016	Need patient consent for sharing	Thank you for your comment. This is implied as the recommendation referenced should be read in conjunction with the previous recommendation which reads 'Use the rehabilitation needs assessment...and the person's rehabilitation goals...to develop a rehabilitation plan for the person (this may be in the form of a rehabilitation prescription). The rehabilitation plan should include: • who the rehabilitation plan should be shared with (with the

					person's consent) and details about any information that the person wants to remain confidential'.
Association of Trauma and Orthopaedic Chartered Physiotherapists	Guideline	020	013	1.4.2 '……. Written in clear English…' This should read appropriate language for EDI	Thank you for your comment. No amendment has been made as it is not always possible for standard forms to be provided in a range of languages. However, communication of information with patients is covered in both CG138 'Patient experience in adult NHS services: improving the experience of care for people using adult NHS services' and NG204 'Babies, children and young people's experience of healthcare'. These guidelines are signposted in the 'Principles for sharing information and involving family and carers' section for further information, and have recommendations regarding people who do not have English as their first language, people who may need a translation service and people who need information in different formats.
Association of Trauma and Orthopaedic Chartered Physiotherapists	Guideline	023	001 - 004	1.5.1 This section is not inclusive of the range of AHPs only 4 and 'injury specific therapies and treatments' seems vague. Would read better as a	Thank you for your comment. The examples were only included as excluded to indicate the breadth of treatments and therapies which would be considered. To list all possible AHPs is not practical.

				more general statement including the 'range of AHPs'	
Association of Trauma and Orthopaedic Chartered Physiotherapists	Guideline	025	009 - 021	1.57 Self-management; Would be of benefit to include cultural considerations with work, social activities and hobbies.	Thank you for your comment. We were not completely clear about your suggestion but we believe we have covered cultural considerations with regards adjustment etc. throughout the guideline but particularly in section 1.8 Coordination of rehabilitation care at discharge and 1.9 Supporting access and participation in education, work and community (adjustment and goal settings)
Association of Trauma and Orthopaedic Chartered Physiotherapists	Guideline	031	016 - 031	1.7.8 Would be improved with inclusion of cultural needs and language	Thank you for your comment. We have added "the person's cultural, language and communication needs".
Association of Trauma and Orthopaedic Chartered Physiotherapists	Guideline	037	009 - 011	1.8.20 '…….. key contact after discharge…' could also be AHP	Thank you for your suggestion. This was added to the recommendation.
Association of Trauma and Orthopaedic Chartered Physiotherapists	Guideline	049	009 - 011	1.11.22 '…… consider use of orthoses if there is a risk of ankle ROM' would be better if left more generic and included to restore function in addition to movement.	Thank you for your comment. This recommendation was intended to be specific. The committee discussed that, due to muscle shortening, early loss of ankle range of movement is common in

					lower limb fractures and/or nerve injuries. If not managed with an exercise programme and appropriate orthosis, this can lead to pain, physical impairment and prolonged rehabilitation. A more generic recommendation regarding the use of splints and orthoses to maintain range of movement is provided in the section 'Physical rehabilitation – early interventions and principles'. Therefore, no changes have been made.
Association of Trauma and Orthopaedic Chartered Physiotherapists	Guideline	049	012 - 013	1.11.23 'for people with ex fix' …. Change ankle to lower limb	Thank you for your comment. The committee wished to specifically highlight the possibilities of losing ankle range of movement in people with external fixation for lower limb fractures, and the role splinting can play to prevent this. Therefore, no change has been made.
Association of Trauma and Orthopaedic Chartered Physiotherapists	Guideline	053	018	1.12.4 Clear '*appropriate'* language	Thank you for your comment. We do not agree that the word 'appropriate' is needed here. The phrase 'use clear language' conveys the message the committee wanted to get across when providing information to someone who is experiencing problems with cognitive functioning. If included, the word

					appropriate' would need to be defined and this would be a different recommendation. There are other recommendations throughout the guideline stressing the importance of tailoring communication of information to the patients' needs and circumstances, which would cover 'appropriate' language. Both the guidelines referenced in 'Principles for sharing information and involving family and carers' section (CG138 'Patient experience in adult NHS services: improving the experience of care for people using adult NHS services' and NG204 'Babies, children and young people's experience of healthcare' have recommendations) cover communication with patients. Therefore, no changes have been made.
Association of Trauma and Orthopaedic Chartered Physiotherapists	Guideline	058	002 - 011	1.4.5 '….after limb reconstruction ….. to maintain ROM.' This needs to include function as ROM not always the goal if restricted.	Thank you for your comment. While retaining function is a long-term goal, the committee discussed that maintaining range of movement was of primary concern so early after limb reconstruction. This is the time period when range of movement can decrease rapidly, which can adversely impact future rehabilitation programmes and goal attainment.

Association of Trauma and Orthopaedic Chartered Physiotherapists	Guideline	059	008	1.14.9 Play for children would read better on new bullet point	Thank you for your comment. We have amended the wording to read 'functional independence, including play for children'.
Association of Trauma and Orthopaedic Chartered Physiotherapists	Guideline	061	005 - 006	1.14.17 Need to consider importance of home and adaptations assessment	Thank you for your comment. Home visits and adaptations are covered in the guideline section 'Coordination of rehabilitation care at discharge'. Therefore, no change has been made.
Association of Trauma and Orthopaedic Chartered Physiotherapists	Recommendation	090	021 - 028	1.6.1 – 1.6.7 No mention of consent for sharing of information	Thank you for your comment. Consent is covered in existing NICE recommendations and it therefore out of scope for this guideline. However, the guideline does signpost relevant guidelines (CG138 'Patient experience in adult NHS services: improving the experience of care for people using adult NHS services' and NG204 'Babies, children and young people's experience of healthcare') at the end of this section on sharing information. Recommendations on sharing information between healthcare professionals, as well as with families or carers, mention the need to obtain consent.

British Association of Art Therapists; British Association of Music Therapists; Association for Dance Movement Psychotherapy UK; British Association of Dramatherapists	Evidence review B3	General	General	We are concerned that neither the evidence review protocol nor the search terms include any of the arts therapies under the heading psychological therapies. Relevant search terms: 'art therapy', 'art psychotherapy', 'dramatherapy', 'drama therapy', 'dance therapy', 'dance movement therapy', 'dance movement psychotherapy', 'music therapy'.	Thank you for your comment. Unfortunately, NICE guidelines cannot cover every aspect of an area. The scope of this guideline was already very large, and arts therapy was not identified as a high priority during scoping. As such, art therapy search terms were not included specifically in the search strategies for psychological and psychosocial interventions evidence review (B3). However, due to the breadth of the scope, search strategies were designed to be as inclusive of the rehabilitation after traumatic injury population as possible. If any studies had been identified during the initial sift or during full-text review that examined the effectiveness of arts therapy and otherwise met the inclusion criteria of this review (i.e. population, comparison and outcomes), they would have been included by the systematic review team. This is because they could be classified under 'therapy for advanced activities of daily living'. Additional areas covered in the children protocols would be 'play therapy' and 'interventions for adaptive

					dysfunction and behavioural disturbance'. No such studies were identified.
British Association of Art Therapists; British Association of Music Therapists; Association for Dance Movement Psychotherapy UK; British Association of Dramatherapists	Evidence review B4	General	General	We are concerned that neither the evidence review protocol nor the search terms include any of the arts therapies under the heading psychological therapies. Relevant search terms: 'art therapy', 'art psychotherapy', 'dramatherapy', 'drama therapy', 'dance therapy', 'dance movement therapy', 'dance movement psychotherapy', 'music therapy'.	Thank you for your comment. Unfortunately, NICE guidelines cannot cover every aspect of an area. The scope of this guideline was already very large, and arts therapy was not identified as a high priority during scoping. As such, art therapy search terms were not included specifically in the search strategies for the participation in society evidence review (B4). However, due to the breadth of the scope, search strategies were designed to be as inclusive of the rehabilitation after traumatic injury population as possible. If any studies had been identified during the initial sift or during full-text review that examined the effectiveness of arts therapy and otherwise met the inclusion criteria of this review (i.e. population, comparison and outcomes), they would have been included by the systematic review team. This is because the could be classified under 'therapy for advanced activities of daily living'. An additional area covered in

					the children protocols would be 'play therapy'. No such studies were identified.
British Association of Art Therapists; British Association of Music Therapists; Association for Dance Movement Psychotherapy UK; British Association of Dramatherapists	Evidence review C3	General	General	We are concerned that neither the evidence review protocol nor the search terms include any of the arts therapies under the heading psychological therapies. Relevant search terms: 'art therapy', 'art psychotherapy', 'dramatherapy', 'drama therapy', 'dance therapy', 'dance movement therapy', 'dance movement psychotherapy', 'music therapy'.	Thank you for your comment. Unfortunately, NICE guidelines cannot cover every aspect of an area. The scope of this guideline was already very large, and arts therapy was not identified as a high priority during scoping. As such, art therapy search terms were not included specifically in the search strategies for the spinal cord injury rehabilitation evidence review (C3). However, due to the breadth of the scope, search strategies were designed to be as inclusive of the rehabilitation after traumatic injury population as possible. If any studies had been identified during the initial sift or during full-text review that examined the effectiveness of arts therapy and otherwise met the inclusion criteria of this review (i.e. population, comparison and outcomes), they would have been included by the systematic review team. This is because they could be classified under 'psychological therapies for adjustment and engagement '. An additional area covered in the children

					protocols would be 'early specialist play therapy'. No such studies were identified.
British Association of Art Therapists; British Association of Music Therapists; Association for Dance Movement Psychotherapy UK; British Association of Dramatherapists	Guideline	007	021	In assessment and early intervention for people with complex rehabilitation needs, considering music therapy may be relevant for reducing the psychological effects of pain from early on. For example, there is evidence that music therapy can help during painful nursing procedures: Rohilla L, Agnihotri M, Trehan SK, Sharma RK, Ghai S (2018) Effect of music therapy on pain perception, anxiety, and opioid use during dressing change among patients with burns in India: A quasi-experimental, cross-over pilot study. *Ostomy Wound Management*. 64(10):40-46, 2018 10. Tan X, Yowler CJ, Super DM, Fratianne RB (2010) The efficacy of music therapy protocols for decreasing pain, anxiety, and muscle tension levels during burn dressing changes: a prospective randomized crossover trial. *Journal of Burn Care & Research*. 31(4):590-7, 2010 Jul-Aug.	Thank you for your comment. Music therapy was not a term specifically searched for as it was not highlighted in the scoping process, and the committee did not consider it a high enough priority to be included separately in the context of all the other potential interventions. However, if any studies had been identified that examined the effectiveness of music therapy and otherwise met the inclusion criteria, they would have been included as part of 'psychological therapies for adjustment and engagement' and 'therapy for advanced activities of daily living'. Additional areas covered in the children protocols would be '(early specialist) play therapy' and 'interventions for adaptive dysfunction and behavioural disturbance'. No such studies were identified. After reviewing your references, unfortunately none of these studies can be included in our systematic reviews as they did not meet the protocol inclusion criteria for the following reasons: Rohilla et al. (2018) Effect of music

				Kwon IS, Kim J, Park KM (2006) Effects of music therapy on pain, discomfort, and depression for patients with leg fractures. *Daehan Ganho Haghoeji*. 36(4):630-6, 2006 Jun. Ortega A, Gauna F, Munoz D, Oberreuter G, Breinbauer HA, Carrasco L (2019) Music therapy for pain and anxiety management in nasal bone fracture reduction: Randomized controlled clinical trial. Otolaryngology - Head & Neck Surgery. 161(4):613-619, 2019 10.	therapy on pain perception, anxiety, and opioid use during dressing change among patients with burns in India: A quasi-experimental, cross-over pilot study. • Study design not in protocols – Crossover study Tan et al. (2010) The efficacy of music therapy protocols for decreasing pain, anxiety, and muscle tension levels during burn dressing changes: a prospective randomized crossover trial. • Study design not in protocols – Crossover study Kwon et al. (2006) Effects of music therapy on pain, discomfort, and depression for patients with leg fractures • Unclear population – Participants with leg fracture (inclusive of tibia, femur, ankle and pelvic fractures) who subsequently needed surgery. No mention of hospitalisation at the time of injury. Ortega et al. (2019) Music therapy for pain and anxiety management in nasal bone fracture reduction: Randomized controlled clinical trial. • Population not in guideline – Nasal bone

					fractures do not normally require admission to hospital at the time of injury.
British Association of Art Therapists; British Association of Music Therapists; Association for Dance Movement Psychotherapy UK; British Association of Dramatherapists	Guideline	023	001 - 004	In terms of general principles for rehabilitation after severe and complex traumatic injury, including the offer of music therapy within a multi-disciplinary approach may be helpful in the following ways: engendering hope, assisting in regaining movement, re-connecting with pre-injury life, social re-integration, quality of life and motivation for recovery: Vaudreuil R, Avila L, Bradt J, Pasquina P (2019) Music therapy applied to complex blast injury in interdisciplinary care: a case report. *Disability & Rehabilitation*. 41(19):2333-2342, 2019 09.	Thank you for your comment. Unfortunately, NICE guidelines cannot cover every aspect of an area. The scope of this guideline was already very large, and music therapy was not identified as a high priority during scoping. As such, 'music therapy' was not included specifically in the search strategies for the systematic reviews. However, due to the breadth of the scope, search strategies were designed to be as inclusive of the rehabilitation after traumatic injury population as possible. If any studies had been identified during the initial sift or during full-text review that examined the effectiveness of music therapy and otherwise met the inclusion criteria of this review (i.e. population, comparison and outcomes), they would have been included by the systematic review team. This is because they could have been classified as 'psychological therapies for adjustment and engagement' and 'therapy for advanced activities of daily living'. Additional areas covered in

					the children protocols would be '(early specialist) play therapy' and 'interventions for adaptive dysfunction and behavioural disturbance'. No such studies were identified. After reviewing Vaudreuil et al (2019), unfortunately it cannot be included in our systematic reviews as case reports are excluded as per the protocol.
British Association of Chartered Physiotherapists in Amputee Rehabilitation	Comments form	Q1		***Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why*** Many are already standard practice. Routine referral to psychological support already recommended but this is not always available. One of the most important recommendations but probably the most challenging to implement in some centres due to lack of services.	Thank you for your response. We agree that most of these recommendations represent current practice and will have little impact on resources. We are also aware that some services are under-resourced, or there is a lack of services, which may affect the implementation of these recommendations. We have passed your comment onto the NICE implementation support team.
British Association of Chartered Physiotherapists in Amputee Rehabilitation	Comments form	Q2		***Would implementation of any of the draft recommendations have significant cost implications?*** None identified.	Thank you for your comment.

British Association of Chartered Physiotherapists in Amputee Rehabilitation	Comments form	Q3		***What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.)*** Improving access to psychological support.	Thank you for your comment. We have made a number of recommendations on psychological support. Your comment implies the lack of psychological services and the need for additional funding in this area. The team at NICE will note this; however, NICE is not involved in funding decisions. This may also impact the implementation of the guidance, so we passed your comment onto the NICE team, which plan implementation support.
British Association of Chartered Physiotherapists in Amputee Rehabilitation	Comments form	Q4		***The recommendations in this guideline were largely developed before the coronavirus pandemic. Please tell us if there are any particular issues relating to COVID-19 that we should take into account when finalising the guideline for publication.*** Outpatient prosthetic rehabilitation services were significantly impacted by the pandemic; however, they have not been mentioned in this guideline. These services were considered non-essential and many people with traumatic amputations suffered enormous delays with their prosthetic rehabilitation as a result.	Thank you for your comment. The committee agreed that the COVID-19 pandemic has significantly impacted rehabilitation services. However, they discussed that this has been true for all rehabilitation services, not just the outpatient prosthetic services. Therefore, no change has been made.

British Association of Chartered Physiotherapists in Amputee Rehabilitation	Evidence review C.1	General		As most recommendations are based on committee experience, we would be interested to know more about the lay members of the committee.	Thank you for your comment. In order to protect their privacy, NICE does not disclose personal information on our committee members.
British Association of Chartered Physiotherapists in Amputee Rehabilitation	Guideline	General		No recommendations regarding prosthetic rehabilitation. Should this be an additional section? Or could reference British Association of Chartered Physiotherapists in Amputee Rehabilitation (BACPAR) guideline *Evidence based clinical guidelines for the physiotherapy management of adults with lower limb prostheses - 3rd edition*	Thank you for your comment. We cannot make specific recommendations on prosthetic rehabilitation as evidence was not searched for. This was due to the broad range of the guideline and the fact that it is a very specialised area. However, we have included a recommendation for referral to the amputee and prosthetic rehabilitation service as soon as possible, which will be able to provide this specialist rehabilitation. The committee discussed including the guideline mentioned in your comment, as well as several others. While they recognise that these are NICE-accredited clinical guidelines, they have not followed the same development processes as NICE guidelines. For example, the BAPCAR guidelines used all levels of evidence, including case reports and Delphi consensus. These would not meet the inclusion criteria for our evidence

					review protocols. The committee felt that they could not reference these guidelines over other professional guidelines, and decided not to include links to them in the recommendations. However, we have amended the discussion of evidence section of review C1 to include links to the mentioned guidelines.
British Association of Chartered Physiotherapists in Amputee Rehabilitation	Guideline	059	019	1.14.12 – We recommend graded motor imagery (GMI) to manage phantom limb pain	Thank you for your comment. We have included graded motor imagery as an example in the recommendation on interventions for phantom limb pain.
British Association of Chartered Physiotherapists in Amputee Rehabilitation	Guideline	060	002	1.14.13 – Compression therapy should be more specific to compression garments made for residual limbs. PPAM aid use is another effective method of compression which we recommend.	Thank you for your comment. The term 'therapy' was deliberately used to cover all possible garments and devices (including PPAM aid). Therefore, no change has been made.
British Association of Chartered Physiotherapists in Amputee Rehabilitation	Guideline	062	017	1.14.23 Should also include prosthetics review (for amputation)	Thank you for your comment. We have amended the text to read 'When completing a rehabilitation plan (see the section on developing a rehabilitation plan and making referrals) for people after limb reconstruction, limb loss or amputation, ensure that the following are always

					included in the person's rehabilitation programme:...• prosthetics team review, if relevant'.
British Society of Rehabilitation Medicine	Guideline	General		We welcome these guidelines, which have a great deal to recommend them. There is a sustained emphasis on patient-centred care, which we fully support There is frequent reference to rehabilitation plans and the rehabilitation prescription. There is concern that lip service is often paid to this with just a list given of interventions and referral. It might be helpful to include as an appendix an example of what such a document should include. Specialist rehabilitation and consultants in rehabilitation medicine play an important role in the holistic approach to assessing and managing patients with complex needs that include the complex interaction of physical cognitive, emotional and psychosocial factors. MDT working is mentioned in section 1.2 (Thank you!) but elsewhere the recommendations seem to default	Thank you for your comment. The committee did not want to create a template for a rehabilitation plan or prescription, as they believed it would be too prescriptive across the wide range of settings and injuries this guideline covers. They decided to leave the discussion on what to include to the expertise and experience of healthcare professionals and settings. However, they have included recommendations which detail what should be included within the document.

				to the physical aspects with emphasis on P/T and O/T..	
British Society of Rehabilitation Medicine	Guideline	General		Although there is frequent reference to the need to keep family members informed the guidelines do not address the rehabilitation needs of family members themselves who will also have been affected by the injury. This is especially important when the injured person has parental responsibility.	Thank you for your comment. We agree that rehabilitation after trauma can be a strain on the entire family unit, not just the individual with the injuries. As there is already NICE guidance on supporting carers with the physical and psychological demands of this role (see NG150 Supporting adult carers), this is beyond the scope of the current guideline. However, in the section entitled 'Principles for sharing information and involving family and carers' we have included a recommendation to advise carers on the support available to them and signposting to the relevant guidelines.
British Society of Rehabilitation Medicine	Guideline	General		We welcomed the inclusion of the Rehabilitation Complexity Scale, The Patient Categorisation Tool and the Complex Needs Checklist as recommended scales to assess patients for specialist rehabilitation needs but looked for the inclusion of other validated assessment and outcome scales for instance for PTA	Thank you for your comment. The committee was of the view that the scales suggested are on specific functioning outcomes leaning to traumatic brain injury/post traumatic amnesia, whereas the examples included were scales that are more generic. We did however add the line to the recommendation "Additional specific clinical assessments may be used as appropriate", to indicate that further

				assessment and physical and psychological functioning	assessment and outcome scales may also need to be utilised as appropriate.
British Society of Rehabilitation Medicine	Guideline	General		Greater emphasis could be given to the identification and management of patients a particular continuing risk after hospital admission with trauma. Recommendations on the management of patients with tracheostomy and those in need of spinal immobilisation would be examples of this. You mention on page 3 of the need for several AHP disciplines to work together in trauma rehabilitation but there is also often a need for several medical specialties, including Rehabilitation Medicine, to work together to secure recovery and avoid risks.	Thank you for your comment. We have made some changes to the context section to address your points. The section on the multidisciplinary team includes a range of examples concerning involvement of medical specialities including • surgeons, rehabilitation medicine specialists and intensive care specialists. Pharmacists have been added to the list of possible AHPs involved in the MDT. The sections on specific injuries such as spinal cord injury and limb loss also include more specific references to these specialities.
British Society of Rehabilitation Medicine	Guideline	General		We welcomed the recommendation to include all spinal cord injury patients into the national database but suggest including a section on central data reporting and data linkage, using the NHS number to track patients as they move along the care pathway. It is very useful for Major Trauma Centres and Trauma Units to hold a database of	Thank you for your comment. The committee agreed with your suggestion and have added a new recommendation to the coordination or rehabilitation care in hospital, which reads "Use a unique identifier, preferably the NHS number if this is known, when exchanging clinical information about the person's assessment, rehabilitation plan, onward referral, transition between services,

				trauma patients under their care and what happens to them.	discharge to community services, and all aspects of their care pathway."
British Society of Rehabilitation Medicine	Guideline	033 - 036		**Recommendation 1.8 – discharge planning and multi-disciplinary approach.** All of the points are well made, but again can be usefully incorporated and recorded in an RP. We suggest that recommendation 1.8.2 should say: *"Reassess the person's needs and review the rehabilitation plan and prescription before discharge to ensure that their needs are addressed and documented alongside any long-term, existing health conditions or disabilities."*	Thank you for your comment. The population covered in the guideline includes those with an injury severity score (ISS) under 9 as well as those currently defined within NHS England commissioning arrangements as suffering from major trauma (ISS>15) or moderately severe trauma (ISS>8). The committee wrote the guideline to cover all these groups and some of the terms used are explained in the 'terms used in this guideline' section. When the guideline uses the term rehabilitation plan it also means rehabilitation prescription for those entitled to one.
British Society of Rehabilitation Medicine	Guideline	022 - 024		**Recommendation 1.5. General principles for rehabilitation programmes** – This section outlines some of the key principles of rehabilitation including the importance of review of progress and outcomes and tailoring rehabilitation to the needs of the individual. We believe it would be appropriate to make a stronger recommendation for a formal consultant	Thank you for your comment. We have included follow up as part of the programme itself in the final bullet "include post-programme follow-up, in person or virtually", as well as recommending to reviews to assess progress, needs and document outcomes throughout the sections on assessment, rehabilitation planning and monitoring, as well as in the coordination of care sections. The

				and MDT clinic review to assess progress, needs, document outcomes and signpost to appropriate services. Currently follow up of this kind does not occur in trauma and is confined to follow-up following ABI, stroke, critical care and spinal cord injury. There is no reason to think this would not also be appropriate for patients with complex rehabilitation needs following trauma. This is a section in which the impact of disabling trauma on other family members could be specifically mentioned	committee did not want to make a single specific recommendation for a formal consultant and MDT clinic review to assess progress because it did not agree all follow up needed to be done in this way.
British Society of Rehabilitation Medicine	Guideline	025 -026		**Recommendation 1.5. Guided self-management**– We strongly support the principle of guided self-management for those patients who are able, and this encourages empowerment and autonomy. However, patients often require support and advice to guide them through the maze and assist them when they have difficulty accessing the services they need. Reviews may be managed either virtually or face to face by the relevant members of the MDT, but should include access to advice	Thank you for your comment. We are unable to specifically recommend access to a consultant in rehabilitation medicine for people undertaking guided self-management rehabilitation. Not all settings will have regular access to a rehabilitation medicine consultant, resulting in a large resource impact when trying to implement the guideline. However, the recommendations in the 'Rehabilitation skills, knowledge and expertise in the workforce' section stress the importance of healthcare professionals having

				from a consultant in RM, especially when funding barriers are identified, as negotiating referrals and funding that is not otherwise immediately available is one of the key skills of an RM physician.	appropriate skills, as well as access to training and peer support.
British Society of Rehabilitation Medicine	Guideline	031 - 032		**Recommendation 1.7.6-9 – when transferring between services.** Once again the rehabilitation prescription is a person-centred patient held tool that can support not only the sharing of information as patients transfer between services, but (if centrally recorded) represents an audit tool to ensure that patients and information do not get lost as they move between services	Thank you for your comment. The population covered in the guideline includes those with an injury severity score (ISS) under 9 as well as those currently defined within NHS England commissioning arrangements as suffering from major trauma (ISS>15) or moderately severe trauma (ISS>8). The committee wrote the guideline to cover all these groups and some of the terms used are explained in the 'terms used in this guideline' section. When the guideline uses the term rehabilitation plan it also means rehabilitation prescription for those entitled to one.
British Society of Rehabilitation Medicine	Guideline	064 - 065		**Recommendation 1.15 - Rehabilitation after spinal cord injury.** This section fails to acknowledge that about a third of patients presenting with SCI are managed in the Level 1 and 2 specialist	Thank you for your comment. This section starts with a clear statement that "These recommendations focus on the rehabilitation and supportive needs of people with spinal cord injury who are not currently in a regional specialist spinal

				rehabilitation centres, where rehabilitation is shown to be both effective and cost effective. This is a significant omission, please see the following recent study https://pubmed.ncbi.nlm.nih.gov/34282991/ That study expands on the existing evidence base for the effectiveness and cost-efficiency of SCI in https://bmjopen.bmj.com/content/6/2/e010238	cord injury centre. See also the NICE guideline on spinal injury: assessment and initial management."
British Society of Rehabilitation Medicine	Guideline	007	015 - 017	**Recommendation 1.1.2** – We are pleased to see the recommendation for a consultant in rehabilitation, but suggest change wording to *"involving rehabilitation specialists, including a consultant in rehabilitation medicine, alongside acute care teams etc…"* RM consultants are part of NHSE national service contract for major trauma and, working with trauma MDT, they provide the necessary expertise to address complex rehabilitation needs and assist with the development of the Rehabilitation Prescription which should	Thank you for your comment. We made it more explicit in the guideline that we are looking at a much wider cohort, not only very severe or major trauma with ICCS score >8 (see the Context section). In people with less severe trauma, rehabilitation specialists will not be generally involved. Also, paediatric cases will not have access to rehabilitation specialists because they do not exist for this population. We also have a full section (1.4) on a rehabilitation plan.

				be started within 48 hours of admission for patients with ISS scores >8.	
British Society of Rehabilitation Medicine	Guideline	008	013 - 017	**Recommendation 1.1.6** – Once again this section is restricted to physical impairment involving PT and OT only. It would better read '..assess how the person's *physical, cognitive and emotional impairments* might affect their ability to engage.. etc' The recommendation should not just be for OT but for a holistic MDT approach, with coordinated input from all the relevant rehabilitation disciplines (eg P/T, O/T SLT, Psychology, Dietetics, Social work, Rehabilitation Medicine etc). There is strong evidence for this coordinated MDT approach in other areas, including acquired brain Injury, stroke, spinal cord injury, progressive neurological conditions – so it is hard to see why would this not apply to complex trauma.	Thank you for your suggestion. We added a new recommendation to this section, i.e. "As soon as possible after traumatic injury start to assess whether the person has emotional, cognitive, hearing, visual or communication impairments that might affect their ability to engage in rehabilitation and in activities of daily living. Involve OT, psychology and SLT as appropriate."
British Society of Rehabilitation Medicine	Guideline	008	002 - 003	**Recommendation 1.1.4** – *"*Avoid delays in acute treatment so that rehabilitation can start as soon as possible, for example, *to maintain movement".*	Thank you for your comment. The first section about 'initial assessment" includes a number of recommendations about whether taking a holistic approach to assessment or specifically about

				We recommend rewording to *'so that rehabilitation can start as soon as possible to minimise complications of disability and optimise physical, cognitive and emotional recovery'*	emotional and psychological needs. Some examples of these recommendations are: 1.1.1, 1.1.3, 1.1.7. The specific recommendation you refer to here is about avoiding delays to surgery for example, to enable rehabilitation to begin as early as possible.
British Society of Rehabilitation Medicine	Guideline	009	013 - 014	**Recommendation 1.2:** We very much welcome this section on MDT team rehabilitation needs assessment, including physical, cognitive and psychosocial aspects, and of context such as the patient's environment and family / social support network. Within Rehabilitation Medicine (RM) we are using the term Biopsychosocial Assessment to describe this approach which might be considered for this guideline.	Thank you for your comment. The committee discussed the term 'Biopsychosocial assessment'. They thought this was not common terminology outside rehabilitation medicine professionals and that including it in the guideline might confuse professionals outside of this discipline, as well as people undergoing rehabilitation after traumatic injury. Therefore, no change has been made.
British Society of Rehabilitation Medicine	Guideline	010	015 - 018	**Recommendation 1.2.3:** We support the need to think about brain injury and refer patients for specialist assessment if TBI is a possibility. The guidance should be stronger on this, refer to the NICE guidelines on TBI management and recommend checking retrograde and posttraumatic amnesia, GCS	Thank you for your comment. Specialist assessment and specific rehabilitation interventions for traumatic brain injury are not covered by this guideline but will be covered by a new NICE guideline about Rehabilitation for chronic neurological disorders including traumatic brain injury. We have made a number of additions to

				assessments, circumstances of the injury and clinical evidence of cranial trauma. It is important to emphasise that patients with a normal CT Scan of head may still have sustained a significant brain injury.	the guideline including changes to recommendation 1.2.3 which now reads "Always think about the mechanism of injury and whether the person may have had a head injury. Be aware that the symptoms of traumatic brain injury can be subtle and regular screening may be necessary. If there are clinical symptoms, refer the person for a specialist assessment with healthcare professionals with expertise in traumatic brain injury rehabilitation. See also the NICE guideline on head injury.". We have also added information at the start of the cognitive assessment section to explain more clearly that assessment of traumatic brain injury is not covered in that section.
British Society of Rehabilitation Medicine	Guideline	011	025 029	Suggest including spirituality and religious practice Suggest including their aspirations and priorities, what are their core values? **Recommendation 1.2.5:** Should also address critical risks eg falls, aspiration, Autonomic Dysreflexia, Paroxysmal Sympathetic Hyperactivity, contracture	Thank you for your suggestions. We have included priorities and core values, and also spirituality and religion in relevant recommendations. In relation to the last suggestion, for most people, these key clinical issues would be addressed in ICU/acute stages, which is beyond the scope of this guideline. The aim of this recommendation is to make sure that

					people are able to engage rather than assessing clinical issues.
British Society of Rehabilitation Medicine	Guideline	012	002 - 007	**Recommendation 1.2.8:** – We strongly support the recommendation for regular MDT team meetings to ensure efficient coordinated care. Liaison with medical specialties, around the patient, will inform those involved with their rehabilitation of not only relevant pre-existing conditions but also new medical risks or instability that may affect their rehabilitation. Discussing plans for more complex cases together with nursing and medical teams, and ideally a specialist RM consultant, is helpful in determining prognosis, rehabilitation approaches and future care and can significantly reduce duplication and improve efficiency.	Thank you for your comment.
British Society of Rehabilitation Medicine	Guideline	014 015 016	013 027 012 - 014	Should include assessing tone as well as range of movement **Recommendation 1.2.13** There should also be access to specialist nursing expertise in the fitting and use of Miami-J collars and other forms of spinal immobilization	Thank you for your comment. We have responded to each of your suggestions below. • The committee discussed your suggestion to assess tone as well as range of movement. They agreed that this is adequately covered by the comprehensive neuromusculoskeletal

		017 018		Patients may also experience cognitive difficulty because of fatigue and pain as well as the psychological impact of the trauma. It would seem important to include measures to improve sleeping in hospital here **Recommendation 1.2.18** Please refer to validated assessments of Post Traumatic Amnesia/Confusion eg Westmead, Galverston, O-Log **Recommendation 12.20** Include consideration of family and work responsibilities **Recommendation 1.3: Setting rehabilitation goals.** We strongly support the mention of goal setting as this is the cornerstone of rehabilitation. However, the recommendation should emphasise that goals should *person-centred* and framed around the patient's own priorities, but also need to be realistic and achievable. Although the recommendation says they would be 'reviewed' this is ambiguous. It is vital that these goals are followed through and the achievement (or	assessment noted in the recommendation. • In the absence of evidence, these recommendations are too specific to recommend as part of the rehabilitation needs assessment. • The committee did not recommend any specific scales as this recommendation can be performed by several members of the multidisciplinary team as part of a basic screen for cognitive functioning. The bullet points included in this recommendation include elements of validated cognitive assessment tools, but do not require training to implement. This means more healthcare staff will be able to implement the screening. • The committee disagreed that family and work responsibilities are psychological risk factors. Home environment may be, but this is covered in any experience of interpersonal violence or social factors requiring additional support. • Realistic and achievable goals are covered by the following bullet points in the same recommendation: 'a strengths-based approach, which builds on positive function and ability' and 'an understanding

				otherwise) of these goals is monitored and documented. Although it may be difficult to carry out in a trauma setting Goal attainment scaling (GAS) provides a useful framework for provides a useful framework for setting goals and monitoring their achievement.	that there may be setbacks as well as gains, so goals should be flexible'. Additional support can also be found in the next recommendation, which recommends agreeing small steps towards long-term rehabilitation goals to monitor and motivate people undergoing rehabilitation.
British Society of Rehabilitation Medicine	Guideline	019	007 - 011	**Recommendation 1.4.1:** We strongly support the recommendation for developing a rehabilitation plan centred on the person's individual rehabilitation goals. However the recommendation for use of a rehabilitation should be strengthened so that the recommendation reads *"Use the rehabilitation needs assessment (see the section on multidisciplinary team rehabilitation needs assessment) and the person's rehabilitation goals (see the section on setting rehabilitation goals) to develop a rehabilitation plan for the person supported by a rehabilitation prescription (RP)".* The RP a person-centred, patient-held tool that is mandated in the major trauma centres and NCASRI audit provides proof of principle that the RP	Thank you for your comment. The population covered in the guideline includes those with an injury severity score (ISS) under 9 as well as those currently defined within NHS England commissioning arrangements as suffering from major trauma (ISS>15) or moderately severe trauma (ISS>8). The committee wrote the guideline to cover all these groups and some of the terms used are explained in the 'terms used in this guideline' section. When the guideline uses the term rehabilitation plan it also means rehabilitation prescription for those entitled to one.

				is not only an effective way of documenting a rehabilitation plan – it also supports tracking of individuals down the care pathway and clinical audit to determine whether the person received the rehabilitation they required, as well as the outcomes that resulted from it. https://www.kcl.ac.uk/cicelysaunders/about/rehabilitation/nhs-audit-report-v9-rgb.pdf The rehabilitation plan should also consider important risk and legal issues such as returning to swimming or driving if at risk of seizures, advice on alcohol or drug use and measures to prevent loss of employment or educational opportunity.	
British Society of Rehabilitation Medicine	Guideline	27	003 - 008	**Recommendation 1.5.10 – monitoring progress against goals:** As noted above, Goal Attainment Scaling (GAS) is an effective tool for goal management training to support self-management, and also an important person-centred outcome that includes both patient and clinician report	Thank you for your comment. The committee preferred to use descriptive terms which they thought would be more helpful for the patient and professionals involved. The tools included were just examples

British Society of Rehabilitation Medicine	Guideline	030	010 - 013	**Recommendation 1.7.3** Reflecting point 12 above, we suggest adjustment of this wording to ***"****The trauma team should agree the core members of the rehabilitation multidisciplinary team who will establish an injury management plan and start developing a rehabilitation plan, goals and rehabilitation prescription. See recommendation 1.2.4 for details of the multidisciplinary team after hospital admission and recommendation 1.4.1"*	Thank you for your comment. Due to the differences in terminology throughout rehabilitation healthcare, the committee decided to use the term 'rehabilitation plan' throughout the guideline to describe a general patient-held document which assists communication when people transfer. This is further defined in the glossary, which notes rehabilitation prescription as a possible format for this document. Therefore, no change has been made. The population covered in the guideline includes those with an injury severity score (ISS) under 9 as well as those currently defined within NHS England commissioning arrangements as suffering from major trauma (ISS>15) or moderately severe trauma (ISS>8). The committee wrote the guideline to cover all these groups and some of the terms used are explained in the 'terms used in this guideline' section. When the guideline uses the term rehabilitation plan it also means rehabilitation prescription for those entitled to one.

British Society of Rehabilitation Medicine	Guideline	034	014 - 015	**Recommendation 1.8.11** Follow up clinic attendance could ensure that rehabilitation recommendations are carried out	Thank you for your comment. We have included references to follow up in the sections on 1.4 developing a rehabilitation plan and making referrals, 1.5 guided self-managed rehabilitation, 1.7 planning for rehabilitation and support following discharge and 1.10 commissioning and organisation of rehabilitation services.
British Society of Rehabilitation Medicine	Guideline	035	019 - 025	**Recommendation 1.8.15** – This section would benefit from a clearer statement recommending NHS vocational rehabilitation resources to be available with urgent referral if someone is at risk of losing employment. There is evidence of this being effective in enabling work retention after mild TBI. Where work re-entry is likely to be difficult seek support from a consultant in RM and a community rehabilitation team.	Thank you for your suggestion. The committee was of the view that making a suggested change would mean that everyone will be referred to employment services, whereas in practice, only a small sub-group of people will require such services. Also, making a suggested change would result in a substantial resource impact, which the committee thought was not justified.
British Society of Rehabilitation Medicine	Guideline	035	003 - 006	**Recommendation 1.8.14 –** We recommend re-wording as follows: *"Document in the rehabilitation plan, prescription and handover report how rehabilitation after discharge will be delivered"*	Thank you for your comment. Due to the differences in terminology throughout rehabilitation healthcare, the committee decided to use the term 'rehabilitation plan' throughout the guideline to describe a general patient-held document which assists communication when people

					transfer. This is further defined in the glossary, which notes rehabilitation prescription as a possible format for this document. Therefore, no change has been made. The population covered in the guideline includes those with an injury severity score (ISS) under 9 as well as those currently defined within NHS England commissioning arrangements as suffering from major trauma (ISS>15) or moderately severe trauma (ISS>8). The committee wrote the guideline to cover all these groups and some of the terms used are explained in the 'terms used in this guideline' section. When the guideline uses the term rehabilitation plan it also means rehabilitation prescription for those entitled to one.
British Society of Rehabilitation Medicine	Guideline	039	001 - 028	**Recommendation 1.9.2** – This section describes a vocational rehabilitation resource for trauma patients. It would be clearer to recommend that vocational rehabilitation is an important element of the MDT rehabilitation programme and specialist advice should be available within the treating	Thank you for your comment. There is a focus on rehabilitation for returning to education, work and leisure throughout the guideline, from the assessment sections, through to goal setting, agreeing a plan and designing and delivering programmes. The roles you mention are both already included in the MDT recommendation in

				rehabilitation team (e.g. consultant in RM and vocational OT) to offer support to this population, many of whom are of working age.	section 1.2 about the MDT. It is not possible to recommend that these resources are allocated for everyone at every stage of the pathway and community services are too varied for the committee to be any more prescriptive about this.
British Society of Rehabilitation Medicine	Guideline	042		**Recommendation 1.10.5** – We welcome the section on commissioning and setting out responsibility for commissioning of rehabilitation services and commissioning across the whole care pathway.	Thank you for your comment.
British Society of Rehabilitation Medicine	Guideline	045	001 - 022	**Recommendation 1.11** – This section is back to being uni-disciplinary and lacks an MDT introductory section along the lines of the importance of a multidisciplinary review involving medical, therapy, nursing and psychological review to agree appropriate interventions to support patient centred goals etc as outlined above	Thank you for your comment. We disagree with your comment that this section is uni-disciplinary. Due to the breadth of the guideline, the committee decided to separate types of rehabilitation into different guideline sections (i.e. physical, psychological and cognitive), to avoid very long lists of recommendations and increase the ease of navigation throughout the document. Therefore, section 1.11 only deals with physical rehabilitation as part of this overall design. However, it does include referrals to other sections of the guideline as appropriate.

					Regarding your suggestion of a multi-disciplinary team introductory section, the committee think this has been adequately covered at the beginning of the guideline. The 'Multidisciplinary team rehabilitation needs assessment' section goes into depth about what a multidisciplinary team in hospital might look like, how they should assess someone's rehabilitation needs and how to develop a holistic rehabilitation plan. Similarly, there are recommendations in the sections concerned with coordination of rehabilitation care that advise on how multidisciplinary teams should function after the assessment stage.
British Society of Rehabilitation Medicine	Guideline	053	007 - 009	**Recommendation 1.12.1** – *"Reassure people that most trauma-related problems with cognitive functioning are temporary."* This sentence is problematic. Whether cognitive dysfunction is temporary or not depends on a full review to establish undiagnosed traumatic brain injury or significant psychological dysfunction. The wording is loose and should be amended to say:	Thank you for your comment. As this guideline does not cover rehabilitation after traumatic brain injury, this recommendation only covers people without traumatic brain injury which reflects your suggested amended wording. However, the committee are aware that this exclusion is not always clear to the reader, which becomes especially important in the sections relating to cognitive functioning. Therefore, they have

				”Once occult brain injury has been excluded, patients can be reassured that most trauma-related problems with cognitive functioning are temporary”	included an introductory reminder for both the 'Assessing cognitive functioning' and 'Cognitive rehabilitation' sections which reads 'Please note this guideline does not cover assessment or specific rehabilitation interventions for people with traumatic brain injuries. See recommendation 1.2.3 in the section on multidisciplinary team rehabilitation needs assessment.'.
British Society of Rehabilitation Medicine	Guideline	054	014 - 016	**Recommendation 1.12.3** – Fluctuation in mental capacity is only usually observed early on after an injury. Specialist assessment should be obtained when cognition remains a problem from a Consultant in RM, a Neuropsychologist or a Consultant Neurologist	Thank you for your comment. Due to the resource impact of recommending rehabilitation medicine consultants or neurologists carry out further assessment. Not all cognitive problems will require this specialists review. Instead, they worded the recommendation to allow healthcare professionals to decide the most appropriate assessment and the most appropriate assessor.
British Society of Rehabilitation Medicine	Guideline	092	026 - 029	This would be better expressed as ‘ involving specialist rehabilitation as early as possible in the trauma pathway will ensure timely care with a reduction in secondary disability and will support optimal physical, cognitive and emotional recovery for patients	Thank you for your suggestion. This was slightly rephrased.

British Society of Rehabilitation Medicine	Guideline	098	001 - 006	While there are specific programmes for spinal injury, neurorehabilitation and amputee services, there are no such commissioned services for patients with complex polytrauma. Patients with polytrauma would benefit from an intensive inpatient rehab resource to address complex injury and maximise function reducing the burden on carers and community services.	Thank you for your comment. The committee hope that the recommendations made in 'Intensive rehabilitation programmes', combined with those in 'Commissioning' and 'Organisation', will support services with their development plans. Also, because rehabilitation services are already being carried out, intensive rehabilitation could be delivered through service redesign and repurposing of existing funds and resources rather than introducing them as completely new resources. Moreover, intensive rehabilitation would potentially represent value for money as per the economic model, and only a small group of people with the most severe injuries / complex polytrauma would be eligible for an intensive rehabilitation programme.
Day One Trauma Support	Equality Impact Assessment			It is well documented in a whole range of fields that a person's sense of agency, levels of patient activation, engagement with and even understanding of complex healthcare systems is significantly impacted by a variety of socio-economic factors. While it is perhaps implicit in a number of	Thank you for your comment. The committee disagrees with the assertion that the guideline does not consider the support needed to enable people to achieve their best possible outcomes based on needs and preference, regardless of background.

				recommendations (eg seeing the whole person and the importance of tailored care planning and support), there is little/ no explicit consideration of the support needed and should be in place to allow someone to achieve the best possible outcomes based on their needs and preferences, and regardless of their background. While the importance of supporting people who lacked mental capacity in decision making is welcome, as is the whole person approach and recognitions that may be a factor in patient outcomes, this omission is concerning as it is both critical to the value the voluntary sector can bring to Trauma networks and runs the risk patients will continue to achieve sub-optimal outcomes simply because they did not have access to or even an awareness of the support they could access outside of statutory provision to navigate the often complex, confusing and alienating system.	The guideline sets out a very clear pathway from hospital through to transition back into the community between sections 1.1 and 1.9. It sets out how to facilitate a smooth transition to the community through involvement of community rehabilitation providers (which might include third sector providers and peer support networks). It also talks about signposting and supporting people to get access to grants and other financial help, aid and equipment, benefits and help with access to work or education including adult education.
Day One Trauma Support	Equality Impact Assessment			Ensuring appropriate scaffolding is in place so all people can achieve the best possible outcomes, based on both	Thank you for your comment. The committee agrees with the important role of using lived experiences to drive

				patient experience as well as clinical outcomes, is critical to using their lived experience to inform and drive all developments and delivery across major trauma. The voluntary sector is uniquely placed to advocate and champion patient voice as has been demonstrated in many health and social care setting, especially those voices which are least likely to be heard without it, directly impacting on equality of outcomes and overall system efficacy.	rehabilitation commissioning, as well as the unique role the voluntary sector play in supporting the delivery of rehabilitation services. The guideline sets out a very clear pathway from hospital through to transition back into the community between sections 1.1 and 1.9. It sets out how to plan a smooth transition to the community through involvement of community rehabilitation providers, mentioning where third sector providers and peer support networks could be utilised effectively. The committee highlighted that patient circumstances and preferences should be central to this planning experience. It also talks about signposting and supporting people to get access to grants and other financial help, aid and equipment, benefits and help with access to work or education including adult education. Similarly, the section on 'Commissioning' includes recommendations on how to provide a whole-pathway rehabilitation service that is suitable to the local population needs. One such recommendation includes co-designing

					services in collaboration with the people who use rehabilitation services, which would include input from relevant voluntary organisations.
Day One Trauma Support	Guideline	002	018	We would also note the financial impact in addition to the physical and mental	Thank you for your comment. We have amended the section to include the financial impact of traumatic injury.
Day One Trauma Support	Guideline	007	017	Identifying appropriate support to help a person or their family through this process is also critical for its successful outcome, this may be a coordination/ navigation role, with real value if this comes from outside statutory provision and a vital role for the third sector in providing this.	Thank you for your comment. This section relates to immediate and initial assessment which would take place soon after injury in hospital. The committee recognises the important role the third sector play in rehabilitation in the community as well as when planning the transition from hospital to home based care and support. This is reflected in a number of recommendations in the coordination of rehabilitation care sections (1.7 to 1.9). When the guideline talks about rehabilitation services it is including within that any services with may be commissioned for delivering rehabilitations services, including voluntary and private sector providers. See section 1.10 on commissioning and organisation of rehabilitation services.

Day One Trauma Support	Guideline	007	021	Support organisations can also play an essential role here, eg picking up practical, financial, emotional needs on top of specialist psychology services	Thank you for your comment. This section relates to immediate and initial assessment which would take place soon after injury in hospital. The committee recognises the important role the third sector play in rehabilitation in the community as well as when planning the transition from hospital to home based care and support. This is reflected in a number of recommendations in the coordination of rehabilitation care sections (1.7 to 1.9). When the guideline talks about rehabilitation services it is including within that any services with may be commissioned for delivering rehabilitation services, including voluntary and private sector providers. See section 1.10 on commissioning and organisation of rehabilitation services.
Day One Trauma Support	Guideline	011	001	We have seen real value in west Yorkshire in including a voluntary sector caseworker in the MDT to ensure a holistic view on need, both when considering discharge and beforehand	Thank you for your comment. However, it is not common practice to involve voluntary sector caseworkers at this stage. We refer to voluntary sector practitioners in the discharge planning section.
Day One Trauma Support	Guideline	011	018	It is also helpful to consider potential needs after discharge as early as possible within this process to ensure	Thank you for your comment. This consideration is covered in the guideline section titled '1.8 Discharge planning and

				appropriate provision is in place (for example, access to benefits)	a multidisciplinary approach'. This section promotes early discharge planning and includes several specific recommendations regarding the important of providing support with benefits access and funded equipment application.
Day One Trauma Support	Guideline	011	019	Explicit consideration should also be given to the support needs of the family/ loved ones supporting the patient in order to allow them to provide ongoing support and care. We have seen first hand how voluntary sector provision in this area provides better self assessed patient outcomes and also less resourcing requirements within statutory provision and fewer downstream costs to the public sector	Thank you for your comment. We agree that rehabilitation after trauma can be a strain on the entire family unit, not just the individual with the injuries. We have made sure to include family and carers in discussions about treatment options, rehabilitation planning and support needs. We also have included a recommendation to advise carers on the support available to them and signpost to relevant guidelines in the section entitled 'Principles for sharing information and involving family and carers'.
Day One Trauma Support	Guideline	018	007	Appropriate support to ensure they are able to fully engage in this process is also helpful to ensure the best outcomes based on the needs and preferences of the patient	Thank you for your comment. Support, information and advice recommendations are woven in throughout the guideline. The fact that the assessment, goal setting and rehab planning process is designed to be individualised and person-centred means that it is a process that puts the person at the centre of the work. The committee did

					not think they needed to add more to these recommendations. Please also see the section 1.6 which is about supporting people and sharing information and involving people and their families in decision making.
Day One Trauma Support	Guideline	023	022	Identifying other community support services to help manage other needs and support rehabilitation post discharge is also a key element of successful ongoing support and self management	Thank you for your comment. These points are already covered in other sections of the guideline e.g. about planning for discharge and about supporting access and participation in education, work and community (adjustment and goal setting)".
Day One Trauma Support	Guideline	029	001	It is important to recognise that in order to capture a comprehensive and holistic view of need these conversations may take place in a variety of settings, some non- clinical, and with a variety of people. There has been significant work around Living With and Beyond Cancer to ensure all meaningful conversations are captured as part of the ongoing holistic needs assessment	Thank you for your comment. Throughout the document, we have recommended a multi-disciplinary approach to rehabilitation, with frequent communication both between professionals and between rehabilitation professionals and patients. This is captured in the rehabilitation plan, forming a holistic view of a person's needs and goals.
Day One Trauma Support	Guideline	032	022	Voluntary sector grants to support non-statutory provision	Thank you for your comment. We have added this.
Day One Trauma Support	Guideline	039	014	Identifying other support organisations at this point is also helpful, especially	Thank you for your comment. This topic was already covered in the earlier section

				when even an informal referral may help with engagement and uptake	on 1.8 coordination of rehabilitation care at discharge at other points in the guideline did not see it was necessary to repeat the point here
Day One Trauma Support	Guideline	041	003	The recognition of the role of the voluntary sector in a commissioning context is welcome here, especially as it directly addresses question three above on using existing practical resources to overcome any challenges, in this case financial where there are simply not enough resources to meet existing levels of need entirely within statutory provision and the voluntary sector can provide highly cost effective high quality provision within whole care pathways	Thank you for your comment.
Day One Trauma Support	Guideline	055	015	Timely low level psychological support can be provided by a number of agencies and initiatives (for example peer support programmes) and play a significant role in avoiding any deterioration in condition, allowing limited specialist support to focus where the need is greatest and their input will have the greatest impact	Thank you for your comment. We have made reference to the MDT role in emotional support in the very first section of the guideline about initial assessment. This is picked up throughout the guideline. The default position is that members of the MDT should all be offering emotional and psychological support and that they also have the skills to see when onward referral for more specialist psychological

					assessments are needed. The role of third sector organisations and peer support networks in emotional wellbeing and recovery are also highlighted in sections about discharge planning and adjustment in the community.
Day One Trauma Support	Guideline	055	015	Voluntary sector provision can also help address the gaps in psychological provision where there is either insufficient resources to meet the needs that are currently identified or waiting times for support will in themself have an impact on the severity of concerns and/or level of support needed to appropriately address them (for example we provide counselling to families affected by trauma who may not qualify for NHS provision allowing them to better continue in their role as carer for the patient).	Thank you for your comment. The role of third sector organisations and peer support networks in emotional wellbeing and recovery are also highlighted in sections about discharge planning and adjustment in the community. Their role in delivery of services is also recognised in the commissioning and organisation or rehabilitations services as well. See sections 1.7 to 1.10.
Day One Trauma Support	Guideline	078	014	The James Lind Alliance has identified the role and impact of peer support as a priority area for further research based on their Priority Setting Partnership on complex fractures which we believe is relevant to this and should be included.	Thank you for your comment. The committee agree that peer support is a valuable resource for people undergoing rehabilitation after traumatic injury. However, they wished to prioritise research recommendations in areas that they believed would expand the existing

					evidence base and allow them to either strengthen recommendations or make new ones. As some qualitative evidence was identified for peer support groups and it is not a contentious area of current practice, it did not meet this criteria. Therefore, no new research recommendation has been added.
Day One Trauma Support	Guideline	079	004	The explicit recognition of the role of the voluntary sector in supporting effective self management and its impact would be a welcome addition to this research area	Thank you for your comment. The committee wished to prioritise research recommendations in areas that they believed would expand the existing evidence base and allow them to make new recommendations. As they were able to make recommendations on self-managed rehabilitation, it did not meet this criteria. Therefore, no new research recommendation has been added.
Day One Trauma Support	Guideline	091	004	As noted previous we have seen the role of support organisations within this context can be critical and this is well documented in other areas (eg cancer care). Including this to further validate it's role with trauma rehabilitation is therefore highly relevant and ensure a fully person centred holistic view of care and support	Thank you for your comment. This comment is regarding the section 'Principles for sharing information and involving family and carers'. While the committee agree that the voluntary community can provide valuable support for people in many areas after traumatic injury, this section is purely focussed on communication between people after

					traumatic injury (plus family members and carers if appropriate) and rehabilitation professionals. However, there are other recommendations in the 'Guided self-managed rehabilitation' and 'Coordination of care in hospital - When transferring between services and settings' sections that recommend providing information on local support groups, online forums and national charities.
Day One Trauma Support	Guideline	093	029	The voluntary sector also has a role here, in providing advice, signposting to other services and support and potentially providing/ identifying funding where available	Thank you for your comment. This is covered in the recommendation that states 'Give people, and their family members or carers (as appropriate), information about services that provide independent legal, financial, employment and welfare advice.'. If there are appropriate charities that offer these services, it is implied that they would be included in this list.
Day One Trauma Support	Guideline	095	021	As noted earlier in the guidelines the ongoing impact of trauma can last for many years if not a lifetime. While a time limited provision of a single point of contact is sensible identifying how the withdrawal of this support transitions to other long term support, for example around supporting self-	Thank you for your comment. The limited time period suggested for the single point of contact if for when people first leave an inpatient setting. The committee wanted to include a time frame because it is important that rehabilitation care is moved from the hospital to the community, where it will be more appropriate to provide the

				management, is a key part of this discussion	majority of long term care. There are other recommendations in the 'A single point of contact, key contact and key worker after discharge' that recommend appointing a key contact/worker once a person has returned to the community. These do not have a time limit attached.
Defence Medical Rehabilitation Centre	Guideline	General	General	Transition from acute care setting to rehabilitation requires joint working from both areas to ensure acute care needs can be supported once transferred and should include moving and handling of the patient as well as equipment needs of the patient.	Thank you for your comment. The guideline includes a number of sections about effective transition planning and administration, including transition between in-patient settings and transition to the community. The committee did not think that the additions around moving and handling were needed, as these would already be skills of rehabilitation staff involved in the persons care and support. There were a number of references to equipment needs and ensuring that applications for funded support to help with equipment needs at home, at school or in the workplace were made in a timely manner.
Defence Medical Rehabilitation Centre	Guideline	General	general	Query use of the word “stump” where the more clinically correct phrase “residual limb” may be more appropriate	Thank you for your comment. We have changed any references to stump to 'residual limb'.

Defence Medical Rehabilitation Centre	Guideline	015 - 017	General	There needs to be an assessment of ADLs which assesses psychological, physical, social and cognitive performance at the same time as well as assessing individual areas.	Thank you for your comment. As with the individual rehabilitation sections, the guideline does not recommend that individual assessment sections should be performed individually. This is why they are part of the 'Multidisciplinary team rehabilitation needs assessment' section, which stresses that the assessment should be holistic. However, given the scope of the guideline, the committee decided that organising recommendations by rehabilitation type (where possible and appropriate) made it more accessible to readers who were concerned with a specific area. No evidence was identified regarding specific assessment tools for activities of daily living, and the committee therefore left the decision of which tool to use to the experience and expertise of the individual healthcare professionals.
Defence Medical Rehabilitation Centre	Guideline	002	017 - 021	Agree with the impact but would also like to add the social impact on an individual which includes ability to engage with others, legislation and impact on family and carers. All of which, if not supported impacts on	Thank you for your comment. We have amended the section to include the social impact of traumatic injury.

				recovery and rehabilitation of the individual.	
Defence Medical Rehabilitation Centre	guideline	003	003	Agree with point and would also like to add in relation to function; support with Activities of Daily Living which incorporates self-care, Leisure (from sport engagement to play) and Productivity (which includes work to being a parent).	Thank you for your comment. We believe that support with activities of daily living, leisure and productivity are all included in the phrase 'return to previous functional level'. Therefore, no change has been made.
Defence Medical Rehabilitation Centre	Guideline	005	004 - 006	Agree with types of rehabilitation and would like to include psychosocial rehab	Thank you for your comment. The bullet points referenced are hyperlinks to corresponding areas of the guideline to direct readers to appropriate sections. The wording used is identical to the section titles to reduce confusion, and therefore has not been changed.
Defence Medical Rehabilitation Centre	Guideline	010	001 - 005	Agree these types of assessment but also assessment of ADLs to see how the biopsychosocial components work together.	Thank you for your comment. The list of assessments your comment refers to are included as signposting to subsequent guideline sections, in order to make the document more reader friendly. It is not meant to be a complete list of type of assessment. Therefore, no amendment has been made. However, assessment of ADLs is covered in 'Assessing physical functioning'.

Defence Medical Rehabilitation Centre	Guideline	010	027	In the military environment we also have access to Exercise Rehabilitation Instructors whose role is invaluable in rehabilitation. They assess, design and implement progressive treatment programmes for patients utilising a variety of sport and exercise methods either in group or one to one. – This asset would be utilised in the wider healthcare community.	Thank you for your comment. The committee are aware of the good practice with regards rehabilitation in the military. The committee were unable to recommend the creation of particular new roles like this due to the resource impact on the NHS and the lack of economic evidence. However the committee utilised an expert witness from the military to help inform recommendations about the timing, intensity and design of rehabilitation programmes
Defence Medical Rehabilitation Centre	Guideline	017	015	Agree with comment but feel it would be better placed in a social functioning section as doesn't fit within psychological and could include other relationships and impact on culture etc	Thank you for your comment. The committee placed the recommendation in this section in order to stress that these factors should be identified early in the rehabilitation process in order to note additional support to maximise engagement.
Defence Medical Rehabilitation Centre	Guideline	022	007	Agree would like to re-word outcomes to functional outcomes and include self-care activities. These are often the starting point a patient's goal setting following a TI.	Thank you for your comment. The committee chose the included outcome examples based on their experience, as these tend to be what people want to achieve after traumatic injury. We have added the line 'to promote self care' to the third bullet, and included a link to the section 'Setting Rehabilitation Goals'

					which includes a recommendation on smaller, motivational goals.
Defence Medical Rehabilitation Centre	Guideline	023	002	Comma between exercise and occupational therapy.	Thank you for your comment. This was a typo and was meant to read 'exercise, occupational therapist'. We have amended the text as such.
Defence Medical Rehabilitation Centre	Guideline	023	014	Agree and could expand on the benefits of using groups as peer support	Thank you for your comment. Reference to the value of 'peer support services' was included in the section on "guided self-managed rehabilitation' which is already referenced in this bullet point.
Defence Medical Rehabilitation Centre	Guideline	025	001 - 002	Agree and the challenge will be having access to these services onsite so psychological and emotional wellbeing interventions can be delivered alongside physical rehabilitation.	Thank you for your comment.
Defence Medical Rehabilitation Centre	Guideline	025	015 - 016	Activities of daily living includes work, social activities and hobbies as well as self-care so you could merge these 2 sentences	Thank you for your comment. The committee was thinking more of home based daily livings tasks such as feeding oneself, bathing, dressing, grooming, personal care etc. and wanted to include work, leisure etc. as broader headings separately.
Defence Medical Rehabilitation Centre	Guideline	025	013	bullet point on ‘energy conservation and pacing’: Would be helpful for it to also mention the term fatigue management	Thank you for your comment. The committee discussed the term 'fatigue management' but agreed that this did not add any extra meaning that was not there

					in the original recommendation wording. Therefore, no change has been made.
Defence Medical Rehabilitation Centre	Guideline	034	014	Agree and would add use of third sector agencies such as charities, support groups etc	Thank you for your comment. The use of voluntary sector after discharge is covered in a subsequent recommendation that states 'Liaise with community teams (such as community and voluntary sector providers, physiotherapists and occupational therapists, education support, and special educational needs coordinators in schools and nurseries for children and young people) to agree a staged return to the workplace or education.'.
Defence Medical Rehabilitation Centre	Guideline	035	019	Agree and would add Sports Rehabilitator in list of professions.	Thank you for your comment. The roles included were just examples and not designed to be comprehensive. The committee did not want to add any further examples.
Defence Medical Rehabilitation Centre	Guideline	038	General	Vocational section: Should state: consider referral to a Vocational Occupational Therapist for support with return to work or finding alternative employment accommodating their functional abilities. Also consider their local Job Centre as a source of	Thank you for your comment. The committee was of a view that not every service has vocational occupational therapists and that this would represent a change in practice and result in a resource impact. In their view, this was not justified without supporting effectiveness evidence. We also referenced the related NICE

				information on benefits and support for returning to work	guidance on workplace health: long-term sickness absence and capability to work, which includes guidance on issues you raise. We made the suggested addition related to job centres as a source of advice on disability employment and access to work schemes, to acknowledge that job centres have already trained disability advisors and access to work funds from Department for Work and Pensions.
Defence Medical Rehabilitation Centre	Guideline	038	009 - 010	change wording of bullet point: the support they think they will need by asking about their views, difficulties anticipated and levels of function.	Thank you for your comment. This recommendation is more about getting to know the person and their views and feelings rather than these more functional assessment focused questions, which are covered in detail elsewhere.
Defence Medical Rehabilitation Centre	Guideline	039	015 - 016	add in physical and cognitive recovery too when reviewing rehabilitation goals.	Thank you for your comment. Rehabilitation goals are already defined in the guideline as including those things. We have included a link here to the earlier section on rehabilitation goals to make this clearer.
Defence Medical Rehabilitation Centre	Guideline	039	011	Agree and would like to include vocational rehabilitation plus liaison with Occupational Health. Also could	Thank you for your comment. We have already included voluntary work in 1.9.4. The committee didn't think it was

				include volunteering if unable to return to paid employment.	necessary to include any more specific examples.
Defence Medical Rehabilitation Centre	Guideline	044	006 onwards	Agree and might be useful to add in other professions to this list such as Physiotherapists and Occupational Therapists	Thank you for your comment. This list is not exhaustive and the committee did not want to add any more examples.
Defence Medical Rehabilitation Centre	Guideline	045	General	For all rehab a consideration is needed to not over tire the the patient and where appropriate treatment sessions should be delivered jointly across professional groups, to reduce this risk and ensure collaborative working across the team.	Thank you for your comment. The committee agree that rehabilitation should not overtire people, and have a recommendation in the section 'General principles for rehabilitation programmes' that advises that the time, frequency, intensity and duration of rehabilitation programmes be designed to have the most beneficial effect on the person's recovery. The committee have also stressed the importance of a multidisciplinary approach in successful rehabilitation after traumatic injury throughout the guideline with recommendations on multidisciplinary team assessments, holistic rehabilitation plans and communication between settings, as well as frequent recommendations to either refer to or seek advice from other professionals.

Defence Medical Rehabilitation Centre	Guideline	045	General	It states under Physical rehabilitation early interventions and principles – 'Provide individualised exercises as soon as possible after a traumatic injury to maintain and improve muscle function, strength and range of movement'. However after this point physical rehabilitation starts with 'Early weight bearing (WB) exercises' Non-weight bearing exercises can be given in the earlier stages so therefore it is felt these should be mentioned and points listed under this title before Early WB. This meets the statement of providing exercises as soon as possible for all patients needs and abilities.	Thank you for your comment. As with physical, cognitive and psychological assessment and rehabilitation sections, the sub-headings in 'Physical rehabilitation' are not organised in any particular order and should be considered as part of a whole rehabilitation programme. There is a recommendation in the 'Aerobic and strengthening exercises' that covers your concerns and reads 'For people with limited lower limb mobility or immobility after a traumatic injury, consider a programme of upper body aerobic training or seated exercises.'. Therefore, no changes have been made.
Defence Medical Rehabilitation Centre	Guideline	045	003	Agree could also add exercises/ activities. This reflects the options of engaging in activities that are meaningful to the individual to maintain and improve muscle function, strength and range of movement.	Thank you for your comment. While the committee agree that including activities meaningful to the individual could increase engagement in this early stage of rehabilitation, 'exercises' is the terminology used in the rest of the section. In order to be consistent, the committee decided not to make this addition. However, they commented that this personalised approach to rehabilitation is a central

					theme of the guideline and should apply to all recommendations where possible.
Defence Medical Rehabilitation Centre	Guideline	049	General	Splinting and Orthotics: add in consideration when sensory impairments could limit the person's ability to tolerate, or be self-caring. – Lack of sensation could reduce effective management/monitoring and lead to a breakdown in skin integrity. Therefore, if any sensation impairments are present careful consideration for use, type of device chosen and close monitoring should be considered.	Thank you for your suggestion. This is already covered in other sections, e.g. assessment, nerve injuries, spinal cord injuries, splinting and orthotics.
Defence Medical Rehabilitation Centre	Guideline	051	General	Scar: Therapists should consider providing prescribed scar management programmes when appropriate to help prevent and manage potential complications such as tethering, keloid/hypertrophic scars.	Thank you for your comment. The committee discussed that, due to the complexity of scar management and treatment, general rehabilitation services often do not have the expertise or equipment to manage and treat people with problematic scars (for example, hypertrophic scars or contracture across the joint). They therefore recommended that these cases should be referred for further specialist advice and treatment, rather than rehabilitation professionals trying to prove a scar management programme themselves.

Defence Medical Rehabilitation Centre	Guideline	053	General	Cognitive rehab: We think there should be a point on providing education and introduction of strategies to help manage deficits.	Thank you for your comment. This guideline does not cover traumatic brain injury, which is when most long-term deficits will occur. Rehabilitation for this (including education and strategies to manage decreased cognitive functioning) will be covered in an upcoming NICE guideline on rehabilitation for chronic neurological disorders.
Defence Medical Rehabilitation Centre	Guideline	055	General	Agree and can we strengthen the message that this process of adjustment is normal. Also education on adjustment for patients should be considered. Peer support for both patient and family members is also a proven useful tool.	Thank you for your comment. We have included reference to adjustment being a normal part of the process in various places within the guideline. There is also a guideline section about “1.9 Supporting access and participation in education, work and community (adjustment and goal settings)"
Defence Medical Rehabilitation Centre	Guideline	060	001 - 007	The words residual limb and stump are used interchangeably, query if “stump” is still an acceptable clinical term or if the phrase “residual limb” is more clinically correct.	Thank you for your comment. After discussion with the committee, we have changed 'stump' to 'residual limb' throughout the guideline.
Defence Medical Rehabilitation Centre	Guideline	060	008	Agree and add strengthening to the following sentence ‘Maintain and improve range or movement and strength after limb loss or amputation’. Although the title mentions strength it is	Thank you for your comment. We have made this change.

				not mentioned in the information below it.	
Defence Medical Rehabilitation Centre	Guideline	061	007 - 012	Agree and please can assessment for wheelchairs, seating and pressure care be included. This should involve taking appropriate measurements, pressure score and functional assessment as well as taking into account activities of daily living requirements and home/ work/ school environment. To ensure correct provision.	Thank you for your comment. The recommendation referenced is about the timing of wheelchair provision (as soon as possible). The specific assessment details noted in your comment would be left up to the expertise of the wheelchair service. Therefore, no change has been made.
Defence Medical Rehabilitation Centre	Guideline	062	general	Agree and would add Psychological support can be provide be provided by a range of mental health practitioners and better recovery if psychological support is delivered multidisciplinary.	Thank you for your comment. No changes have been made to the recommendations because they do not include information on who should deliver psychological support. The only recommendation that specifies a certain mental healthcare professional is simply recommending that the multidisciplinary team has access to a practitioner psychologist. Additionally, the importance of multidisciplinary teams is stressed throughout the guideline and does not need to be repeated here.
Defence Medical Rehabilitation Centre	Guideline	072	025	The importance of this support being embedded within the IDT for this group of patients provides better outcomes.; a challenge maybe that this level of	Thank you for your comment. The committee recommended that everybody has a rehabilitation plan that details a programme of rehabilitation therapy in one

				support is often delivered separately within the NHS.	place (see sections 1.4 developing a rehabilitation plan and making referrals and 1.5 Rehabilitation programmes of therapies and treatments)
Defence Medical Rehabilitation Centre	Guideline	078	008	Agree traditionally delivered by Occupational therapists and should include liaison with school and current/ future employer as well as identifying work-based placements as appropriate.	Thank you for your comment. No changes have been made to the definition of vocational therapy as the committee felt as though the roles mentioned in your comment are covered by 'return to or stay in work, education or training. This may involve adapting working conditions, job roles or retraining'. Occupational therapy was not mentioned as the committee did not want to specify which rehabilitation professional should perform the job, to prevent resource implications for smaller settings.
Defence Medical Rehabilitation Centre	Guideline	094	General	Agree and where possible create patient accommodation that can be staged based on dependency from wards to areas where patients can live independently whilst continuing their rehab.	Thank you for your comment. Due to the resource implications, we cannot recommend for settings to create new accommodations for rehabilitation patients without strong effectiveness and economic evidence. However, we have recommended arranging overnight or weekend visits home for people to gradually decrease the level of care they are receiving. Additionally, the committee

					have made a new recommendation centred around promoting independence in activities of daily living for people after trauma in settings where healthcare professionals may be doing many everyday tasks for them.
HCML	Guideline	N/A	N/A	Psychological profiling to identify and avoid triggers to disengagement (not the same as simply involving practitioner psychologists, or ACT therapists) is not considered or commented on within the draft guideline	Thank you for your comment. The guideline was unable to go into further depth about psychological profiling as this was too specific an area to cover in such a broad scope. The assessment is also focusing on the early stages of rehabilitation and the triggers will not necessarily be known at this early stage.
HCML	Guideline	N/A	N/A	There is no mention of the use of or potential benefit of Virtual Reality and other assistive technologies in helping those with phantom limb pains, psychological adjustment difficulties following amputation, functional restoration etc. Whilst in its infancy, these approaches are already available, and becoming more widely used owing to relative low cost, and portability.	Thank you for your comment. The committee did consider the use of assistive technologies. Unfortunately, no evidence was identified to support either the effectiveness or cost effectiveness of these interventions. Due to the fact that these techniques are not current practice in all settings, and the cost implications of implementing a recommendation in this area, the committee agreed to not make any. Further details of the committee's discussion of the evidence around

					assistive devices can be found in evidence report B1 and C1-C3.
HCML	Guideline	003	023	The costs extend significantly beyond the NHS, in particular to insurers, and to all parties where there is uncertainty over liability (if any) and where there is a disagreement between different funding parties (social, NHS and private).	Thank you for your comment. We agree that trauma is associated with costs beyond the NHS. However, for NICE clinical guidelines, the NHS and Personal and Social Services perspective is a standard. Also, NICE does not have a remit to make recommendations on funding decisions.
HCML	Guideline	008	010	Psychological preparedness should also be included here	Thank you for your comment. Psychological preparedness is covered in the preceding recommendation, which reads 'After a traumatic injury:...Start rehabilitation when the person is ready and able to engage and participate.'. Therefore, no amendment has been made.
HCML	Guideline	011	001	Or a Rehabilitation Case Manager (a role in the insured space that works alongside NHS provision, similar to a Rehabilitation Coordinator).	Thank you for your comment. The hospital based MDT includes the roles of trauma coordinator and rehabilitation coordinator because these are roles that commonly coordinate care in the early parts of the pathway. Both of these roles are defined in the 'terms used in the guideline' section. The guideline also goes on to talk about the role of the key worker, a role that is

					particularly important for people undertaking longer term rehabilitation and with ongoing care needs. Again this term is defined in the glossary as including the role of caseworker within it. The definition says: "This role may also be performed by case managers or case coordinators, who would coordinate care as well as liaise with insurers and legal teams, particularly following discharge"
HCML	Guideline	012	020	I could not see why you have excluded the AIS or MAIS3+ scales	Thank you for your comment. The scales included were example generic scales. The committee did not think further examples were necessary.
HCML	Guideline	014	003	It is unclear why a physiotherapist is specifically singled out here, there are other disciplines that can undertake this work, and extended scope OTs, physios, and sports and rehab therapists (non-exclusive) can all contribute. We are unable to identify why a Physiotherapist was singled out within the MDT. Better to use the term ‘allied healthcare professional’ if you wish to draw attention to the need.	Thank you for your comment. We have amended the recommendation stem to read 'As part of the rehabilitation needs assessment after a traumatic injury, the multidisciplinary team with appropriate skills and competencies, should assess the person’s pre-injury and current physical functioning, which should include:...'.
HCML	Guideline	014	024	No mention of other functions, such as continence, safe transfers.	Thank you for your comment. We have added '• assessing ability to do transfers,

					for example, to move from lying to sitting, and sitting to standing' as suggested. The committee discussed including continence as described, but agreed it was only a priority consideration in children and young people and was adequately covered in the existing recommendation '• for children and young people, asking about previous developmental attainment and functioning'.
HCML	Guideline	023	007	There is no mention of vocational rehabilitation	Thank you for your comment. The list of links in this recommendation reflects the sections within the guideline, which in turn is a reflection of the evidence reviews that were undertaken. Vocational rehabilitation is referred to throughout the guideline.
HCML	Guideline	030	009	There should also be provision of information explaining the role of the coordinator to the patient/family	Thank you for your comment. We have added the line "how they will coordinate care".
HCML	Guideline	032	008	This should include managing expectations around not potentially expecting pre-injury functioning, and that some goals may not be achieved.	Thank you for your comment. No amendment has been made to the guideline as this is covered in the section 'Setting rehabilitation goals'.
HCML	Guideline	033	009	This should include third sector where appropriate	Thank you for your comment. The phrase 'community services' would include third sector services. There are more specific

					references to third sector later in this and other sections.
HCML	Guideline	045	012	There is no mention here of neuro-vestibular deconditioning, only blood pressure. This should include imbalance / incoordination secondary to possible decline in vestibular function. (this is mentioned on page 46, but not in the context of caution prior to remobilisation).	Thank you for your comment. The consideration of neuro vestibular symptoms is mentioned throughout in other sections, including assessment and physical rehabilitation. The committee was of a view that these symptoms will either settle very quickly or require very specialist management, which is beyond this guideline's scope.
HCML	Guideline	047	022	There is no guidance on the frequency of these reviews or appointments.	Thank you for your comment. The committee were unable to recommend the frequency of reviews because this will differ so much for different people and different injuries.
HCML	Guideline	059	019	Evidence for mirror therapy is limited, and primarily for those with CRPS following a CVA, the quality of data for this intervention is moderate. This statement should therefore include comment around where Mirror therapy may be considered. Quality of evidence around phantom limb pain should be addressed separately.	Thank you for your comment. The recommendation was written based on moderate quality evidence showing the beneficial effect of mirror therapy on pain after limb loss. However, the committee discussed the variety of alternative therapies available for pain after limb loss. As the committee did not want to limit healthcare professionals treatment choices, they decided recommend considering mirror therapy. Alternative

					therapies can be explored based on a rehabilitation professional's experience and expertise. Further information on the quality of the evidence used to make the recommendation will be published along with the guideline.
HCML	Guideline	072	014	It is not clear why 6 weeks has been chosen – this is a significant delay for those with fine motor (UL) impairments, where advances in treatments can improve outcomes when instigated during (rather than after) the scar formation window.	Thank you for your comment. We have changed this recommendation to now read: 1.16.6 Consider nerve conduction or a specialist opinion to help determine prognosis and guide future therapy and management if early surgical intervention was not needed and: • there are no signs of nerve recovery 6 weeks after the injury or • if recovery is not as expected. We think this makes it clearer that early surgical intervention might be needed. We also made a change to rec 1.16.2 so this now includes: The surgical team should decide whether early surgical intervention is necessary
HCML	Guideline	093	006	The section makes no recommendation towards coordination of care on discharge with non-statutory services, or with complex case management	Thank you for your suggestion. Reference to services delivered by private providers and third sector organisations are made in this section. We have also added a

				services within the insured space. These services offer opportunities for accelerated recovery and rehabilitation not available in the NHS, but where available the statutory Key Worker should actively engage with the 2-way relationship with a Case Manager in the private sector to achieve the optimal outcomes available.	reference to voluntary sector grants in recommendation 1.8.6. Community services include NHS and related providers from social care, the third sector and private providers, where these are part funded by the NHS or local authorities There are also references to different types of providers, including third sector providers in 1.10 Commissioning and organisation of services and a number of other sections.
Health and Social Care Board NI – NI Major Trauma Network	Evidence Review A1 and A2	General	General	PTSD, depression and other psychological sequelae impact on patients' ability to participate in rehabilitation and should be identified early. As per the evidence and the American College of Surgeons statement on PTSD, victims of interpersonal violence have an increased risk of PTSD. There is sufficient evidence about the risk of PTSD and depression after injury to warrant screening patients for risk	Thank you for your comment. We agree that people are at an increased risk of PTSD, depression and other psychological sequelae following traumatic injury, which can affect engagement in and effectiveness of rehabilitation. As there is already NICE guidance on the treatment of PTSD and depression (including the stepped care approach mentioned in your comment), this was outside of the scope of this guideline. However, the committee highlighted the importance of identifying indicators of psychological problems beyond that of an acute stress response,

				factors for PTSD and depression in major trauma centres. For additional references that are not cited in A1 and A2, see link: https://www.facs.org/about-acs/statements/109-adult-ptsd Depression and PTSD are commonly comorbid in injury survivors, especially those who require long term rehabilitation due to orthopaedic injuries. UK study: Kendrick, D., Baker, R., Hill, T….Morris, R. (2018). Early risk factors for depression, anxiety and post-traumatic distress after hospital admission for unintentional injury: Multicentre cohort study. *Journal of Psychosomatic Research, 112,* 15-24. US study: Zatzick, D., Jurkovich, G. J., Rivara, F. P., Wang, J., Fan, M. Y., Joesch, J., & Mackenzie, E. (2008). A national US study of posttraumatic stress disorder, depression, and work and functional outcomes after hospitalization for traumatic injury. *Annals of surgery*, *248*(3), 429–	and referred readers to NICE guidelines on PTSD and depression where appropriate.

				437. https://doi.org/10.1097/SLA.0b013e318185a6b8 For adults exposed to a potentially traumatic event, a stepped care, screening approach tailored to individual need is advised. This would involve ongoing monitoring of people who are more distressed and/or at heightened risk of adverse mental health impact, with targeted assessment and intervention when indicated. See International Society for Traumatic Stress Studies for additional summary of evidence.	
Health and Social Care Board NI – NI Major Trauma Network	Guideline	008	015	*1.1.6 Assessment*– This should perhaps read "involve Occupational and Physiotherapy for:" As Physiotherapy input would be required at assess ability to mobilise with an appropriate aid and advise on benefits to be gained from physiotherapy input.	Thank you for your comment. The committee specifically wanted to target this action at occupational therapists for an early view on ADL. A fuller and more detailed assessment of these, involving other practitioners is covered in section 1.2.
Health and Social Care Board NI – NI Major Trauma Network	Guideline	027	003	*1.5.10 Monitoring progress* – Would an appendix, which included recommended patient-reported outcome measures and clinician reported outcome measure, assist	Thank you for your comment. We did not undertake a review about monitoring progress specifically so would be unable to recommend specific outcomes measures in this way.

				clinicians in monitoring clinical and quality of life benefits for patients?	NICE does not usually include appendices of this kind as part of the guideline. Though there are sometimes produced as implementation tools after publication.
Health and Social Care Board NI – NI Major Trauma Network	Guideline	042	004	*1.10.5 Commissioning and organisation of rehabilitation services*- Currently looking to enhance the musculoskeletal trauma rehabilitation program and establish dedicated inpatient rehabilitation beds. The section on tertiary specialist rehabilitation and the guideline recommendations to consider commissioning of intensive rehabilitation programmes will support service development.	Thank you for your comment.
Health and Social Care Board NI – NI Major Trauma Network	Guideline	054	017	Responsive and timely clinical psychology or counselling service- current provision through local mental health services with long waiting times and inconsistent provision. Guideline would be useful to support commissioning. Examples of best practice currently in UK would be beneficial to service development.	Thank you for your comment. The committee included a section of recommendations within the guideline about the commissioning and organisation of services (1.10) to support the implementation of the recommendations. We will feed your comments about best practice examples back to the NICE implementation team.
Health and Social Care Board NI –	Guideline	055	019	*1.13.4 Clinical Psychology* - Recognise the key role in the long term management of patients, in particular	Thank you for your comment. See sections 1.8 about coordination of rehabilitation care at discharge and 1.9 1.9

NI Major Trauma Network				after transition home or to other rehabilitation settings. No specific mention of outpatient follow-up service, which is a significant gap in current service provision. In a challenging economic environment NICE guidelines will have a crucial role in commissioning.	Supporting access and participation in education, work and community (adjustment and goal settings). These sections cover the issue of transition and follow up for all rehabilitation services, in relation to the rehabilitation plan, of which psychological service provision would be part.
Health and Social Care Board NI – NI Major Trauma Network	Evidence review C.1	058	018	*1.14 Rehabilitation after limb reconstruction, limb loss or amputation* – No reference to either the 2016 NICE accredited clinical guidelines for the pre and post-operative physiotherapy management of adults with lower limb amputations, or the 2021 NICE accredited evidence based guidelines for the physiotherapy management of adults with lower limb prosthesis.	Thank you for your comment. The committee discussed including both guidelines mentioned in your comment, as well as several others. While they recognise that these are NICE-accredited clinical guidelines, they have not followed the same development processes as NICE guidelines. For example, the BAPCAR guidelines used all levels of evidence, including case reports and Delphi consensus. These would not meet the inclusion criteria for our evidence review protocols. The committee felt that they could not reference these guidelines over other professional guidelines, and decided not to include links to them in the recommendations. However, we have amended the evidence reports to include links to the mentioned guidelines.

Health and Social Care Board NI – NI Major Trauma Network	Guideline	067	004	*1.15.13 Rehabilitation after spinal cord injury*- Recognise the role of physiotherapists in the assessment and management of respiratory function after spinal cord injury. A prophylactic respiratory support programme implemented by the physiotherapy team. Emphasis on the need for a 24 hour approach to respiratory management and role of the extended multidisciplinary team.	Thank you for your comment. The recommendation does not include a reference to a specific healthcare professional, just that respiratory function is assessed and managed. It is implied that this will be performed by a rehabilitation professional with appropriate knowledge and skills. Including physiotherapy would make the recommendation more restrictive, and therefore no change has been made.
Health and Social Care Board NI – NI Major Trauma Network	Guideline	069	001	*1.15.21 Rehabilitation after spinal cord injury*- Recognise the role of occupational therapists in hand therapy/splintage for tenodesis grasp.	Thank you for your comment. The recommendation does not include a reference to a specific healthcare professional, just that specialist advice is sought. Including occupational therapy would make it more restrictive, and therefore no change has been made.
Health and Social Care Board NI – NI Major Trauma Network	Guideline	071	006	*1.16 Nerve Injury- General principles*- It is assumed that brachial plexus injury included in the nerve injury section. No mention of neuropathic pain assessment and management.	Thank you for your comment. Brachial plexus injury due to trauma is included in this guideline, although no evidence was identified regarding brachial plexus rehabilitation that met our inclusion criteria. There is existing NICE guidance on neuropathic pain and it is therefore out of scope for this guideline. However, the

					committee do have a section on 'Pain management after limb loss or amputation' which refers to neuropathic pain and recommends referral to a specialist pain team if needed.
Health and Social Care Board NI – NI Major Trauma Network	Guideline	073	008	*1.17.1 Rehabilitation following chest injury*- Early respiratory assessment by a physiotherapist as soon as possible after injury to optimise respiratory function and prevent deconditioning, is there a specific time frame. No mention of consideration for underlying respiratory conditions or smoker as part of assessment.	Thank you for your comment. The committee used ASAP specifically because no particular time frame worked for everyone and it was important it was done with urgency. Please note all the recommendations about assessment in sections 1.1 and 1.2 also apply to people with chest injury, this details the need to establish personal history, health conditions etc.
Health and Social Care Board NI – NI Major Trauma Network	Guideline	074	001	*1.17.5* Consideration be given to oxygenation and use of humidification to optimise airway clearance.	Thank you for your comment. The committee included just a few examples of techniques related to breathing and secretion clearance and did not wish to make any amendments to these examples.
Mid Yorkshire Hospitals NHS Trust	Comments form	Q1		Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why Psychology – due to lack of resource	Thank you for your response. We are aware that some services are under-resourced, or there is a lack of services, which may affect the implementation of these recommendations. However, intensive rehabilitation is already available

				Intensive rehabilitation – residential or community – lack of resource	for some people (for example, people who have lost a limb), and because rehabilitation services are already being carried out, intensive rehabilitation could be delivered through service redesign and repurposing of existing funds and resources rather than introducing them as completely new resources. We have passed your comment onto the NICE implementation support team..
Mid Yorkshire Hospitals NHS Trust	Comments form	Q2		Intensive rehabilitation, self management online programme, creating patient record for rehab plan, linking community to inpatient for visits	Thank you for your response, and we do agree that there may be some resource impact in areas you have highlighted, which was acknowledged throughout the guideline. Intensive rehabilitation is already available for some people (for example, people who have lost a limb), and because rehabilitation services are already being carried out, intensive rehabilitation could be delivered through service redesign and repurposing of existing funds and resources rather than introducing them as completely new resources. We have acknowledged the potential resource impact associated with developing self-management resources. However, as suggested, much of the

					content could be standardised for most people, so the costs for creating these programmes would be mostly one-off. These programmes could also be developed at a national level, reducing costs to individual services. Practitioners should already be producing rehabilitation plans, but some extra time might be needed to ensure they fulfil the expectations set out in these recommendations. However, having such plans will ensure a person-centred, individualised, holistic care at all stages, which would improve individuals care and outcomes, and would represent value for money. We also agree that coordination of rehabilitation care at discharge may have some resource implications, and this has been acknowledged in the guideline. We have also passed your comment onto the NICE team, which plan implementation support.
Mid Yorkshire Hospitals NHS Trust	Comments form	Q3		Examples of good practice and sharing material so not to reinvent the wheel and create many different documents which would have to go through each local level governance, national	Thank you for your comment.

				resources of education, national rehab prescriptions and documents	
Mid Yorkshire Hospitals NHS Trust	Comments form	Q4		The changes in inpatient services with discharge to assess (rehabilitation services TBI/ spinal injuries largely unaffected as not driven by being medically stable) The changes in community services and availability of rehabilitation bed and resources in community now that discharge to assess has been brought in. More focus on sustaining patient in the home than rehabilitation as described through the guideline.	Thank you for your comment. The committee were aware of the principles of discharge to assess but thought that it is the job of the rehabilitation MDT to ensure that people are discharged from hospital with a rehabilitation plan in place that meets their needs following discharge. Whilst further assessments are likely to take place once in the community, the guideline sets out the key ways in which care should be coordinated at the point of discharge to a community setting.
Mid Yorkshire Hospitals NHS Trust	Evidence review D2	General	General	Anecdotal concerns that there are very few places in country with trache/TBI/Spinal specific support in community, including our own CCG area, and this is a large gap which is a risk to the rehabilitation of our patients.	Thank you for your comment. We are aware of inconsistencies in community services throughout the country and agree that this can affect access to rehabilitation support. NICE guidelines serve to reduce inconsistencies and inequalities of access through helping commissioners and service providers identify the actions that will yield the most positive outcomes for people using services.

Mid Yorkshire Hospitals NHS Trust	Guideline	General	General	The amount of focus on psychology services concerns us because the availability of these services and the current difficulty in accessing this resource especially with pandemic. This again may be a barrier for just our trust but feel it is likely to be nationally as may need to rely on 3rd sector help.	Thank you for your comment. The committee were acutely aware of the limited psychological services available to people after traumatic injury. The recommendations focused on the need for emotional support from all staff and on regular screening for psychological problems resulting from injury as well as cross-referencing to other NICE mental health guidance. The committee felt that psychological support should be targeted for those most in need and the guidelines are aimed at helping practitioners target the right people for referral to psychology services.
Mid Yorkshire Hospitals NHS Trust	Guideline	General	General	Our overarching comment is does this guideline need a inclusion/exclusion criteria such as a particular TARN score as there is definitely different levels of severity & this guideline seems to be more directed at the extreme higher level found in major trauma centres but does not state this; a lot of patient in trauma centres/general hospitals would find this guideline very difficult to do for all patients even with a dedicated team.	Thank you for your comment. This guideline does have inclusion criteria for traumatic injury. This guideline defines traumatic injury as any injury that requires admission to hospital at the time of injury. This could include musculoskeletal injuries, visceral injuries, nerve injuries, soft tissue damage, spinal injury, limb reconstruction and limb loss. This definition can be found in the 'Context' section of the guideline, as well as the glossary. The committee discussed that

					even minor injuries can lead to hospital admission, and that the population should be defined by the complexity of their need rather than an injury severity score. They therefore made the recommendations applicable to as wide a range of settings as possible (for example, not specifying healthcare professionals within recommendations where possible, giving a variety of examples for different settings). Details of possible resource impacts of implementing recommendations can be found towards at the end of the recommendations.
Mid Yorkshire Hospitals NHS Trust	Guideline	General	General	Guideline is very extensive and useful, however could be better focused on a patients timeline of their journey from acute, sub acute, rehab and community as all recommendations cannot be met across all parts of the pathway. Recommendations can suggest that has to be met across all parts when financially, staffing wise not viable and is dependent on phase of rehab journey.	Thank you for your comment. The guideline is designed to follow a person's rehabilitation journey from post-acute to discharge into the community. However, due to the breadth of the guideline, a linear narrative was not always possible. In these cases, readers have been signposted to relevant portions of the guideline to read next.

Mid Yorkshire Hospitals NHS Trust	Guideline	General	General	SLT could be more regularly mentioned by name to help promote them as a service of which they should be referred to by other colleagues. Very specialist service that are not invested in at local level and could have greater impact.	Thank you for your comment. We have made several new additional references to SLTs in the guideline, as well as adding a new recommendation to the Initial assessment section. This recommends involving SLTs in early assessment with regards cognitive or communication impairments which may affect their ability to engage in rehabilitation. We have also added a new recommendation to the spinal injury section recommendation that reads "Assess voice quality and refer to a speech and language therapist and/or ear, nose and throat specialist as needed". There are a number of other areas in the guideline where the committee felt the role of the SLT specifically needed to be referenced. However, there were other recommendations where the committee chose not to indicate that a task should be performed by a specific role when there were several roles that could complete this task. SLTs are also included as examples of roles that should form part of a multidisciplinary team.

Mid Yorkshire Hospitals NHS Trust	Guideline	018	010 - 013	We fully support recommendations relating to how to set goals (making them meaningful for the person, strengths-based approach which builds on positive function and ability, related to the person's aspirations).	Thank you for your comment.
Mid Yorkshire Hospitals NHS Trust	Guideline	020	013	We are concerned by plan should be written in clear English, it may need to be reworded for any language suitable for patient as we have access to translating apps, perhaps needs to say limit abbreviations.	Thank you for your comment. No amendment has been made as it is not always possible for standard forms to be provided in a range of languages. However, communication of information with patients is covered in both CG138 'Patient experience in adult NHS services: improving the experience of care for people using adult NHS services' and NG204 'Babies, children and young people's experience of healthcare'. These guidelines are signposted in the 'Principles for sharing information and involving family and carers' section for further information, and have recommendations regarding people who do not have English as their first language, people who may need a translation service and people who need information in different formats.

Mid Yorkshire Hospitals NHS Trust	Guideline	020	024	Patient held document – this implies paper copy and realistically most trusts trying to get away from paper based documents, so it should be reworded to recommend a patient accessible document but this will vary from trust to trust.	Thank you for your comment. The committee did not agree that the term document implies a paper copy, as document is routinely used in related to electronic documents
Mid Yorkshire Hospitals NHS Trust	Guideline	024	002	As a trust we feel that this level of rehabilitation is not available in our area, and nationally there are very few facilities that provide this level of rehab. Complex is not defined; TBI or spinal injuries are likely to get some inpatient stay but stating 3 weeks may not be suitable for majority of trauma patients.	Thank you for your comment. We agree that practice is variable and such rehabilitation may not be available in some areas. However, intensive rehabilitation is already available for some people (for example, people who have lost a limb). Because rehabilitation services are already being carried out, intensive rehabilitation could be delivered through service redesign and repurposing existing funds and resources. Only a small group of people with the most severe injuries would be eligible for an intensive rehabilitation programme. It has to be noted that intensive rehabilitation provided over three weeks is only an example for which we had supporting economic evidence. There is some flexibility as to how such intensive rehabilitation will be delivered in practice. Also, it is envisaged

					that such intensive rehabilitation is given in addition to standard care rehabilitation but is timed to significantly impact change in function and facilitate, e.g. the return to work or education or independent living. The definition of what we mean by complex is provided in the context section of the guideline, i.e. "This guideline focuses on people with complex rehabilitation needs after a traumatic injury. Complex needs cover multiple needs, and will involve coordinated multidisciplinary input from at least 2 or more allied health professional disciplines, and could also include, e.g. vocational or educational social support for the person to return to their previous functional level, including a return to work, school or college; emotional, psychological and psychosocial support etc."
Mid Yorkshire Hospitals NHS Trust	Guideline	025	009	Little available resources at the moment and would need a huge resource at each trust level, need to have something accessible nationally to tap into. Unlikley to be funded at local level for online education/materials.	Thank you for your comment. We acknowledge that there may be a resource impact on services. However, much of the content could be standardised for most people so that the costs would be mostly one-off. Also, as you suggest and stated in the rationale, these programmes could be

					developed at a national level, reducing costs to individual services.
Mid Yorkshire Hospitals NHS Trust	Guideline	025	011	We are concerned that current community investment means that this is highly unlikely for the vast majority of patients, even those in rehabilitation settings. The focus of community rehabilitation has changed in the face of the pandemic.	Thank you for your comment. We have acknowledged the potential resource impact in the rationale and impact section and also in the committee discussion of evidence section of the relevant full evidence report. We also passed your comment to the NICE implementation team, as this may impact the implementation of this recommendation. We also believe that this recommendation on a guided self-management programme addresses the challenges services faced due to the pandemic. For example, such programmes could be used for those who cannot travel due to travel restrictions.
Mid Yorkshire Hospitals NHS Trust	Guideline	031	016	Detailed handover: we feel this focuses on the most complex patients and is perfectly suitable but the majority of patients who fall under trauma criteria it would be very extensive and would be very time intensive, particularly for a non-complex patient who therapy might not have needed a lot of involvement with.	Thank you for your comment. The population covered in this guideline is people with complex rehabilitation needs after traumatic injury, and therefore the level of detail described is appropriate.

Mid Yorkshire Hospitals NHS Trust	Guideline	034	003	We are concerned that this is unlikely to be possible in a vast majority of cases and will be the abnormal not the normal.	Thank you for your comment. The committee were aware that this recommendation requires more coordination between inpatient teams and other health and social care services, which will take more time. In order to reduce potential pressure on rehabilitation services, the committee caveated that this pre-discharge meeting should only be organised if possible. Additionally, in order to prioritise resources, they highlighted that this is most important for people with ongoing needs.
Mid Yorkshire Hospitals NHS Trust	Guideline	047	009	Practicality of aerobic exercises in physical rehab for acute inpatients, apart from respiratory patients is very limited. Would be a side effect of other rehabilitation techniques e.g. gait re-education.	Thank you for your comment. The recommendations in this guideline do not only cover the acute stages of rehabilitation, but throughout the rehabilitation pathway into the community. Aerobic exercises may be suitable at these later stages.
Mid Yorkshire Hospitals NHS Trust	Guideline	052	023	As soon as possible –this needs a time frame for SLT referral eg 24 -72 hours considering SLT not 7 day service in all areas.	Thank you for your comment. Considering the first part of the recommendation is to keep a person nil by mouth until a swallowing assessment is performed, the committee were wary of limiting this recommendation to speech and language therapists, as they were aware that not all

					settings have access to a 7-day speech and language service and were worried that people could be left over the weekend with non-oral nutrition only. Committee members worked in setting where nurses and others had been trained to perform this assessment, and so they intentionally used the phrase 'trained healthcare professional'. Because of this, they thought 'as soon as possible' was a reasonable recommendation. Therefore, no change has been made.
Mid Yorkshire Hospitals NHS Trust	Guideline	064	General	1.15 Our regional spinal injuries centre fully agree with the section of the guideline. It brings together a range of recommendations in one document which is easy to follow and supports the treatment/rehabilitation they currently give. The clinicians feel it will help create greater equity across NHS for spinal injury patients and provide an ability to benchmark themselves against other s& the guideline.	Thank you for your comment.
Mid Yorkshire Hospitals NHS Trust	Guideline	068	013 - 014	Regularly assess – we feel a timeframe is needed eg minimum weekly	Thank you for your comment. The recommendation referred to asks healthcare professionals to regularly

					assess people with a spinal cord injury who are using a spinal orthosis for a variety of complications. Rather than specify a timeframe for each, which the committee felt would be too restrictive, the recommendation allows healthcare professionals to use their clinical judgement and expertise.
NHS England and NHS Improvement	Guideline	General		These guidelines are welcomed. The emphasis on patient centred care is fully supported. We do, however, feel that greater emphasis should be given to the emotional, cognitive and psychosocial effects of traumatic injury as these guidelines appear to focus on the physical aspects of trauma. There is also very little mention of communicative rehabilitation, which is an essential component for patients with head, neck, facial fractures, high spinal cord and injury and tracheostomies.	Thank you for your comment. We were unable to include very specific recommendations about the most effective psychological interventions for traumatic injury because there was a lack of good quality evidence and because the population as too broad to be more specific. However, the committee feel that the importance of emotional and psychological support is absolutely key and have therefore woven recommendations in throughout the guideline covering emotional support and wellbeing at every step of the pathway. Due to the limited resources in psychological services the committee felt that referral for these would need to be justified and that it was for members of the MDT to decide whether a more specialist

					psychological assessment was needed. We have included some additional recommendations which may relate to communicative rehabilitation throughout e.g. *1.11.8 Be aware that traumatic injury that requires intubation, or causes facial trauma, oedema, or loss of dentition may lead to voice disorder, decreased speech intelligibility and/or swallowing difficulties. Consider early referral to appropriate professionals as required, this may include maxillofacial specialists, dental services, ear nose and throat services or speech and language therapy*. With regards cognitive intervention specialist assessment and specific rehabilitation interventions for traumatic brain injury are not covered by this guideline but will be covered by a new NICE guideline about Rehabilitation for chronic neurological disorders including traumatic brain injury. We have made a number of additions to the guideline including changes to recommendation 1.2.3 which now reads "Always think about the mechanism of injury and whether the person may have had a head injury. Be

					aware that the symptoms of traumatic brain injury can be subtle and regular screening may be necessary. If there are clinical symptoms, refer the person for a specialist assessment with healthcare professionals with expertise in traumatic brain injury rehabilitation. See also the NICE guideline on head injury.". We have also added information at the start of the cognitive assessment section to explain more clearly that assessment of traumatic brain injury is not covered in that section
NHS England and NHS Improvement	General	General	General	NICE should recommend that local services are commissioned within the spirit of 'co-design' which includes service users, carers and families and constantly seeks feedback to update and refine the pathways	Thank you for your comment. We have made a suggested addition.
NHS England and NHS Improvement	Guideline	018 - 019	007	1.3 We strongly support the mention of goal setting as this is the cornerstone of rehabilitation. However, the recommendation should emphasise that goals should be person-centred and framed around the patient's own priorities, but also need to be realistic and achievable.	Thank you for your comment. We say throughout the guideline that goals should be realistic and that people should be supported to achieve these. We also state throughout that rehabilitation goals should be set with the person, i.e. are person-centred. We slightly revised the recommendation in the setting rehabilitation goals section to say that

					rehabilitation goals should also be based on what an individual most values.
NHS England and NHS Improvement	Guideline	007	015 - 017	1.1.2 – This could be more strongly worded. Rehab medicine consultants are part of national service contract for major trauma and working with trauma MDT provide the necessary expertise to address these needs	Thank you for your comment. The population covered in the guideline includes those with an injury severity score (ISS) under 9 as well as those currently defined within NHS England commissioning arrangements as suffering from major trauma (ISS>15) or moderately severe trauma (ISS>8). The committee wrote the guideline to cover all these groups. This has been explained in more detail in the context section. Therefore they did not want to suggest that rehab medicine consultants would always be needed, as there would have been a major resource and practice impact is this were implemented.
NHS England and NHS Improvement	Guideline	007	002	Firstly, a general comment. It would be good to have a definition of what we agree is trauma. In this document it seems that trauma is being considered as severe physical injury either accidental or intentional. Patients can and do experience trauma as a result of medical intervention for example an emergency C section, surgical mistakes	Thank you for your comment. The definitions of 'complex rehabilitation needs' and 'traumatic injury' can be found in the opening 'Context' section of the guideline and in the glossary. The guideline does not exclude purely mental trauma, as long as it otherwise meets the criteria for complex rehabilitation needs after traumatic injury.

				etc. Please make it clear what the documents means by trauma. Also why does this definition not reference purely mental health trauma. This is an 'unseen' trauma that can result from a minor accident or an emergency medical procedure, witnessing something catastrophic-if this isn't what they mean then just make it clear.	
NHS England and NHS Improvement	Guideline	007	012	"helping the person, and their family members or carers (as 12 appropriate), to think about <u>what matters to them and their</u> preferred rehabilitation goals ~~to inform decisions~~ and <u>having a shared decision making conversation</u> about medical or surgical options"	Thank you for your comment. We have amended to read "to inform shared decision making about medical or surgical options"
NHS England and NHS Improvement	Guideline	008	013 - 017	1.1.6 - This section is restricted to physical impairment involving PT and OT only. It would better read 'assess how the person's physical, cognitive and emotional impairments might affect their ability to engage' Involve not just OT but use an MDT approach to address holistic needs	Thank you for your suggestion. We added a new recommendation to this section, i.e. "As soon as possible after traumatic injury start to assess whether the person has emotional, cognitive, hearing, visual or communication impairments that might affect their ability to engage in rehabilitation and in activities of daily

					living. Involve OT, psychology and SLT as appropriate."
NHS England and NHS Improvement	Guideline	008	002 - 003	1.1.4 - 'maintaining movement' is only one element of the aims of early rehab- this section would better say 'to reduce the complications of severe disability and optimise physical, cognitive and emotional recovery	Thank you for your comment. Maintaining movement was offered as an example here. The other important aspects of initial and early rehabilitation which you mention are all covered in different recommendations in this first section. Some additions and more detail has been added e.g. 1.1.7 As soon as possible after a traumatic injury, start to assess whether the person has new or existing cognitive, hearing, visual or communication impairments or emotional difficulties that might affect their ability to engage in rehabilitation and in activities of daily living. Involve occupational therapy, psychology and speech and language therapy as appropriate.
NHS England and NHS Improvement	Guideline	009	012	With regards to the MDT approach it would be really helpful for the GP if on discharge a Single Point of Access number is provided or a lead clinician for future liaison	Thank you for your comment. This is covered in the subsequent section 'Developing a rehabilitation plan and making referrals'. This recommends that the rehabilitation plan document should be shared with the person's GP, which will include contact details for future liaison.

NHS England and NHS Improvement	Guideline	009	013	Please could the term “personalised” be used in place of “individualised”? This is in line with the NHS Long Term Plan and Universal Model for Personalised Care.	Thank you for your comment. We have replaced 'individualised' with 'personalised' throughout.
NHS England and NHS Improvement	Guideline	009	014	“Involving the person” is a fairly passive term, better to say “in partnership with the person”	Thank you for your comment. We have included "in partnership with the person" as suggested.
NHS England and NHS Improvement	Guideline	011	General	Whilst social workers are mentioned this is an essential consideration as well as financial advice, signposting, and support. This support should be a part of an MDT for a truly holistic approach	Thank you for your comment. The committee have made recommendations covering the role of social care workers in rehabilitation after traumatic injury, as well as the importance of informing people of any support available, in the section of the guideline 'Coordination of rehabilitation care at discharge'. Therefore, no amendments have been made to this recommendation.
NHS England and NHS Improvement	Guideline	011	009 - 018	1.2.5 – This section is incomplete and should include management of tone issues as well as the complications of traumatic brain injury such as paroxysmal sympathetic hyperactivity	Thank you for your comment. The committee discussed your comment, and agreed that these concerns would be assessed at this point in the clinical pathway. Assessment and management of tone is covered in the guideline sections on physical rehabilitation. Complications after traumatic brain injury is outside of scope for the current guideline, and will be

					covered in upcoming NICE guidance on rehabilitation for chronic neurological disorders. Therefore, no amendments have been made to the referenced section.
NHS England and NHS Improvement	Guideline	011	016	It would be really helpful for GPs if the analgesia withdrawal process is strengthened. So often patients are discharged on enormous doses of opiates etc and the plan for reduction is flimsy and dependent on the resources in that locality. Dedicated pain management teams need to be commissioned to make this work and this should not be considered to be solely the job for the GP as this needs intense 1-2-1 engagement. GPs will not have the time or resources to do this. The gold standard should be for commissioners to have in place a separately commissioned pathway.	Thank you for your comment. We have included a new recommendation in discharge planning section to ensure that that advice about pain management, including a plan to reduce analgesia, is passed onto the person's GP or another lead clinician. Since we have not looked for evidence on the analgesia withdrawal process, we cannot make specific recommendations in this area, but have signposted reader's to the NICE guideline on medicines optimisation where relevant. Hopefully, the new addition addressed some of your concerns.
NHS England and NHS Improvement	Guideline	011	024	Include work and "meaningful activity" e.g. it may not be paid work	Thank you for your comment. We have included "meaningful activities" as suggested.
NHS England and NHS Improvement	Guideline	011	024	Work rehabilitation is mostly overlooked. It would be better to look at the patient proactively to establish	Thank you for your comment. Vocational rehabilitation is covered further in the 'Setting rehabilitation goals', 'Developing a

				whether they may or may not be likely to return to their employment, whether modifications are needed or retraining. Whilst it is accepted that functional improvement may take many months or even years this should be discussed early on. Why isn't an Occupational Health professional part of the MDT?	rehabilitation plan and making referrals' and 'Supporting access and participation in education, work and community' sections.
NHS England and NHS Improvement	Guideline	012	007	1.2.8 – The recommendation rightly notes that it is best to discuss the findings together to reduce duplication and improve efficiency. It would be helpful to put this more definitively by recommending that in complex cases the treating team should meet with specialist RM consultant, surgeons etc as appropriate to support the patient's care at least once during the recovery process in a team around the patient model- there is much delay when this does not occur with the risk of delayed care for the patient	Thank you for your comment. The suggested members of the multidisciplinary team are provided in an earlier recommendation in this section and do not need to be repeated in the referenced recommendation. Therefore, no change has been made.
NHS England and NHS Improvement	Guideline	015	012 - 014	1.2.14 Clarity of thinking may be affected by medical complications and psychological distress. In addition, TBI may be missed where a standard CT scan only has been performed.	Thank you for your comment. This recommendation is assessing if there are cognitive issues that will affect rehabilitation and will need to be considered when developing the

				Mechanism of injury should be considered in this instance to ensure that TBI is not missed and MRI may be required to assess for diffuse axonal injury	rehabilitation plan. Subsequent recommendations acknowledge that cognitive functioning can be affected by trauma, and healthcare professionals should bear this in mind when communicating with people. Regarding your second point, the committee have amended the wording of a previous recommendation in this section to include consideration of the mechanism of injury. It now reads 'Always think about the mechanism of injury and whether the person may have had a head injury. Be aware that the symptoms of traumatic brain injury can be subtle and regular screening may be necessary….'.
NHS England and NHS Improvement	Guideline	017	001	It is good that there is a large section on mental health, but the wording suggests it is an 'add on' '***the 2 multidisciplinary team should ask about psychological and psychosocial risk factors***,' should this not read **must** ask about?	Thank you for your comment. Unless it is a legal requirement, NICE guidelines do not use 'must' in their recommendations. Should is already the strongest language that can be used here. Therefore, no changes have been made.
NHS England and NHS Improvement	Guideline	017	016	Also include those who are socially isolated i.e. have no support network to assist their recovery	Thank you for your comment. We have included "socially isolated" into the final bullet.

NHS England and NHS Improvement	Guideline	018	006	Discuss and agree goals – this should be a partnership approach based on what is important to the individual.	Thank you for your comment. The committee discussed your suggested addition, but have not made any changes to the wording. They have stressed a partnership throughout the guideline, and believe that the word 'agree' implies a collaboration.
NHS England and NHS Improvement	Guideline	018	013	Add “and helps to build their knowledge, skills and confidence to manage their own health and wellbeing”	Thank you for your comment. We have added this as suggested
NHS England and NHS Improvement	Guideline	018	014	And support network. It might also be helpful to reference caring responsibilities here as having dependants may increase pressure on recovery timescales	Thank you for your comment. The committee didn’t think it was necessary to add further examples and the persons family/support circumstances and any caring responsibilities would already have been accounted for in some detail as part of the needs assessment.
NHS England and NHS Improvement	Guideline	019	001	Again, members of the MDT ‘should’ be skilled in…. should this not read MUST be skilled in? Most patients will have experienced psychological trauma, and this is the business of the whole team	Thank you for your comment. Unless it is a legal requirement, NICE guidelines do not use 'must' in their recommendations. Additionally, recommendations on training lie with relevant professional bodies and are outside of NICE's remit. Should is already the strongest language that can be used here. Therefore, no changes have been made.

NHS England and NHS Improvement	Guideline	019	020	Also include sources of support e.g. peer support groups	Thank you for your comment. References to peer support groups are included in other sections of the guideline e.g. guided self-managed rehabilitation and transferring between services and settings. The committee did not feel it was necessary to include them here as well.
NHS England and NHS Improvement	Guideline	020	007	As above, please could the term “personalised” be used in place of “individualised”? This is in line with the NHS Long Term Plan and Universal Model for Personalised Care.	Thank you for your comment. We have changed this throughout.
NHS England and NHS Improvement	Guideline	020	013	Or can be translated or available in another accessible format as required	Thank you for your comment. The definition of a 'rehabilitation plan' is included in the 'terms used in this guideline' and includes that the plan itself may be reproduced in different accessible and may be produced in different formats. The committee did not want to repeat that here.
NHS England and NHS Improvement	Guideline	020	013	‘**written in clear English** ‘ What about EDI? Yes, for the health professional but also translated into the language appropriate for the patient including considering the patients	Thank you for your comment. No amendment has been made as it is not always possible for standard forms to be provided in a range of languages. However, communication of information with patients is covered in both CG138 'Patient experience in adult NHS services:

				communication needs such as braille, audio etc The patient held document should suit the needs of the patient	improving the experience of care for people using adult NHS services' and NG204 'Babies, children and young people's experience of healthcare'. These guidelines are signposted in the 'Principles for sharing information and involving family and carers' section for further information, and have recommendations regarding people who do not have English as their first language, people who may need a translation service and people who need information in different formats.
NHS England and NHS Improvement	Guideline	022	007	Return to Work and “meaningful activity” e.g. it may not be paid work	Thank you for your comment. These are just examples included against the bullet about 'outcomes'. We have added reference to 'meaningful activities' as an alternative to 'work' elsewhere in the guideline but have not added here.
NHS England and NHS Improvement	Guideline	023	018 - 022	1.5.1 – This section outlines the importance of review of progress and outcomes and lists the different aspects of care that patients may need to access. It would seem reasonable to include a stronger recommendation for a formal consultant and MDT clinic review to assess progress, needs, document outcomes and signpost to	Thank you for your comment. We refer to follow-up throughout the guideline. However, the committee did not want to be too prescriptive and left it open to local arrangements. Also, the committee was of a view that the proposed consultant-led follow up would not be appropriate for everyone covered by this guideline.

				appropriate services. Currently follow up of this kind does not occur in trauma and is confined to TBI follow up, critical care follow up and spinal follow up. There is an opportunity to recommend this approach here which would address the list of recommendations within the section	
NHS England and NHS Improvement	Guideline	023	023	Should also include a reference to the patient's psychological rehabilitation needs-very 'medicalised'	Thank you for your comment. We disagree that this recommendation is heavily medicalised. The wording 'Tailor the start time, frequency, intensity and duration of the rehabilitation programme to have the most beneficial effect on the person's recovery' does not make any reference to what the rehabilitation programme would include. Therefore, no change has been made.
NHS England and NHS Improvement	Guideline	025	011	Include: Education settings; Transportation; Housing adaptations	Thank you for your comment. The education and learning materials included in this recommendation are illustrative examples only as it is not possible to cover all possibilities. The exact composition will depend on the person, their injuries and their rehabilitation needs. However, the committee have included education, transport and adaptations as examples in

					other recommendations on support needs and information.
NHS England and NHS Improvement	Guideline	025	023	Guided self management-consideration to the needs of patients with language challenges, blind etc and EDI needs would be essential here including cultural differences and pre existing disabilities	Thank you for your comment. We have added 'communication needs'.
NHS England and NHS Improvement	Guideline	026	005 - 009	1.5.8 - As per the point above, this review would be best managed either virtually or face to face by a review appointment involving RM consultant and relevant members of MDT	Thank you for your comment. The format for the follow-up review is covered in the recommendation 'Consider technology-enabled follow-up, support and rehabilitation sessions if people request more local, accessible therapy or if rehabilitation practitioners are not available in their area, for example, in rural areas.'. Regarding the involvement of a rehabilitation medicine consultant and all relevant members of the multidisciplinary team, the committee did not want to be too prescriptive and left it open to local arrangements. Also, the committee was of a view that the proposed consultant-led follow up would not be appropriate for everyone covered by this guideline.

NHS England and NHS Improvement	Guideline	026	001	Strengthen peer support services- needs expansion, what does this mean, what should it mean and what is the expected standard eg peer support to include relatable peers/EDI, specific CYP peer support etc	Thank you for your comment. As suggested, we have added some examples of the peer support services that we mean.
NHS England and NHS Improvement	Guideline	031	005	Personalised care and support plans can also be shared which provide key information relevant to different agencies	Thank you for your comment. Personalised care and support plans are covered by rehabilitation plan, which the guideline defines as a document 'used to document information about injuries and rehabilitation treatments in an accessible format.'.
NHS England and NHS Improvement	Guideline	031	005	Please include handover to GP!!	Thank you for your comment. No amendment has been made as handover to a person's GP is covered by 'any other service providers involved in the person's care and support'.
NHS England and NHS Improvement	Guideline	033	017	Include here whether they would be eligible for a personal health budget or personal wheelchair budget to give them more choice and control of how their health and care needs are met, particularly if they are eligible for NHS Continuing Healthcare or Children's Continuing Care.	Thank you for your support. The committee felt that eligibility for a personal wheelchair budget or personal health budget would be covered in advice regarding 'funding for equipment' or 'other forms of support' respectively. Therefore, no change has been made.

NHS England and NHS Improvement	Guideline	034	014 - 015	1.8.11 – As above- follow up clinic could act as appropriate format to ensure these recommendations are addressed	Thank you for your comment. The committee disagree that these arrangements can be left until a follow-up review. Communication of rehabilitation needs and establishing ongoing funding should occur before discharge for people who are likely to have continuing health and social care needs, to ensure that plans are in place in time for discharge.
NHS England and NHS Improvement	Guideline	034	016	And GP!	Thank you for your comment. No amendment has been made as communication with a person's GP is covered by 'relevant healthcare professionals'.
NHS England and NHS Improvement	Guideline	034	022	Also add assessments for Children's Continuing Healthcare	Thank you for your comment. The committee argued that this is covered by the recommendation to complete a NHS continuing healthcare checklist for people likely to have continuing health and social care needs after discharge. Therefore, no change has been made.
NHS England and NHS Improvement	Guideline	035	019 - 025	1.8.15 – This section would benefit from a clear recommendation for vocational rehabilitation resource available in the community with specialist recommendations and support from consultant in RM and MDT	Thank you for your suggestion. The committee was of a view that in most cases, this would involve simple advice only and would not necessarily require support from a consultant or MDT. Also, we have a whole section on supporting

					access and participation in education, work, and community section, where we make references to related NICE guidance that provide more detail on issues related to vocational rehabilitation, e.g. the NICE guideline on workplace health: long-term sickness absence and capability to work.
NHS England and NHS Improvement	Guideline	037	002	And SPC for the GP	Thank you for your comment. This is covered in a previous section 'Developing a rehabilitation plan and making referrals'. This recommends that the rehabilitation plan document should be shared with the person's GP, which will include contact details for future liaison.
NHS England and NHS Improvement	Guideline	039	001 - 028	1.9.2 – This section describes a vocational rehabilitation resource for trauma patients. It would be clearer to recommend that vocational rehabilitation is an important element of the MDT rehabilitation programme and specialist advice should be available within the treating rehabilitation team (e.g. consultant in RM and vocational OT) to offer support to this population, many of whom are of working age	Thank you for your comment. Further recommendations on vocational rehabilitation and its part in the rehabilitation plan can be found in the 'Setting rehabilitation goals' and 'Developing a rehabilitation plan and making referrals' sections. Therefore, no amendments have been made to this section.

NHS England and NHS Improvement	Guideline	041	013	Also include exploring options for personal health budgets, personal budgets and integrated personal budgets.	Thank you for your comment. The committee discussed your suggested inclusions, but felt they were adequately covered in the points surrounding establishing eligibility for funded social care support, full continuing healthcare assessment, emergency education funding and education, health and social care plan. Therefore, no change has been made.
NHS England and NHS Improvement	Guideline	042		1.10.5 We welcome the section on commissioning and setting out responsibility for commissioning of rehabilitation services and commissioning across the whole care pathway. However, we strongly advise to remove *"(for example, 3-week)"* from this recommendation. Patients who have complex needs requiring tertiary services are generally unlikely to make the requisite changes in that time scale.	Thank you for your comment. Intensive rehabilitation of 3 weeks duration is only an example for which we had supporting economic evidence. Also, the examples that the committee reviewed for intensive musculoskeletal rehabilitation and intensive police physio rehabilitation were all of approximately three weeks duration. It has to be noted that intensive rehabilitation would be given in addition to standard care rehabilitation, and hopefully, some improvement would have been achieved by the time-intensive rehabilitation is initiated. Please refer to the Rehabilitation programmes of therapies and treatments section that includes more detail on intensive

					rehabilitation and its timing. We also clarified that it is a "tertiary service for trauma rehabilitation".
NHS England and NHS Improvement	Guideline	044	003	Both physical and psychological	Thank you for your comment. Physical, psychological and cognitive rehabilitation is implied in the recommendation wording so it does not need further stipulation. No amendment has been made for this reason.
NHS England and NHS Improvement	Guideline	045	001 - 022	1.11 – This section is uni-disciplinary and lacks an MDT introductory section along the lines of the importance of a multidisciplinary review involving medical, therapy, nursing and psychological review to agree appropriate interventions to support patient centred goals	Thank you for your comment. We disagree with your comment that this section is uni-disciplinary. Due to the breadth of the guideline, the committee decided to separate types of rehabilitation into different guideline sections (i.e. physical, psychological and cognitive), to avoid very long lists of recommendations and increase the ease of navigation throughout the document. Therefore, section 1.11 only deals with physical rehabilitation as part of this overall design. However, it does include referrals to other sections of the guideline as appropriate. Regarding your suggestion of a multi-disciplinary team introductory section, the committee thought this has been adequately covered at the beginning of the

					guideline. The 'Multidisciplinary team rehabilitation needs assessment' section goes into depth about what a multidisciplinary team in hospital might look like, how they should assess someone's rehabilitation needs and how to develop a holistic rehabilitation plan. Similarly, there are recommendations in the sections concerned with coordination of rehabilitation care that advise on how multidisciplinary teams should function after the assessment stage.
NHS England and NHS Improvement	Guideline	050	012	A reminder that if unilateral lower limb swelling exists exclude DVT which is more common in sedentary patients	Thank you for your comment. As suggested, we added a new recommendation to consider alternative causes of unexpected swelling.
NHS England and NHS Improvement	Guideline	053	007 - 009	1.12 – Whether cognitive dysfunction is temporary or not depends on a full review to establish un-diagnosed traumatic brain injury or significant psychological dysfunction.	Thank you for your comment. With regards cognitive interventions, specialist assessment and specific rehabilitation interventions for traumatic brain injury are not covered by this guideline but will be covered by a new NICE guideline about Rehabilitation for chronic neurological disorders including traumatic brain injury. We have made a number of additions to the guideline including changes to recommendation 1.2.3 which now reads

					"Always think about the mechanism of injury and whether the person may have had a head injury. Be aware that the symptoms of traumatic brain injury can be subtle and regular screening may be necessary. If there are clinical symptoms, refer the person for a specialist assessment with healthcare professionals with expertise in traumatic brain injury rehabilitation. See also the NICE guideline on head injury.". We have also added information at the start of the cognitive assessment section to explain more clearly that assessment of traumatic brain injury is not covered in that section.
NHS England and NHS Improvement	Guideline	053	014 - 015	1.12.3 – This section should include that where cognitive functioning remains a problem, appropriate specialist review should be undertaken ideally by consultant in RM in first instance with involvement of neurologist if appropriate	With this in mind, the committee were comfortable recommending that most trauma-related problems with cognitive functioning are temporary. However, the committee are aware that the exclusion of TBI is not always clear to the reader, which becomes especially important in the sections relating to cognitive functioning. Therefore, they have included an introductory reminder for both the 'Assessing cognitive functioning' and 'Cognitive rehabilitation' sections which

					reads 'Please note this guideline does not cover assessment or specific rehabilitation interventions for people with traumatic brain injuries…'.
NHS England and NHS Improvement	Guideline	055	005	Include Bedwetting for CYP	Thank you for your comment. We have added bedwetting for children and young people to the list.
NHS England and NHS Improvement	Guideline	061	007	Ensure selection of wheelchair is based on the needs and preferences of this individual and that consider wide access needs and housing adaptations required.	Thank you for your comment. The committee wished to leave specific assessment details noted in your comment to the expertise of the wheelchair service. Therefore, no change has been made.
NHS England and NHS Improvement	Guideline	061	007	Rehabilitation back to driving after amputation	Thank you for your comment. We have included return to driving rehabilitation for the whole trauma population in the 'Supporting access and participation in education, work and community', under supporting independence in activities of daily living.
NHS England and NHS Improvement	Guideline	070	013	Spinal cord injury and impact on sexual health?	Thank you for your comment. We have added a recommendation advising of the increased risk of physical functioning problems after spinal cord injury, including bladder, bowel and sexual function.
NHS England and NHS Improvement	Guideline	072	011	Include play therapy	Thank you for your comment. This has now been added.

NHS England and NHS Improvement	Guideline	092	026 - 029	Rather than ‘ there may be more referrals to specialist rehab services earlier in the pathway’ this would be better expressed as ‘ involving specialist rehabilitation as early as possible in the trauma pathway will ensure timely care with a reduction in secondary disability and will support optimal physical, cognitive and emotional recovery for patients.	Thank you for your suggestion. This was slightly rephrased.
NHS England and NHS Improvement	Guideline	096	001 - 006	It is stated that recommendations will have little impact on resources. While reconfiguration of services may have little resource implication, support for development of an intensive programme for trauma survivors will be of benefit for these patients. While there are specific programmes for spinal injury, neurorehab and amputee services, there are no such commissioned services for patients with complex polytrauma. Patients with polytrauma would benefit from an intensive inpatient rehab resource to address complex injury and maximise function reducing the burden on carers and community services.	The committee hope that the recommendations made in ‘Intensive rehabilitation programmes’, combined with those in ‘Commissioning’ and ‘Organisation’, will support healthcare organisations when applying for expansion of services.

Peer reviewer	Rehabilitation after SCI	-	-	Recommendation 1.15.8 It should be ensured that they are followed up as per national standards and should have access to appropriate surveillance such as USG of renal tract. Where possible, they should be captured by the surveillance and follow up programme offered through regional SCI centres.	Thank you for your comment. The recommendations suggested are too detailed for the scope of this guideline. As stated at the beginning of this guideline section, the subsequent recommendations are designed to focus on the rehabilitation and supportive needs of people with spinal cord injury (after initial acute assessment) who are not currently in a regional specialist spinal cord injury centre. Therefore, no new recommendations have been made. However, the committee believe that the initial 2 recommendations about early and continued contact with regional SCI centres and referral through the national spinal injuries database will ensure people are followed up as per national standards and have access to appropriate surveillance. This has been re-enforced by amending recommendation wording to include maintaining communication with the regional SCI centre at discharge and follow-up.
Peer reviewer	Rehabilitation after SCI	-	-	Recommendation 1.15.9 Urinary catheter is mandatory and is the safest option in the setting of a suspected acute spinal cord injury. This can be	Thank you for your comment. The committee discussed that urinary catheter placement is not mandatory in the rehabilitation phase of spinal cord injury,

				removed later if there is no evidence of a SCI. Patients will not be able to always sense a full bladder.	although it may be in the initial management. Therefore, they believe that the current recommendation wording of 'protect upper renal function at all times by maintaining safe bladder emptying (inserting a urinary catheter if necessary), and ensuring that people understand and use bladder management techniques as a key part of their rehabilitation' is more reflective of the guideline population. However, they note that lifelong surveillance of urinary complications following SCI is recommended in the NICE guideline 'Urinary incontinence in neurological disease', which is signposted at the end of this recommendation.
Peer reviewer	Rehabilitation after SCI	-	-	Recommendation 1.15.9 Ensure appropriate surveillance including USG of the renal tract and where necessary pressure studies of the bladder.	Thank you for your comment. Appropriate surveillance of bladder function following spinal cord injury is covered in the NICE guideline 'Urinary incontinence in neurological disease', which is signposted at the end of this recommendation. This guideline includes specific recommendation on renal ultrasound and pressure studies. Therefore, no changes have been made.

Peer reviewer	Rehabilitation after SCI	-	-	Recommendation 1.15.9 Early commencement of IC in those with hand function. Plan and execute definitive bladder management at the earliest opportunity.	Thank you for your comment. Assessment and management of bladder function following spinal cord injury is covered in the NICE guideline 'Urinary incontinence in neurological disease', which is signposted at the end of this recommendation. This guideline includes recommendations on catheter initiation and management. Therefore, no changes have been made.
Peer reviewer	Rehabilitation after SCI	-	-	Recommendation 1.15.11 This is relevant in the early period after a spinal cord injury. It can sometimes take many days for the paralytic ileus to resolve.	Thank you for your comment. The committee believe that this is covered by the wording 'avoid unnecessary delays', and that interventions would be taken as appropriate depending on results. Therefore, no amendments have been made.
Peer reviewer	Rehabilitation after SCI	-	-	Recommendation 1.15.16 This section seems particularly thin. This is key as respiratory problems are the leading cause of morbidity and mortality in this group. The measures outlined for young individuals are also relevant to all SCI patients (cervical)	Thank you for your comment. No evidence was identified for respiratory management in SCI rehabilitation, so recommendations were all made using the committee's expertise and experience. Therefore, respiratory support recommendations are designed to be generalizable to a range of non-specialist SCI centres. The mention of children and young people is not to say it should only be offered to them, but that

					their results might differ from reference values because of their age and ability. In order to clarify this, the recommendation wording has been slightly amended so it now begins 'Assess and manage respiratory function (taking into account age and ability when assessing children and young people) as follows:…'.
Peer reviewer	Rehabilitation after SCI	-	-	Recommendation 1.15.17 This is vague. The standard would be to nurse patients in the early phase in a setting where they can be monitored closely - typically HDU / ITU. There is also evidence that supporting the blood pressure to a mean MAP of 80 mm could have a beneficial effect on neurological outcomes.	Thank you for your comment. As set out in the scope and review protocol, this guidance is not meant to cover people in A+E and critical care units were outside of scope. The committee made this recommendation in order to prevent complications during all stages of SCI rehabilitation, so rehabilitation can start and/or proceed without delays. Your suggestion would only apply to people admitted to critical care and therefore is outside of this guideline's scope. However, the word 'potential' has been removed from the recommendation in order to decrease ambiguity.
Peer reviewer	Rehabilitation after SCI	-	-	Recommendation 1.15.18 Bony stability should be considered when deciding to use a AP air mattress or similar. Also during turns.	Thank you for your comment. The committee agree that bone stability should be considered during the assessment of skin and pressure care, and have

					expanded the recommendation to read '…start a 24-hour positioning and turning programme and use a pressure mattress if appropriate (ensuring that the spinal column has been assessed as mechanically stable) or indicated…'.
Peer reviewer	Rehabilitation after SCI	-	-	Recommendation 1.15.23 Awareness about common deformities / positions that can develop following aprticular levels of injury eg shoulder abduction, elbow flexion and forearm supination in C5 injuries etc etc	Thank you for your comment. The committee discussed your suggestion, but believe it is adequately covered by the subsequent recommendation regarding seeking specialist advice for people with a higher level cervical spinal. Therefore, no changes have been made.
Peer reviewer	Rehabilitation after SCI	-	-	Recommendation 1.15.24 Not just hand, but upper limb. Elbows and shoulders can be equally problematic especially in C5/C6 injuries	Thank you for your comment. The committee specifically wanted to highlight hand function rehabilitation in this population. The specialist knowledge referenced within the recommendation is critical for the long-term rehabilitation outcomes for these patients, over and above other therapies to maintain range of movement at other joints. Therefore, no changes have been made.
Peer reviewer	Rehabilitation after SCI	-	-	Recommendation 1.15.25 This is somewhat controversial in the UK and has been the subject of many debates in professional circles. There is a	Thank you for your comment. Due to the lack of evidence, the committee made the following recommendation based on expert opinion from their rehabilitation

				school of thought that a longer spell of supine rehabilitation which its proponents call supine physiological rehabilitation produces better neurological outcomes. A couple of SCI units employ this. The problem is that there is no evidence one way or the other. A standard of practice guideline being developed by the NHSE SCI project board looked at this specific issue and decided to leave it open and to review the national data in 2 years or so to see whether there are any differences between the two centres using this an d the other six. The other six units mobilise patients in2 weeks or less subject to good blood pressure control.	practice. Although the committee are aware of different approaches within specialist spinal units, these recommendations are not designed to apply to these settings (which is caveated at the beginning of the 'Rehabilitation after SCI' section). The committee discussed the potential harm to chest function, muscle integrity and mobility due to prolonged unnecessary bed rest when drafting the recommendation. Because of this discussion, the committee only recommended that this intervention be considered These reasons mean that no amendments have been made.
Peer reviewer	Rehabilitation after SCI	-	-	Recommendation 1.15.29 In more intractable cases, early Baclofen pump can be helpful - especially if it is preventing rehabilitation or patient is not tolerating oral antispasticity agents.	Thank you for your comment. These recommendations only cover initial management and treatments. While the committee agreed that Baclofen pumps can be useful for certain patients, these are highly specialised and would not occur without involvement of specialist spinal injuries and/or neurosurgical teams. Therefore, no additions have been made.

Peer reviewer	Rehabilitation after SCI	-	-	Recommendation 1.15.31 Also hip position and development in very young children	Thank you for your comment. The committee discussed that very young children with a SCI severe enough to be concerned about hip position and development would be managed within a specialist SCI service. As caveated at the beginning of the 'Rehabilitation after SCI' section, these recommendations do not cover this population.
Peer reviewer	Rehabilitation after SCI	-	-	Recommendation 1.15.34 Importance of peer support across all age groups. This is invaluable.	Thank you for your comment. The committee agree that peer support can be invaluable for people undergoing rehabilitation after traumatic injury. They have included recommendations on peer support in other sections of the guideline concerning components of rehabilitation programmes and co-ordination of rehabilitation care.
Royal College of Nursing	General			Thank you for the opportunity to contribute. We don't have any comments to add on this occasion.	Thank you for your comment.
Royal College of Paediatrics and Child Health	Guideline	General	General	Does there need to be a section on Rehabilitation after Hearing Loss with Traumatic Injury?	Thank you for your comment. There is existing NICE guidance on hearing loss (NG98 Hearing loss in adults: assessment and management), and it is therefore out of scope for this guideline. However, the committee have amended the wording of

					several recommendations in the 'Initial assessment and early interventions', 'Multidisciplinary team rehabilitation needs assessment' and 'Assessing physical functioning' sections to ensure that hearing loss resulting from trauma is assessed and managed appropriately.
Royal College of Paediatrics and Child Health	Guideline	General	General	The reviewer is happy with this comprehensive draft guideline on rehabilitation after traumatic injury.	Thank you for your comment.
Royal College of Paediatrics and Child Health	Guideline	005	016	1.2.17 Consider adding hearing difficulties to this list, either pre-existing or worsened or caused by the injury. Hearing difficulties may masquerade as poor cognition.	Thank you for your comment. We have now made reference to assessing for hearing difficulties in the initial assessment section as well as the assessing physical functioning section, including reference to the NICE guideline on hearing loss in adults.
Royal College of Paediatrics and Child Health	Guideline	007	015	Section 1.2.14 indicates hearing loss may affect the ability to engage in physical rehabilitation, but could be applied to all areas of rehabilitation, whereas balance function assessment may just be relevant under the physical rehabilitation section.	Thank you for your comment. We have now made reference to assessing for hearing difficulties in the initial assessment section as well as the assessing physical functioning section, including reference to the NICE guideline on hearing loss in adults.
Royal College of Paediatrics and Child Health	Guideline	013	010	Sections 1.2.1 and 1.2.2 Consider testing hearing before any assessment of cognitive function is	Thank you for your comment. The committee have amended a recommendation in the assessment

				done. Section 1.2.5 later indicates the use of hearing aids and communication aids, but it would be necessary to assess hearing first.	section to include hearing. The recommendation now reads 'As soon as possible after traumatic injury start to assess whether the person has new or existing cognitive, hearing, visual or communication impairments or emotional difficulties that might affect their ability to engage in rehabilitation and in activities of daily living. Involve occupational therapy, psychology and speech and language therapy as appropriate.'.
Royal College of Physicians	Guideline	General		The RCP is grateful for the opportunity to respond to the above consultation. We have liaised with our Joint Specialty Committee for Rehabilitation Medicine and would like to comment as follows. Overall, we welcome these guidelines, which have a great deal to recommend them. There is a great emphasis on patient-centred care, which we fully support. However, in places we feel there is over-focus on the physical aspects of trauma. Even though we recognise that traumatic brain injury (TBI) (on its own)	Thank you for your comment. We are pleased to hear you are supportive of the guideline. We were unable to include very specific recommendations about the most effective psychological interventions for traumatic injury because there was a lack of good quality evidence and because the population was too broad to be more specific. However, the committee feel that the importance of emotional and psychological support is absolutely key and have therefore woven recommendations in throughout the guideline covering emotional support and wellbeing at every step of the pathway.

				is excluded from these guidelines, patients with trauma still experience significant emotional and psychosocial effects from traumatic injury. Moreover, some patients with have cognitive imitations due to other conditions (eg dementia) or associated TBI with multiple trauma – which may be subtle and are often overlooked. Specialist rehabilitation and consultants in rehabilitation medicine play an important role in the holistic approach to assessing and managing patients with complex needs that include the complex interaction of physical cognitive, emotional and psychosocial factors. MDT working is mentioned in section 1.2 but elsewhere the recommendations seem to default to the physical aspects with emphasis on P/T and O/T. Failure to address the whole picture throughout the pathway is likely to lead to poorer results. This could be addressed with some small tweaking - specific pointers for this are given below.	Due to the limited resources in psychological services the committee felt that referral for these would need to be justified and that it was for members of the MDT to decide whether a more specialist psychological assessment was needed. Finally, with regards the role of rehabilitation consultants and specialists we made it more explicit in the guideline that we are looking at a much wider cohort, not only very severe or major trauma with ICCS score >8 (see the Context section). In people with less severe trauma, rehabilitation specialists will not be generally involved. Also, paediatric cases will not have access to rehabilitation specialists because they do not exist for this population.

Royal College of Physicians	Guideline	General		There is mention of 'family' in terms of supporting the patient, giving information etc, but no mention of specific support for family members. Severe trauma affects not only the patient but the whole family, and family members may have psychosocial needs in their own right, which vary from practical coping (eg when the main breadwinner or principal carer is injured) to psychosocial needs. We believe there should be some recommendations specifically about providing support to family members (including the children of severely injured patients).	Thank you for your comment. We agree that rehabilitation after trauma can be a strain on the entire family unit, not just the individual with the injuries. As there is already NICE guidance on supporting carers with the physical and psychological demands of this role (see NG150 Supporting adult carers), this is beyond the scope of the current guideline. However, in the section entitled 'Principles for sharing information and involving family and carers' we have included a recommendation to advise carers on the support available to them and signposting to the relevant guidelines.
Royal College of Physicians	Guideline	General		The guideline appropriately mentions the need to assess mental capacity of patients to make decisions about their care, and recommends that a rehabilitation needs assessment should be conducted on the basis of best interests. We agree that capacity and best interests decision-making is a large topic and the guideline appropriately refers to the NICE guidance in this area. However,	Thank you for your comment. The committee agree with your comment that just because an intervention can be done, this does not mean it should be done. However, we cannot duplicate guidance in another area, only signpost to it. As your comment is already covered in the linked NICE guidance and UK law, we have not included it here.

				rehabilitation professionals often forget that every intervention given to an individual who lacks capacity must be done on the basis of best interests and in line with the patient's likely wishes. Simply writing 'Seen on the basis of best interests' at the top of each entry in the notes is not adequate. Just because one can do something does not mean that one always should. There may be reasons why a given individual might not wish to receive certain types of rehabilitation and due consideration should be given to this. We believe it is worth making this simple point clear.	
Royal College of Physicians	Guideline	General		There are sections on physical, cognitive and psychological rehabilitation but very little mention of communicative rehabilitation. Communication is an essential component of function and may be affected in those with associated brain injury, tracheostomy, head/neck/facial fractures, high spinal cord injury etc. If it does not have a section of its own, communicative rehabilitation should at	Thank you for your comment. We have amended the rehabilitation needs assessment recommendation to include assessing new difficulties with communication, speech and language, in order to document potential communication rehabilitation needs. This is reinforced in the 'Assessing cognitive function' section. There are 2 new recommendations in the 'Rehabilitation after SCI' section, which highlight the risk

				least be mentioned under cognitive or psychosocial rehabilitation.	of communication difficulties in people with cervical spine injuries and the importance of assessment and referral. Regarding communication rehabilitation after traumatic brain injury, this outside of the scope of this guideline. It will be covered in an upcoming NICE guideline focusing on Rehabilitation for Chronic Neurological Disorders.
Royal College of Physicians	Guideline	General		Having good data is key to any guideline. In rehabilitation the data must be available across the whole pathway and is therefore no contained in any one dataset. Data linkage using the NHS humber is required to track patients as they move between services. The National Clinical Audit for Specialist Rehabilitation following major Injury (NCASRI) provides proof of principle. https://www.kcl.ac.uk/cicelysaunders/about/rehabilitation/nhs-audit-report-v9-rgb.pdf We recommend including a section on central data reporting and data linkage, using the NHS number to track patients as they move along the care pathway.	Thank you for your comment. The committee discussed your comment and agreed that collecting reliable data across the rehabilitation pathway is key, especially concerning audits and service reviews. Therefore, the committee has included the following recommendation in the co-ordination of care portion of the guideline: '1.7.6 Use a unique identifier, preferably the NHS number if this is known, when exchanging clinical information about the person's assessment, rehabilitation plan, onward referral, transition between services, discharge to community services, and all aspects of their care pathway.'

Royal College of Physicians	Guideline	009 - 012		**Recommendation 1.2:** We very much welcome this section on MDT team rehabilitation needs assessment, including physical, cognitive and psychosocial aspects, and of context such as the patient's environment and family / social support network. We particularly support the use of validated tools such as the Rehabilitation Complexity Scale Patient Categorisation Tool or the Complex Needs Checklist and continued re-assessment.	Thank you for your comment.
Royal College of Physicians	Guideline	033 - 036		**Recommendation 1.8 – discharge planning and multi-disciplinary approach.** All of the points are well made, but again can be usefully incorporated and recorded in an RP. We suggest that recommendation 1.8.2 should say: *'Reassess the person's needs and review the rehabilitation plan and prescription before discharge to ensure that their needs are addressed and documented alongside any long-term, existing health conditions or disabilities.'*	Thank you for your comment. The population covered in the guideline includes those with an injury severity score (ISS) under 9 as well as those currently defined within NHS England commissioning arrangements as suffering from major trauma (ISS>15) or moderately severe trauma (ISS>8). The committee wrote the guideline to cover all these groups and some of the terms used are explained in the 'terms used in this guideline' section. When the guideline uses the term rehabilitation plan it also

					means rehabilitation prescription for those entitled to one.
Royal College of Physicians	Guideline	022 - 024		**Recommendation 1.5. General principles for rehabilitation programmes** – This section outlines some of the key principles of rehabilitation including the importance of review of progress and outcomes and tailoring rehabilitation to the needs of the individual. We believe it would be appropriate to make a stronger recommendation for a formal consultant and MDT clinic review to assess progress, needs, document outcomes and signpost to appropriate services. Currently follow up of this kind does not occur in trauma and is confined to follow-up following ABI, stroke, critical care and spinal cord injury. There is no reason to think this would not also be appropriate for patients with complex rehabilitation needs following trauma.	Thank you for your comment. We have included follow up as part of the programme itself in the final bullet "include post-programme follow-up, in person or virtually", as well as recommending reviews to assess progress, needs and document outcomes throughout the sections on assessment, rehabilitation planning and monitoring, as well as in the coordination of care sections. The committee did not want to make a single specific recommendation for a formal consultant and MDT clinic review to assess progress because it did not agree all follow up needed to be done in this way.
Royal College of Physicians	Guideline	025 - 026		**Recommendation 1.5. Guided self-management**– We strongly support the principle of guided self-management for those patients who are able, and this encourages empowerment and	Thank you for your comment. We are unable to specifically recommend access to a consultant in rehabilitation medicine for people undertaking guided self-management rehabilitation. Not all settings

				autonomy. However, patients often require support and advice to guide them through the maze and assist them when they have difficulty accessing the services they need. Reviews may be managed either virtually or face to face by the relevant members of the MDT, but should include access to advice from a consultant in RM, especially when funding barriers are identified, as negotiating referrals and funding that is not otherwise immediately available is one of the key skills of an RM physician.	will have regular access to a rehabilitation medicine consultant, resulting in a large resource impact when trying to implement the guideline. However, the recommendations in the 'Rehabilitation skills, knowledge and expertise in the workforce' section stress the importance of healthcare professionals having appropriate skills, as well as access to training and peer support.
Royal College of Physicians	Guideline	031 - 032		**Recommendation 1.7.6-9 – when transferring between services.** Once again, the rehabilitation prescription is a person-centred patient held tool that can support not only the sharing of information as patients transfer between services, but (if centrally recorded) represents an audit tool to ensure that patients and information do not get lost as they move between services.	Thank you for your comment. The population covered in the guideline includes those with an injury severity score (ISS) under 9 as well as those currently defined within NHS England commissioning arrangements as suffering from major trauma (ISS>15) or moderately severe trauma (ISS>8). The committee wrote the guideline to cover all these groups and some of the terms used are explained in the 'terms used in this guideline' section. When the guideline uses the term rehabilitation plan it also

					means rehabilitation prescription for those entitled to one.
Royal College of Physicians	Guideline	064 - 065		**Recommendation 1.15 - Rehabilitation after spinal cord injury.** This section fails to acknowledge that about a third of patients presenting with SCI are managed in the Level 1 and 2 specialist rehabilitation centres, where rehabilitation is shown to be both effective and cost effective. This is a significant omission, please see the following recent study https://pubmed.ncbi.nlm.nih.gov/34282991/ That study expands on the existing evidence base for the effectiveness and cost-efficiency of SCI in https://bmjopen.bmj.com/content/6/2/e010238	Thank you for your comment. This section starts with a clear statement that "These recommendations focus on the rehabilitation and supportive needs of people with spinal cord injury who are not currently in a regional specialist spinal cord injury centre. See also the NICE guideline on spinal injury: assessment and initial management." The committee did not want to write recommendations for the specialist centres because those pathways are clearer. They wanted to focus on the people with spinal injuries who were receiving care in other hospital settings where the guidance is less clear. There is of course reference to contact with specialist centres as appropriate.
Royal College of Physicians	Guideline	018 - 019	007	**Recommendation 1.3: Setting rehabilitation goals.** We strongly support the mention of goal setting as this is the cornerstone of rehabilitation. However, the recommendation should emphasise that goals should *person-centred* and framed around the	Thank you for your comment. Throughout the guideline, we state that rehabilitation goals should be realistic and that people should be supported to achieve realistic rehabilitation goals. We also say that the rehabilitation plan should include rehabilitation goals and that it should be

				patient's own priorities, but also need to be realistic and achievable. Although the recommendation says they would be 'reviewed' this is ambiguous. There is no point in setting goals unless the achievement (or otherwise) of those goals is also monitored and documented. Goal attainment scaling (GAS) not only provides a useful framework for provides a useful framework for setting goals and monitoring their achievement, it also provides a flexible person centred outcome measure for determining whether the rehabilitation process achieved what it set out to achieve. In addition, the collaborative engagement of patients and/or their families in GAS makes this a useful tool for goal management training and supporting autonomy after patients leave the rehabilitation programme. There are helpful tools for goal setting and GAS that are freely available and a potentially useful resource at	regularly updated in partnership with the person to reflect their progress, goals, and ongoing needs. Goal attainment scaling has not come up in evidence. Also, the committee was of a view that this scale does not apply to everyone, is time-consuming, and would require additional resources to implement, and as such, it would not be appropriate to recommend.

				https://www.kcl.ac.uk/cicelysaunders/resources/tools/gas	
Royal College of Physicians	Guideline	007	015 - 017	**Recommendation 1.1.2** – We are pleased to see the recommendation for a consultant in rehabilitation, but suggest change wording to '*involving rehabilitation specialists, including a consultant in rehabilitation medicine, alongside acute care teams etc…'* RM consultants are part of NHSE national service contract for major trauma and, working with trauma MDT, they provide the necessary expertise to address complex rehabilitation needs and assist with the development of the Rehabilitation Prescription which should be started within 48 hours of admission for patients with ISS scores >8. We also recommend including a specific recommendation for this early start to the rehabilitation prescription, which has been shown to be effective as a tool for identifying and addressing complex rehabilitation needs in the NCASRI audit https://www.kcl.ac.uk/cicelysaunders/ab	Thank you for your comment. We made it more explicit in the guideline that we are looking at a much wider cohort, not only very severe or major trauma with ICCS score >8 (see the Context section). In people with less severe trauma, rehabilitation specialists will not be generally involved. Also, paediatric cases will not have access to rehabilitation specialists because they do not exist for this population. We also have a full section (1.4) on a rehabilitation plan.

				out/rehabilitation/nhs-audit-report-v9-rgb.pdf	
Royal College of Physicians	Guideline	008	013 - 017	**Recommendation 1.1.6** – Once again this section is restricted to physical impairment involving PT and OT only. It would better read '..assess how the person's *physical, cognitive and emotional impairments* might affect their ability to engage.. etc' The recommendation should not just be for OT but for a holistic MDT approach, with coordinated input from all the relevant rehabilitation disciplines (eg P/T, O/T SLT, Psychology, Dietetics, Social work, Rehabilitation Medicine etc). There is strong evidence for this coordinated MDT approach in other areas, including acquired brain Injury, stroke, spinal cord injury, progressive neurological conditions – so it is hard to see why this would not apply to complex trauma.	Thank you for your suggestion. We added a new recommendation to this section, i.e. "As soon as possible after traumatic injury start to assess whether the person has emotional, cognitive, hearing, visual or communication impairments that might affect their ability to engage in rehabilitation and in activities of daily living. Involve OT, psychology and SLT as appropriate."
Royal College of Physicians	Guideline	008	002 - 003	**Recommendation 1.1.4** – 'Avoid delays in acute treatment so that rehabilitation can start as soon as possible, for example, *to maintain movement'*	Thank you for your comment. The first section about 'initial assessment" includes a number of recommendations about whether taking a holistic approach to assessment or specifically about

				Again, there is over-emphasis on physical aspects – we recommend rewording to *'so that rehabilitation can start as soon as possible to minimise complications of disability and optimise physical, cognitive and emotional recovery'*	emotional and psychological needs. Some examples of these recommendations are: 1.1.1, 1.1.3, 1.1.7. The specific recommendation you refer to here is about avoiding delays to surgery for example, to enable rehabilitation to begin as early as possible.
Royal College of Physicians	Guideline	010	015 - 018	**Recommendation 1.2.3:** We support the need to think about brain injury and refer patients for specialist assessment if TBI is a possibility. This recommendation could be strengthened to include consideration of the mechanism of injury. Teams should be aware that CT scans are a crude tool to assess TBI, and MRI may be required for example to assess for diffuse axonal injury.	Thank you for your comment. Specialist assessment and specific rehabilitation interventions for traumatic brain injury are not covered by this guideline but will be covered by a new NICE guideline about Rehabilitation for chronic neurological disorders including traumatic brain injury. We have made a number of additions to the guideline including changes to recommendation 1.2.3 which now reads "Always think about the mechanism of injury and whether the person may have had a head injury. Be aware that the symptoms of traumatic brain injury can be subtle and regular screening may be necessary. If there are clinical symptoms, refer the person for a specialist assessment with healthcare professionals with expertise in traumatic brain injury rehabilitation. See also the NICE guideline

					on head injury.". We have also added information at the start of the cognitive assessment section to explain more clearly that assessment of traumatic brain injury is not covered in that section.
Royal College of Physicians	Guideline	011	019 - 021	**Recommendation 1.2.6:** *'If a person lacks mental capacity, a rehabilitation needs assessment should be carried out in the person's best interests.'* This statement is somewhat ambiguous. Does it mean that assessment should be carried out if it is in the patients best interests, or is it meant to give a stronger steer that assessment will almost always be in the patients best interests, even if the decision is then that they would not want to receive rehabilitation? We believe it is meant to indicate the latter – if so, this could be worded more clearly.	Thank you for your comment. We have clarified the recommendation wording as requested. It now reads 'If a person lacks mental capacity, carry out a rehabilitation needs assessment based on the principles of best interests decision making, as set out in the NICE guideline on decision making and mental capacity.'.
Royal College of Physicians	Guideline	012	007	**Recommendation 1.2.8:** – We strongly support the recommendation for regular MDT team meetings to ensure efficient coordinated care – but these meetings should also include specialist RM consultant, surgeons etc as appropriate	Thank you for your comment. Recommendation 1.2.4 sets out who should form part of the MDT, this includes surgeons and RM specialists. When subsequent recommendations mention the MDT they will be referring potentially to all

				and it would be helpful to state this specifically.	these people attending meetings, but the committee were unable to be more prescriptive because of the breadth of injuries and rehabilitation needs.
Royal College of Physicians	Guideline	019	007 - 011	**Recommendation 1.4.1:** We strongly support the recommendation for developing a rehabilitation plan centred on the person's individual rehabilitation goals. However, the recommendation for use of a rehabilitation should be strengthened so that the recommendation reads '*Use the rehabilitation needs assessment (see the section on multidisciplinary team rehabilitation needs assessment) and the person's rehabilitation goals (see the section on setting rehabilitation goals) to develop a rehabilitation plan for the person supported by a rehabilitation prescription (RP)'.* The RP a person-centred, patient-held tool that is mandated in the major trauma centres and NCASRI audit provides proof of principle that the RP is not only an effective way of documenting a rehabilitation plan – it also supports tracking of individuals	Thank you for your comment. The population covered in the guideline includes those with an injury severity score (ISS) under 9 as well as those currently defined within NHS England commissioning arrangements as suffering from major trauma (ISS>15) or moderately severe trauma (ISS>8). The committee wrote the guideline to cover all these groups and some of the terms used are explained in the 'terms used in this guideline' section. When the guideline uses the term rehabilitation plan it also means rehabilitation prescription for those entitled to one.

				down the care pathway and clinical audit to determine whether the person received the rehabilitation they required, as well as the outcomes that resulted from it. https://www.kcl.ac.uk/cicelysaunders/about/rehabilitation/nhs-audit-report-v9-rgb.pdf	
Royal College of Physicians	Guideline	027	003 - 008	**Recommendation 1.5.10 – monitoring progress against goals:** As noted above, Goal Attainment Scaling (GAS) is an effective tool for goal management training to support self-management, and an important person-centred outcome that includes both patient and clinician report.	Thank you for your comment. The committee preferred to use descriptive terms which they thought would be more helpful for the patient and professionals involved. The tools included were just examples
Royal College of Physicians	Guideline	030	010 - 013	**Recommendation 1.7.3** Reflecting point 12 above, we suggest adjustment of this wording to *'The trauma team should agree the core members of the rehabilitation multidisciplinary team who will establish an injury management plan and start developing a rehabilitation plan, goals and rehabilitation prescription. See recommendation 1.2.4 for details of the*	Thank you for your comment. Due to the differences in terminology throughout rehabilitation healthcare, the committee decided to use the term 'rehabilitation plan' throughout the guideline to describe a general patient-held document which assists communication when people transfer. This is further defined in the glossary, which notes rehabilitation prescription as a possible format for this document. Therefore, no change has been

				multidisciplinary team after hospital admission and recommendation 1.4.1'	made. The population covered in the guideline includes those with an injury severity score (ISS) under 9 as well as those currently defined within NHS England commissioning arrangements as suffering from major trauma (ISS>15) or moderately severe trauma (ISS>8). The committee wrote the guideline to cover all these groups and some of the terms used are explained in the 'terms used in this guideline' section. When the guideline uses the term rehabilitation plan it also means rehabilitation prescription for those entitled to one.
Royal College of Physicians	Guideline	034	010 - 012	**Recommendation 1.8.10 –** we particularly support the recommendation for graded discharge (including overnight or weekend visits for people with complex needs)	Thank you for your comment.
Royal College of Physicians	Guideline	035	019 - 025	**Recommendation 1.8.15** – The principle is fine, but there is limited point in a recommendation to liaise with services that are currently non-existent. This section would benefit from a clearer starting recommendation for vocational rehabilitation resource to be	Thank you for your comment. Please see section 1.10 on commissioning and organisation of rehabilitation services. These guidelines should help those who plan and commission rehabilitation services to build rehabilitation capacity and expertise within the NHS, voluntary

				available in community with specialist recommendations and support from consultant in RM and MDT.	and private sectors to support delivery of this guideline.
Royal College of Physicians	Guideline	035	003 - 006	**Recommendation 1.8.13 –** We recommend re-wording as follows: *'Document in the rehabilitation plan, prescription and handover report how rehabilitation after discharge will be delivered'*	Thank you for your comment. Due to the differences in terminology throughout rehabilitation healthcare, the committee decided to use the term 'rehabilitation plan' throughout the guideline to describe a general patient-held document which assists communication when people transfer. This is further defined in the glossary, which notes rehabilitation prescription as a possible format for this document. Therefore, no change has been made. The population covered in the guideline includes those with an injury severity score (ISS) under 9 as well as those currently defined within NHS England commissioning arrangements as suffering from major trauma (ISS>15) or moderately severe trauma (ISS>8). The committee wrote the guideline to cover all these groups and some of the terms used are explained in the 'terms used in this guideline' section. When the guideline uses the term rehabilitation plan it also

					means rehabilitation prescription for those entitled to one.
Royal College of Physicians	Guideline	039	001 - 028	**Recommendation 1.9.2** – This section describes a vocational rehabilitation resource for trauma patients. It would be clearer to recommend that vocational rehabilitation is an important element of the MDT rehabilitation programme and specialist advice should be available within the treating rehabilitation team (e.g. consultant in RM and vocational OT) to offer support to this population, many of whom are of working age.	Thank you for your comment. There is a focus on rehabilitation for returning to education, work and leisure throughout the guideline, from the assessment sections, through to goal setting, agreeing a plan and designing and delivering programmes. The roles you mention are both already included in the MDT recommendation in section 1.2 about the MDT. It is not possible to recommend that these resources are allocated for everyone at every stage of the pathway and community services are too varied for the committee to be any more prescriptive about this.
Royal College of Physicians	Guideline	042		**Recommendation 1.10.5** – We welcome the section on commissioning and setting out responsibility for commissioning of rehabilitation services and commissioning across the whole care pathway. However, we strongly advise to remove '*(for example, 3-week)'* from this recommendation. Patients who have complex needs requiring tertiary services are generally	Thank you for your comment. Intensive rehabilitation of 3 weeks duration is only an example for which we had supporting economic evidence. Also, the examples that the committee reviewed for intensive musculoskeletal rehabilitation and intensive police physio rehabilitation were all of approximately three weeks duration. It has to be noted that intensive rehabilitation would be given in addition to

				unlikely to make the requisite changes in that time scale.	standard care rehabilitation, and hopefully, some improvement would have been achieved by the time-intensive rehabilitation is initiated. Please refer to the Rehabilitation programmes of therapies and treatments section that includes more detail on intensive rehabilitation and its timing. We also clarified that it is a "tertiary service for trauma rehabilitation".
Royal College of Physicians	Guideline	045	001 - 022	**Recommendation 1.11** – This section is back to being uni-disciplinary and lacks an MDT introductory section along the lines of the importance of a multidisciplinary review involving medical, therapy, nursing and psychological review to agree appropriate interventions to support patient centred goals etc as outlined above	Thank you for your comment. We disagree with your comment that this section is uni-disciplinary. Due to the breadth of the guideline, the committee decided to separate types of rehabilitation into different guideline sections (i.e. physical, psychological and cognitive), to avoid very long lists of recommendations and increase the ease of navigation throughout the document. Therefore, section 1.11 only deals with physical rehabilitation as part of this overall design. However, it does include referrals to other sections of the guideline as appropriate. Regarding your suggestion of a multi-disciplinary team introductory section, the committee think this has been adequately

					covered at the beginning of the guideline. The 'Multidisciplinary team rehabilitation needs assessment' section goes into depth about what a multidisciplinary team in hospital might look like, how they should assess someone's rehabilitation needs and how to develop a holistic rehabilitation plan. Similarly, there are recommendations in the sections concerned with coordination of rehabilitation care that advise on how multidisciplinary teams should function after the assessment stage.
Royal College of Physicians	Guideline	053	007 - 009	**Recommendation 1.12.1** – '*Reassure people that most trauma-related problems with cognitive functioning are temporary.'* This sentence is problematic. Whether cognitive dysfunction is temporary or not depends on a full review to establish undiagnosed traumatic brain injury or significant psychological dysfunction. The wording is loose and should be amended to say: *are te'Once occult brain injury has been excluded, patients can be reassured*	Thank you for your comment. As this guideline does not cover rehabilitation after traumatic brain injury, this recommendation only covers people without traumatic brain injury which reflects your suggested amended wording. However, the committee are aware that this exclusion is not always clear to the reader, which becomes especially important in the sections relating to cognitive functioning. Therefore, they have included an introductory reminder for both the 'Assessing cognitive functioning' and 'Cognitive rehabilitation' sections which

				that most trauma-related problems with cognitive functioning mporary'	reads 'Please note this guideline does not cover assessment or specific rehabilitation interventions for people with traumatic brain injuries. See recommendation 1.2.3 in the section on multidisciplinary team rehabilitation needs assessment.'.
Royal College of Physicians	Guideline	053	014 - 015	**Recommendation 1.12.3** – This section should include a statement that, where cognitive functioning remains a problem, appropriate specialist review should be undertaken ideally by consultant in RM in first instance with involvement of neurologist if appropriate.	Thank you for your comment. Due to the resource impact of recommending rehabilitation medicine consultants or neurologists carry out further assessment. Not all cognitive problems will require this specialists review. Instead, they worded the recommendation to allow healthcare professionals to decide the most appropriate assessment and the most appropriate assessor.
Royal College of Physicians	Guideline	092	026 - 029	This premise is poorly argued- rather than ' there may be more referrals to specialist rehab services earlier in the pathway' this would be better expressed as ' involving specialist rehabilitation as early as possible in the trauma pathway will ensure timely care with a reduction in secondary disability and will support optimal physical, cognitive and emotional recovery for patients.	Thank you for your suggestion. This was slightly rephrased.

Royal College of Physicians	Guideline	096	001 - 006	It is stated that recommendations will have little impact on resources. While reconfiguration of services may have little resource implication, commissioning support for development of an intensive programme for trauma survivors will be of benefit for these patients. While there are specific programmes for spinal injury, neurorehab and amputee services, there are no such commissioned services for patients with complex polytrauma. Patients with polytrauma would benefit from an intensive inpatient rehab resource to address complex injury and maximise function reducing the burden on carers and community services.	Thank you for your comment. We are unsure what section of the guideline this is referring to. The page and line numbers correspond to the impact section of 'A single point of contact, key contact and key worker after discharge', but the context of your comment appears to be referring to the 'Commissioning' section. The committee hope that the recommendations made in 'Intensive rehabilitation programmes', combined with those in 'Commissioning' and 'Organisation', will support healthcare organisations when applying for expansion of services. Also, because rehabilitation services are already being carried out, intensive rehabilitation could be delivered through service redesign and repurposing of existing funds and resources rather than introducing them as completely new resources. Moreover, intensive rehabilitation would potentially represent value for money as per the economic model, and only a small group of people with the most severe injuries / complex polytrauma would be eligible for an intensive rehabilitation programme.

Royal College of Speech and Language Therapists	Comments form	Q1		**Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why** This guideline appears to be attempting to cover a wide spectrum of injury across a broad range of settings including acute treatment and rehabilitation. Some recommendations and statements associated with traumatic brain injury are included, despite the guideline also stating that this is excluded. Where specific injuries such as spinal injury are included this tends to be short on detail, so most recommendations are very broad. This may limit the impact of this guideline. The guideline has not captured the patients typically seen by speech and language therapists and does not clearly state what they can offer to support these patients, therefore there is likely to be a limit to the impact on SLT practices and services.	Thank you for your comment. Due to the large scope of the guideline, recommendations made regarding specific injuries are broad to ensure that they apply to the majority of settings where rehabilitation after traumatic injury may take place. Where more detailed interventions or treatment may be needed, referral to specialist services has been recommended or readers have been signposted to additional NICE guidance. We have added a number of references to the role of SLTs throughout the guideline as well as more references to communication, speech and language therapies. However, specialist assessment and specific rehabilitation interventions for traumatic brain injury are not covered by this guideline but will be covered by a new NICE guideline about Rehabilitation for chronic neurological disorders including traumatic brain injury (this will also cover neurological aspects of spinal injury). We have made a number of additions to the guideline including changes to recommendation 1.2.3 which now reads

					"Always think about the mechanism of injury and whether the person may have had a head injury. Be aware that the symptoms of traumatic brain injury can be subtle and regular screening may be necessary. If there are clinical symptoms, refer the person for a specialist assessment with healthcare professionals with expertise in traumatic brain injury rehabilitation. See also the NICE guideline on head injury." We have also added information at the start of the cognitive assessment section to explain more clearly that assessment of traumatic brain injury is not covered in that section. However we included evidence from people with traumatic brain injury for a number of our reviews, specifically about the coordination of care because coordination of care needed to cover people with multiple injuries, one of which might be traumatic brain injury.
Royal College of Speech and Language Therapists	Comments form	Q2		**Would implementation of any of the draft recommendations have significant cost implications?** There may be cost implications in community services where there is	Thank you for your response. We agree that there may some resource impact in areas where services are currently underperforming or do not have an optimal composition of MDT. The potential

				currently under-investment or lack of co-ordination and for services who need to develop their MDT with appropriate professional disciplines. There may also be cost implications around the intensity of therapy that might be required, subject to existing staffing levels.	resource impact has been acknowledged throughout the guideline. Intensive rehabilitation is already available for some people (for example, people who have lost a limb), and because rehabilitation services are already being carried out, intensive rehabilitation could be delivered through service redesign and repurposing of existing funds and resources rather than introducing them as completely new resources. We have passed your comment onto the NICE implementation support team.
Royal College of Speech and Language Therapists	Comments form	Q4		The recommendations in this guideline were largely developed before the coronavirus pandemic. Please tell us if there are any particular issues relating to COVID-19 that we should take into account when finalising the guideline for publication It would be valuable to explore the benefits and limitations of the use of telehealth to receive assessment and therapy. Please take into account isolation of some people due to COVID restrictions	Thank you for your comment. The committee agree that telehealth can be a valuable tool in making rehabilitation care more accessible, and have made several recommendations concerning its use (for example, during review appointments).

				and how this affects reintegration into society after hospitalisation and injury.	
Royal College of Speech and Language Therapists	Guideline	General	General	This guideline appears to be attempting to cover a wide spectrum of injury across a broad range of settings including acute treatment and rehabilitation. Some recommendations and statements associated with traumatic brain injury are included, despite the guideline also stating that this is excluded. Where specific injuries such as spinal injury are included, this tends to be short on detail, so most recommendations are very broad.	Thank you for your comment. We agree that the guideline covers a wide spectrum of injuries and rehabilitation options. As per the guideline scope, traumatic injury was defined as any injury that required admission to hospital at the time of the injury. Similarly, all inpatient, outpatient and community rehabilitation services were included. The only settings excluded were A+E departments, critical care units and prisons. Due to the breadth of the guideline, recommendations have been designed to be inclusive rather than specific, in order to apply to the large population. Regarding traumatic brain injury (TBI), interventions specific to TBI rehabilitation are excluded as per the scope. However, as traumatic injury is rarely discreet, the committee were aware that people will often have a mix of injuries (of which TBI could be one). To make sure the recommendations were holistic for the whole trauma populations, protocols for assessment, identification and co-

					ordination evidence reviews did not exclude TBI. Rehabilitation after TBI will be covered in an upcoming NICE guideline on rehabilitation for chronic neurological disorders, as will more specific recommendations on spinal cord injury.
Royal College of Speech and Language Therapists	Guideline	General	General	Consideration should be made throughout the guideline for individuals who speak other languages.	Thank you for your comment. Communication with patients is covered in the additional NICE guidelines referenced in the 'Principles for sharing information and involving family and carers' section. Both CG138 'Patient experience in adult NHS services: improving the experience of care for people using adult NHS services' and NG204 'Babies, children and young people's experience of healthcare' have recommendations regarding people who do not have English as their first language.
Royal College of Speech and Language Therapists	Guideline	007 - 009	all	It is not clear why some points are in 1.1 and others in 1.2 e.g. check for any changes in cognition and communication abilities is not listed in 1.1. Best practice would be for all needs to be assessed and addressed by the multi-disciplinary team.	Thank you for your comment. We clarified that in section 1.1, we mean 'Initial' assessment, assessment actions that needed completing immediately because of their importance at the initial stage. All needs would then be subsequently addressed by the MDT, as per the next section (1.2). As suggested, we also added a new recommendation to section

					1.1, i.e. "1.1.7 As soon as possible after a traumatic injury, start to assess whether the person has new or existing cognitive, hearing, visual or communication impairments or emotional difficulties that might affect their ability to engage in rehabilitation and in activities of daily living. Involve occupational therapy, psychology and speech and language therapy as appropriate."
Royal College of Speech and Language Therapists	Guideline	002	019	RCLST recommends this is worded as "**speech, voice, language and other communication difficulties**", to reflect the range of needs that may be experienced by this patient group, (and likely to require treatment by speech and language therapists.)	Thank you for your comment. We have added the word language so this now reads .."cognitive function, speech, language and communication.."
Royal College of Speech and Language Therapists	Guideline	004	005 - 011	The guideline includes holistic and multidisciplinary assessments for rehabilitation, and the coordination of services for people with complex traumatic injuries, of which one may be traumatic brain injury. Content of guideline often suggests brain injury is included despite this initial statement.	Thank you for your comment. Traumatic brain injury (TBI), including interventions specific to TBI rehabilitation, are excluded as per the scope. However, as traumatic injury is rarely discreet, the committee were aware that people will often have a mix of injuries (of which TBI could be one). To make sure the recommendations were holistic for the whole trauma populations, evidence reviews and recommendations

					for assessment, identification and co-ordination for rehabilitation after traumatic injury did not exclude TBI.
Royal College of Speech and Language Therapists	Guideline	008	024	Suggest "checks to see if the person can swallow safely" should be changed to "**checks to judge swallow safety and ability to eat and drink safely and effectively**" or similar. This is because swallow function is part of a broader and more complex eating and drinking process. For example in this patient group there is potential for mastication problems but the "swallow" may be unimpaired. It is not just checking for a potential oro-pharyngeal dysphagia (caused by their injury or their treatment such as intubation trauma) but it also requires a full assessment of any facial injury/swelling/bruising and/or impact on dentition eg if lost or loosened. The potential for facial fractures also needs to be considered. Factors such as ability to feed themselves, maintain appropriate	Thank you for your comment. The committee thought that the focus for the purposes of this guideline should be on the ability to swallow. There may be a number of issues with eating or drinking as a result of injuries and the committee acknowledged these but agreed that treatments for those would fall outside the remit of this guideline. There is recommendation in the initial assessment section to check if the person can swallow safely. The committee did not think they could go into further detail than this and also wanted to direct people to the NICE guideline on nutrition support for adults.

				positioning for eating and drinking etc also need to be considered. Suggest recommendation is expanded to state that **if there is any indication of difficulty with eating and drinking (e.g. coughing, choking, changing vocal tone) that a dysphagia assessment is carried out by a speech and language therapist.**	
Royal College of Speech and Language Therapists	Guideline	010	015	Reference to section on assessing cognitive function should also reference assessing speech, language and communication, as these tend to be inter-linked.	Thank you for your comment. We have amended the recommendation to read 'As part of the rehabilitation needs assessment after a traumatic injury, the multidisciplinary team should ask about any cognitive problems, for example:… •communication, speech or language changes (for example, withdrawal or selective mutism).'.
Royal College of Speech and Language Therapists	Guideline	011	005	There is also a need to highlight the importance of frequent assessments post-traumatic injury due to the high likelihood of daily changes associated with recovery and rapid changes related to clinical management. .	Thank you for your comment. However, we may not know where the individual is along the pathway. As a result, we stated 'regularly' and thought it would not be helpful to be too prescriptive. The frequency of reassessment would depend on an individual and their needs.

Royal College of Speech and Language Therapists	Guideline	012	007	Fully integrated working is of wider importance for coordinating patient care, than suggested by this point. Different disciplines should have the opportunity for team meetings to discuss outcomes of assessment and an integrated rehabilitation programme and to prevent professionals working in parallel. Nancarrow, S.A., Booth, A., Ariss, S. et al. Ten principles of good interdisciplinary team work. Hum Resour Health 11, 19 (2013). https://doi.org/10.1186/1478-4491-11-19	Thank you for your comment. The guideline makes numerous references to the importance of coordinated support and care and a multidisciplinary approach to assessment, programme delivery and review. This is set out particularly in sections 1 to 10 which cover all aspects of the rehab pathway from initial assessment in hospital to supporting access and participation in education ,work and community. The importance of communication between different practitioners and the importance of working as a team around the adult or the child is highlighted throughout.
Royal College of Speech and Language Therapists	Guideline	014	002	RCSLT recommends that this section on physical functioning should be expanded. The team should also include **a speech and language therapist with appropriate skills and competencies**. And the assessment should include: • **Assessing swallow safety and ability to eat and drink safely and effectively (dysphagia)**	Thank you for your comment. Speech and language therapists have been included as an example of allied healthcare professionals in a previous recommendation on multi-disciplinary team composition. Similarly, completion of a swallowing assessment is recommended in the earlier 'Assessment and early intervention' section. The committee discussed that this would include ability to eat and drink, saliva management and oro-motor function. However, we have

				• **Assessing saliva management and oro-motor function** • **Assessing speech intelligibility and voice** Speech intelligibility can be affected for a variety of reasons eg facial fractures, lost dentition, facial oedema, or related to more central neurological changes. Voice can be affected for a variety of reasons related to the traumatic injury itself or due to the treatment received eg intubation	amended the recommendation to include changes in communication, to cover speech intelligibility and voice. The recommendation now reads 'As part of the rehabilitation needs assessment after a traumatic injury, the multidisciplinary team with appropriate skills and competencies, should assess the person's pre-injury and current physical functioning, which should include:… • assessing whether there are any new difficulties with communication, speech and language'.
Royal College of Speech and Language Therapists	Guideline	016	004	The reference to 'communication changes' does not sufficiently cover the broad range of speech, language, voice and communication difficulties that could be seen in this patient group. RCSLT would suggest section heading should be 'Assessing cognitive **and communication** functioning' as it is frequently difficult to separate these in the early phases of recovery.	Thank you for your comment. We have not changed the section heading, as physical, cognitive and psychological are the terms used throughout the guideline headings. However, we have amended the recommendation in question to read 'As part of the rehabilitation needs assessment after a traumatic injury, the multidisciplinary team should ask about any cognitive problems, for example: … •communication, speech or language changes (for example, withdrawal or selective mutism).'.

Royal College of Speech and Language Therapists	Guideline	016	023	Further clarity on need for speech and language therapy referral (and other specialists) would be welcomed.	Thank you for your comment. The committee discussed that the recommendation would not be able to include all possible reasons people with cognitive difficulties should be referred to other specialties without becoming too restrictive. There is also a risk that certain rare conditions would not be included and therefore overlooked in practice. The recommendation is worded to leave the need for referral up to the expertise and experience of individual healthcare professionals. Therefore, no changes have been made.
Royal College of Speech and Language Therapists	Guideline	020	013	"written in clear English" is not a clearly defined recommendation and does not recognise the needs of individuals with specific communication learning or literacy needs (possibly, but not necessarily, as a result of their injury) or who do not speak English as their first language. We would recommend this is worded as: • **presented without jargon, in a format tailored to the person's communication needs and preferences**	Thank you for your comment. No amendment has been made as it is not always possible for standard forms to be provided in a range of languages. However, communication of information with patients is covered in both CG138 'Patient experience in adult NHS services: improving the experience of care for people using adult NHS services' and NG204 'Babies, children and young people's experience of healthcare'. These guidelines are signposted in the 'Principles for sharing information and involving family

					and carers' section for further information, and have recommendations regarding people who do not have English as their first language, people who may need a translation service and people who need information in different formats.
Royal College of Speech and Language Therapists	Guideline	024	002	Please clarify what is meant by 3-week i.e. lasting 3 weeks or 3 times a week ?	Thank you for your comment. We have slightly reworded the recommendation to make it clearer. It was referring a programme that was 3 weeks in duration.
Royal College of Speech and Language Therapists	Guideline	024	011	Please clarify what is meant by 3-week i.e. lasting 3 weeks or 3 times a week ?	Thank you for your comment. We have reworded the recommendation to clarify that we mean intensive rehabilitation programme that is of 3-weeks duration (and not 3-times per week).
Royal College of Speech and Language Therapists	Guideline	028	017	“clear language” is not defined. It would be better if this could be more specific, e.g. **avoid complex language and jargon**	Thank you for your comment. NICE often uses this simple phrase in guidelines and prefers to keep messages succinct where possible. The committee think the message is clear and unambiguous here.
Royal College of Speech and Language Therapists	Guideline	035	004	The discharging service will be unlikely to determine how rehabilitation will be delivered by the receiving service.	Thank you for your support. The committee wrote recommendations about how the discharge service should work together with community to agree this in as much detail as possible before the person is discharged. The committee agreed this would be best practice, whilst

					recognising that rehab plans change rapidly and that information about future rehab may be incomplete on discharge.
Royal College of Speech and Language Therapists	Guideline	044	009	All professions with specialist expertise (which may not be available in the community) could work together with community partners	Thank you for your comment. This list is not exhaustive and the committee did not want to add any more examples.
Royal College of Speech and Language Therapists	Guideline	045	all	Section 1.11 RCSLT recommends that this section on physical functioning should be expanded to include rehabilitation of • **swallow safety and ability to eat and drink safely and effectively (dysphagia)** • **saliva management and oro-motor function** • **speech intelligibility and voice** Speech intelligibility can be affected for a variety of reasons eg facial fractures, lost dentition, facial oedema, or related to more central neurological changes. Voice can be affected for a variety of reasons related to the traumatic injury itself or due to the treatment received eg intubation.	Thank you for your comment. Regarding safely swallowing and dysphagia, this is covered in 'Initial assessment and early interventions' which recommends assessing swallowing and signposts the NICE guideline on nutritional support. We have now included new difficulties with communication, speech and language as part of the rehabilitation needs assessment. The committee have also made a new recommendation in section 1.11, Physical rehabilitation – early interventions and principles , referring to the possibility of voice and speech intelligibility changes after traumatic injuries and recommending early referral to appropriate specialties as needed.

Royal College of Speech and Language Therapists	Guideline	053		These bullet points specifying formats to support understanding are welcome but “clear language” is not defined and could be more specific e.g. **avoiding complex language and jargon**	Thank you for your comment. We disagree - clear language is a common, widely understood term. Additionally, healthcare professional communication styles are covered in the additional NICE guidelines referenced in the 'Principles for sharing information and involving family and carers' section. Both CG138 'Patient experience in adult NHS services: improving the experience of care for people using adult NHS services' and NG204 'Babies, children and young people's experience of healthcare' use the terms 'clear information' and 'clear language' respectively, and expand upon this within these recommendations. Therefore, no change has been made.
Royal College of Speech and Language Therapists	Guideline	053	007	This section does not acknowledge the link between cognition and communication or cover the broad range of speech, language, voice and communication difficulties that could be seen in this patient group. RCSLT would suggest section should be expanded and headed ‘Cognitive **and communication** rehabilitation’.	Thank you for your comment. This link is covered earlier in the guideline, in the 'Assessing cognitive function' section. We have also added a recommendation in the 'Initial assessment and early interventions' section that recommends referral to speech and language therapy for people with cognitive or communication impairments that might affect their ability to engage in rehabilitation and in activities

					of daily living. Therefore, no changes have been made.
Royal College of Speech and Language Therapists	Guideline	067	002	This should be expanded to reflect the evidence about cervical spine injuries/surgery and dysphagia e.g. **Where there are suspicions or concerns about swallow safety, aspiration risk, and eating and drinking difficulties this should be assessed by an speech and language therapist. This is particularly the case if the cervical spine is involved**. Edward Chaw, Kazuko Shem, Kathleen Castillo, Sandra Wong, James Chang; Dysphagia and Associated Respiratory Considerations in Cervical Spinal Cord Injury. *Top Spinal Cord Inj Rehabil* 1 October 2012; 18 (4): 291–299. doi: https://doi.org/10.1310/sci1804-291 Papadopoulou, S. Exarchakos, G, Beris, A & Ploumis, A (2013) Dysphagia Associated with Cervical Spine and Postural Disorders. Dysphagia, 28:469–480 DOI 10.1007/s00455-013-9484-7	Thank you for your comment. Unfortunately, neither of the articles referenced in your comment can be added to our evidence reviews as they did not meet the protocol inclusion criteria for the following reasons: Chaw (2012) Dysphagia and Associated Respiratory Considerations in Cervical Spinal Cord Injury. • Study design not in protocols – No comparative group Papadopoulou (2013) Dysphagia Associated with Cervical Spine and Postural Disorders. • Narrative review with no original data presented Due to the lack of evidence in this area, the committee were not able issue strong recommendations. However, they discussed the increased risk of dysphagia in people with high level spinal cord injury and used their experience and expertise to make the following recommendation: 'Be aware that people with cervical spine injuries and those managed on flat bed

					rest, are particularly at risk of swallowing and speech difficulties and should be assessed early for risk of aspiration.'
Royal College of Speech and Language Therapists	Guideline	067	012	RCSLT recommend an additional recommendation: **Voice quality should be assessed and patient referred to SLT and/or ENT as required.**	Thank you for your comment. The committee have added a new recommendation in the 'Respiratory function' section of the guideline that reads 'Assess voice quality and refer to a speech and language therapist and/or ear, nose and throat specialist as needed.'.
Royal Manchester Children's Hospital	Guideline	Geneeral	General	Does there need to be a separate guideline for children in order to fully address child specific rehabilitation needs? The guideline should incorporate play, distraction therapies, hospital school etc. Return to education is a fundamental aspect of a child's long term recovery the guideline needs to cover this. It should include school reintegration, school fit note and measurement of educational attainment	Thank you for your comment. The guideline is designed to cover all ages of the population, including children and young people, so no separate guideline will be needed. However, the committee agreed that there are unique considerations and concerns for the paediatric population. As such, separate literature searches, sifting and data analysis were undertaken for children and young people. These included additional interventions (for example, play therapy) and additional outcome measures (for example, return to education). Where appropriate, the committee have used the evidence and their expertise to issue recommendations specific to children and

					young people (particularly concerning return to education, growing and developing with traumatic injuries, and increased psychosocial support during puberty and teenage years).
Royal Manchester Children's Hospital	Guideline	General	General	Why does the guidance not cover abdominal injuries? Is this required as per comment above	Thank you for your comment. Traumatic injuries requiring separate recommendations were identified by stakeholders during the guideline scoping process. Abdominal trauma was not identified as one of them.
Royal Manchester Children's Hospital	Guideline	General	General	Why does the guidance not cover poly-trauma/combinations of multiple injuries? There are different sets of considerations for multiple injuries.	Thank you for your comment. The guideline is about people with complex rehabilitation needs resulting from any or multiple traumatic injuries and the recommendations are therefore focused on people with any and multiple traumatic injuries unless otherwise stated. The context section at the beginning of the guideline and the 'terms used in this guideline' at the end of the guideline set how these are defined.
Royal Manchester Children's Hospital	Guideline	Research Recommendations		1. What is the evidence for a graded return to activity after different types of trauma injuries: Head injuries, limb fractures, abdominal injuries? (Systematic reviews of the literature).	Thank you for your comment. Responses to each of your points in turn: 1. We did not ask this as a review question, so are unable to make a research recommendation in this area,

				2. What are the needs of injured children throughout the full trajectory of recovery/what rehabilitation needs are unmet? (This work is currently being undertaken by S. Jones). https://www.research.manchester.ac.uk/portal/en/theses/understanding-and-measuring-the-needs-of-injured-children-the-development-of-the-manchester-needs-tool-for-injured-children-mantic(e7e93812-5774-43d2-83cd-54cde8f6c2fc).html 3. What is the most effective method to deliver follow up support following discharge from hospital i.e telemed appts, face to face, video consultations?	because we have not looked to see what evidence already exists. 2. We did not ask this question across the full trajectory, but only at a certain target point (when being discharged). As some evidence was found in this area, the committee did not prioritise this for further research. They instead focused on areas where no evidence was located. 3. We have asked this question as a qualitative question and identified several moderate to low quality themes relating to flexibility of appointments, format, personalisation and accessibility. The committee discussed this evidence and made recommendations on how rehabilitation after traumatic injury can be supported after discharge from the hospital. The section 'Coordination of rehabilitation care at discharge' recommends offering a variety of appointment formats, including video and telephone ones. The committee therefore decided to prioritise other questions where they feel additional research would have the most impact, allowing new or stronger

					recommendations to be made in future guidelines.

Royal Manchester Children's Hospital	Guideline	Research Recommendations		Research is required to look at the cost effectiveness of children's rehabilitation including
				• Socioeconomic benefits
				  ○ Parental return to work
				  ○ Access to benefits and financial support
				  ○ Social care/family support
				  ○ Long term outcomes and employability of the patient in adulthood
				  ○ Effects on siblings
				  ○ Access to housing
				  ○ Psychological impact to the child and family
				• Health economics
				  ○ Long term requirement for therapy provision and equipment
				  ○ Access to specialist service providers
				  ○ Cost of rehabilitation programmes including - individual funding
					Thank you for your comment. We agreed to add "cost-effectiveness" to the research recommendation questions that did not already include this (1-4) and as outcomes where it is not already included (3). This will cover the health economic outcomes and some of the socio-economic benefits mentioned in your comment. The committee agreed research recommendations based on gaps in the evidence for the research questions and evidence reviews completed as part of this project, and cannot recommend further research in areas where the project did not specifically look for evidence (for example, effect on siblings, education, transport).

				requests, continuing health care, universal services o Cost of inpatient rehabilitation and delayed discharges-both on hospital flow and financial costs • Educational o Attainment levels o Time to return to school o Additional costs to support the child's return to education ▪ Emergency funding ▪ EHCP Transport	
Royal Manchester Children's Hospital	Guideline	General		Jones S, Tyson S, Davis N, Yorke J. Qualitative study of the needs of injured children and their families after a child's traumatic injury. BMJ open [Internet]. 2020 Nov 30 [cited 2020 Dec 8];10(11):e036682. Available from: http://www.ncbi.nlm.nih.gov/pubmed/33257479	Thank you for your comment. Unfortunately, none of the articles referenced in your comment can be added to our systematic reviews as they did not meet the protocol inclusion criteria for the following reasons: Braaf et al. Patient-identified information and communication needs in the context of major trauma.

				Braaf S, Ameratunga S, Nunn A, Christie N, Teague W, Judson R, et al. Patient-identified information and communication needs in the context of major trauma. BMC Health Services Research [Internet]. 2018 Dec 7 [cited 2019 Aug 14];18(1):163. Available from: http://www.ncbi.nlm.nih.gov/pubmed/29514689 Jones S, Tyson S, Yorke J, Davis N. The impact of injury: The experiences of children and families after a child's traumatic injury. Clinical Rehabilitation [Internet]. 2020 Dec 7 [cited 2021 Jan 5];35(4):614–25. Available from: http://journals.sagepub.com/doi/10.1177/0269215520975127 Corfield AR, MacKay DF, Pell JP. Association between trauma and socioeconomic deprivation: A registry-based, Scotland-wide retrospective cohort study of 9,238 patients. Scandinavian Journal of Trauma, Resuscitation and Emergency Medicine [Internet]. 2016 Jul 7 [cited 2021 May 4];24(1):90. Available from:	• Already included in evidence review D.2 and D.4. Corfield et al. Association between trauma and socioeconomic deprivation: A registry-based, Scotland-wide retrospective cohort study of 9,238 patients. • Study design for quantitative review – No comparison group. NCASRI Project team. Specialist Rehabilitation following major Injury (NCASRI) Final Audit Report. • Audits are not included. Jones et al. Qualitative study of the needs of injured children and their families after a child's traumatic injury. Jones et al. The impact of injury: The experiences of children and families after a child's traumatic injury. • Date of last search for qualitative reviews – Jan 2020. However, after reading the above 2 articles, we are confident that no relevant themes were presented which had not been captured in our systematic reviews and resulting recommendations.

				http://sjtrem.biomedcentral.com/articles/10.1186/s13049-016-0275-7 NCASRI Project team, Turner-Stokes L. Specialist Rehabilitation following major Injury (NCASRI) Final Audit Report v.17.0 [Internet]. London; 2019 [cited 2019 May 7]. Available from: https://www.bsrm.org.uk/publications/latest-news/post/31-national-clinical-audit-of-specialist-rehabilitation-following-major-trauma-final-report	
Royal Manchester Children's Hospital	Guideline	045 - 073	General	Guideline from this point on becomes a mix of being generic and very specific. It would be difficult to include all aspects of physical rehabilitation, spinal cord injury rehabilitation, limb loss etc in a few pages. It doesn't include abdominal injuries, pelvic injuries. Should the guideline cover the principles of rehabilitation rather than being prescriptive with links to the guidelines for managing fractures or developing further prescriptive guidance in the future.	Thank you for your comment. The scope for the guideline, which was agreed with stakeholders, focused on evidence about the effectiveness of a wide range of general rehabilitation interventions that would help a wide range of children, young people and adults with a range of injuries. It also chose to focus on 4 specific injury areas: limb, spinal, nerve and chest and aimed to write some 'additional' recommendations for those specific injury areas - although the rest of the guideline also covers those. The committee feels that the guideline contains a lot of recommendations which DO set out the

					core principles of rehabilitation for ALL patients with complex rehabilitation needs after admission to hospital, regardless if their injury severity score
Royal Manchester Children's Hospital	Guideline	002 - 003	001	A patient with one complex need may have significant rehabilitation needs/goals. 2 or more AHP's- A patient with complex rehabilitation needs may not require AHP input but may have significant rehab needs which may be met by other professionals i.e. specialist nurse, psychology, social care, educational support	Thank you for your comment. The definition of complex needs used throughout the guideline evolved during the scoping process, in order to best represent the population of interest. The committee did not wish to define the population by the severity of the injury but by the need for complex rehabilitation involving multiple practitioners. We have changed this in the context section to "at least 2 AHPs, which may include rehabilitation medicine".
Royal Manchester Children's Hospital	Guideline	001		• Who is for? I wondered about including professionals working in education/third sector organisations who also support children after traumatic injury.	Thank you for your comment. These groups would be included within the term 'providers of rehabilitation services'. We have not excluded any types of providers.
Royal Manchester Children's Hospital	Guideline	003	011 - 012	Sentence states "Further assessments are performed over time to capture changing needs" The Major Trauma Networks don't have any formal methods of assessing children's ongoing needs after hospital	Thank you for your comment. The committee discussed the lack of formal, validated methods of assessment for children with traumatic injuries after discharge. The sentence is generic to allow for the range of practice in this area.

				discharge. Identification of ongoing needs may be dependent on what follow up children require after discharge and whether they are being managed by a multi-disciplinary team. Abdominal injuries often receive minimal follow up. Work is underway to develop a tool which injured children and families can use to report their needs throughout recovery. https://www.research.manchester.ac.uk/portal/en/theses/understanding-and-measuring-the-needs-of-injured-children-the-development-of-the-manchester-needs-tool-for-injured-children-mantic(e7e93812-5774-43d2-83cd-54cde8f6c2fc).html	We welcome the development and publication of assessment tools in this area.
Royal Manchester Children's Hospital	Guideline	003	014	Often access to rehabilitation can also be related to injury type or rehabilitation need i.e. PT services for MSK, abdo trauma struggle to access dietectic support, limited SaLT for ABI patient	Thank you for your comment. We have amended the text to include these additional barriers to rehabilitation access.
Royal Manchester Children's Hospital	Guideline	007 008 009	All	Section 1.1 In this section it should include early assessment of pre injury health, education/vocation, psychosocial,	Thank you for your comment. This is already covered substantially in rec 1.2.5 (needs assessment), as well as specific recommendations in physical rehabilitation

				behavioural/learning disability needs and current needs.	and cognitive recommendation. Initial assessment occurs before this full needs assessment. However, we have added an additional recommendation in this section which addresses some of your points because it was thought these were important to identify prior to a full needs assessment taking place. "As soon as possible after a traumatic injury, start to assess whether the person has new or existing cognitive, hearing, visual or communication impairments or emotional difficulties that might affect their ability to engage in rehabilitation and in activities of daily living. Involve occupational therapy, psychology and speech and language therapy as appropriate."
Royal Manchester Children's Hospital	Guideline	007 008 009	All	Section 1.1 This section includes core rehabilitation assessments but not all. Initial assessment may include (as per rehab prescription): Breathing Pain management Nutrition Toileting ADL's	Thank you for your comment. The committee did not want to create a checklist or a template for a needs assessment, rehabilitation plan or prescription, as they believed it would be too prescriptive across the wide range of settings and injuries this guideline covers. They decided to leave the discussion on what to include to the expertise and experience of healthcare professionals

				Wound/Tissue viability Mobility Home layout Sensory Needs Cognitive Function Work and education Access to play and activities Emotional wellbeing Social and family support including benefits, safeguarding Patient and family wishes This would identify who the patient should be referred to as part of the MDT	and settings. Although section 1.1 focuses on assessment, there are also additional sections on assessment for physical, cognitive and psychological rehabilitation and specific assessment considerations for limb loss, spinal injury, nerve injury and chest injury and there are references to assessment throughout the guideline, for example in the sections on coordination of care and discharge.
Royal Manchester Children's Hospital	Guideline	008	001	Section 1.1.14 – Consideration should be given to including in this section the importance of monitoring needs throughout recovery. Evidence shows that new needs often develop after hospital discharge as a child and family reintegrate into their usual life. (1) It may also be important to include "the provision of education" about how to manage their injury, what to symptoms to expect, "do's and don'ts etc. Evidence indicates that is very	Thank you for your comment. The committee discussed that your suggested comments have been covered in other sections of the guideline. Monitoring is as part of an ongoing assessment of rehabilitation needs is highlighted throughout the guideline. For example, the 'General principles for rehabilitation programmes' section recommends carrying out and documenting regular progress reviews and a final assessment. This will allow rehabilitation professionals to review

				important for injured children and families to know what to expect, especially on the return home from hospital. Start rehabilitation when the person is ready and able to engage-patients in PICU, patients with cognitive dysfunction, CYP rehab should start as soon as appropriate i.e tonal management, splints etc In this section it should include assessment of pre injury health, education/vocation, psychosocial, behavioural/learning disability needs and current needs.	outcomes, update the rehabilitation plan and detail any ongoing rehabilitation needs. An additional recommendation advises the need to include post-programme follow-up appointments. Monitoring rehabilitation needs is also referenced in the 'Supporting access and participation in education , work and community (adjustment and goal settings)'. This section includes another 1 of your suggestions, working with education providers. Finally, there are various references to considering pre-injury health and the need to start rehabilitation when the person is ready throughout the initial 2 guideline sections ('Initial assessment and early interventions' and 'Multidisciplinary team rehabilitation needs assessment'). For example, 1 recommendation reads 'As part of the rehabilitation needs assessment after a traumatic injury, the multidisciplinary team should assess the person's pre-injury and current physical functioning , which should include ....'.

Royal Manchester Children's Hospital	Guideline	008	004	States-Start rehabilitation when the person is ready and able to engage. patients in PICU, patients with cognitive dysfunction, CYP rehab should start rehabilitation as soon as clinically indicated i.e tonal management, splints, positioning programmes etc	Thank you for your comment. This is covered in a recommendation located in the next section, which relates to assessing when a person is ready to engage in rehabilitation and what measures can be taken to increase this engagement. We have not amended the recommendation as suggested, but have signposted to the subsequent recommendation. The text now reads 'After a traumatic injury:... • Start rehabilitation when the person is ready and able to engage and participate (see also recommendation 1.2.5).'.
Royal Manchester Children's Hospital	Guideline	010	019	Should the MDT reflect the trauma peer review standards for an MDT? include safeguarding	Thank you for your comment. The committee acknowledge there is a lot of information available in the rehabilitation sector about the constituency of an MDT. The MDTs referenced in this guideline are specific to the population of the guideline or guideline sections and are based on an expert consensus view from the committee members. The importance of safeguarding has been highlighted in recommendation 1.1.13 but the committee did not want to be prescriptive about who should have this expertise on an MDT.

Royal Manchester Children's Hospital	Guideline	011	005	Add safeguarding / social needs / physical ability restrictions, mobility, nausea, level of cooperation, consciousness, level of motivation	Thank you for your comment. The recommendation referred to in your comment is about timing of assessment - as soon as possible after traumatic injury, when measures are being taken to optimise engagement. The subsequent list notes these measures rather than including what the assessment should include. This is covered by other areas of the guideline: physical ability and mobility are covered in physical assessment; consciousness is covered in cognitive assessment; and safeguarding, social needs and levels of co-operation and motivation are covered in psychological assessment. The only consideration not specifically mentioned in the guideline is nausea, which is covered by the recommendation 'Assess the person for factors that may affect their ability to engage in rehabilitation.'. Therefore, no changes have been made.
Royal Manchester Children's Hospital	Guideline	012	009	1.2.9 Later in the guidance it stipulates that information delivery should be consistent, it would be useful to highlight this in this section as well.	Thank you for your comment. NICE guidelines would not usually repeat recommendations in different sections. This recommendation is also more focused on the discussion of available

					information (that may be changing daily) and how this should be done. The committee wanted to keep the focus on this point and also on being clear where information is uncertain e.g. with regards long term prognosis.
Royal Manchester Children's Hospital	Guideline	014	002	1.2.12 When assessing physical functioning, it would benefit professionals if the recommendations were in assessment order.	Thank you for your comment. The committee discussed that the order of the rehabilitation needs assessment would change depending on each patient and their presentation, and specifying a particular order would be too prescriptive for healthcare professionals. Therefore, no amendments have been made.
Royal Manchester Children's Hospital	Guideline	014	026	Add skin care regime, checking pressure points, wound care	Thank you for your comment. We have expanded the recommendation to include skin and wound care. The recommendation now reads as 'As part of the rehabilitation needs assessment after a traumatic injury, the multidisciplinary team with appropriate skills and competencies, should assess the person's pre-injury and current physical functioning, which should include:…. assessing skin care, wound care and pressure area management'.

Royal Manchester Children's Hospital	Guideline	015	007	Assess the patient for factors which may affect engagement - this may be more beneficial at the start of the initial assessment	Thank you for your comment. This recommendation is regarding engagement with rehabilitation, rather than engagement with the assessment process. It is located at the end of the section because it is the step between assessing rehabilitation needs (this section) and developing rehabilitation goals and plans (next sections). Therefore, no change has been made.
Royal Manchester Children's Hospital	Guideline	016	All	1.2.17 and 1.2.18 Should these sections be swapped in position, 1.2.18 would help you to assess if someone has a cognitive functioning problem, should this assessment be in the initial assessment to assess their initial rehab needs. (1.2.17) Would this be completed in the initial assessment as part of the background history	Thank you for your comment. The committee discussed the order of the recommendation, and did not wish to make a change. The reason 1.2.17 is listed first is because, if other causes such as dementia or traumatic brain injury are found to be the cause of cognitive problems, they are out of scope for this guideline and will require assessment, management and rehabilitation from different healthcare specialities. A background history would identify any previous problem with cognitive functioning, but not any that have presented post-trauma.
Royal Manchester	Guideline	017	002	Add:	Thank you for your comment. The risk factors noted in the recommendation are

Children's Hospital				• Past engagement in education and other external services • taking part in risk taking behaviours • learning disabilities, autistic spectrum disorder and behavioural difficulties	purely examples, they are not meant to be an exhaustive list. Therefore, no amendments have been made to the recommendation.
Royal Manchester Children's Hospital	Guideline	018	All	1.3.1 – 1.3.3 Might be useful to mention specific goal setting tools such as the Canadian Occupational Performance Measure for children. Include principles of international classification functional disability and health.	Thank you for your comment. As no evidence was identified for specific goal setting tools, the committee drafted recommendations using descriptive terms, which they thought would be more helpful for the patient and professionals involved to decide what goals would be most beneficial to the individual's rehabilitation journey. We are unsure as to how inclusion of the International Classification of Functioning, Disability and Health would benefit this process. Therefore, no change has been made.
Royal Manchester Children's Hospital	Guideline	020	026	1.4.4 What if the specialist placement does not exist? What is the escalation plan?	Thank you for your comment. This recommendation is only if it is not possible or appropriate for the person undergoing rehabilitation to have access to all the information in the rehabilitation plan (for example, if it contains because extensive medical information and/or language). In

					these situations, important information for continuing rehabilitation progress should be summarised in a separate document. However, this is expected to be an exception, and wouldn't affect how the full rehabilitation plan was kept by trusts.
Royal Manchester Children's Hospital	Guideline	022	010	This section should consider education at their new level of ability e.g. injuries resulting in altered function.	Thank you for your comment. No changes have been made to the guideline as this point is covered in the first bullet point of this recommendation ('Rehabilitation programmes of therapies and treatments should: • form part of the person's rehabilitation plan, and be tailored to their individual needs).
Royal Manchester Children's Hospital	Guideline	023	023	Need to consider the availability of services and resources, especially in the community setting where we know services are inequitable and resources are limited.	Thank you for your response. We are aware that some services are under-resourced, or there is a lack of services, which may impact the implementation of these recommendations. These issues are highlighted in the rationale and impact sections of the guideline and the committee discussion of the evidence sections in evidence reviews. We have passed your comment onto the NICE implementation support team,
Royal Manchester	Guideline	026	010	Add developmental stage	Thank you for your comment. We have added this.

Children's Hospital					
Royal Manchester Children's Hospital	Guideline	027	006	PedsQL was trialled by the major trauma networks and deemed to be an unsuitable tool for use in children's trauma.	Thank you for your comment. As suggested, we have taken out reference to PedsQL.
Royal Manchester Children's Hospital	Guideline	028	016	Information should be: "comprehensive" and "up to date" should be added to the list. There are often gaps in the provision of information. Injured children and families have highlighted information that they considered to be important but wasn't provided by the healthcare team.(1,2) The following articles are relevant studies which support many of the points made about how information should be delivered, particularly the consistency of information. Jones S, Tyson S, Davis N, Yorke J. Qualitative study of the needs of injured children and their families after a child's traumatic injury. BMJ open [Internet]. 2020 Nov 30 [cited 2020 Dec 8];10(11):e036682. Available from:	Thank you for your comment. Unfortunately, none of the articles referenced in your comment can be added to our systematic reviews as they did not meet the protocol inclusion criteria for the following reasons: Braaf et al. Patient-identified information and communication needs in the context of major trauma. • Already included in evidence review D.2 and D.4. Jones et al. Qualitative study of the needs of injured children and their families after a child's traumatic injury. • Date of last search for qualitative reviews – Jan 2020. However, after reading the above article, we are confident that no relevant themes were presented which weren't already captured in our systematic reviews and resulting recommendations.

				http://www.ncbi.nlm.nih.gov/pubmed/33257479 Braaf S, Ameratunga S, Nunn A, Christie N, Teague W, Judson R, et al. Patient-identified information and communication needs in the context of major trauma. BMC Health Services Research [Internet]. 2018 Dec 7 [cited 2019 Aug 14];18(1):163. Available from: http://www.ncbi.nlm.nih.gov/pubmed/29514689.	
Royal Manchester Children's Hospital	Guideline	029	010	Add if the person or family members have a learning disability or mental health need	Thank you for your comment. This recommendation focuses on meeting the needs of someone after a traumatic injury when sharing information. There is information about wider accessibility issues in the following links which are included just about this recommendation "For more guidance on communication, providing information (including different formats and languages) and shared decision making, see the NICE guideline on patient experience in adult NHS services and the NICE guideline on shared decision making.
Royal Manchester	Guideline	029	019	Add consider children who care for adult family members	Thank you for your comment. The recommendation only refers to carers,

Children's Hospital					without mentioning age groups. As it is designed to cover all ages, no changes have been made.
Royal Manchester Children's Hospital	Guideline	033	021	Add emergency school funding	Thank you for your comment. We have now included emergency school funding in a recommendation further down in the 'Planning for rehabilitation and other support following discharge' section. This now reads 'If a person is likely to have continuing health and social care needs after discharge to home: .... • for children and young people, establish their eligibility for emergency education funding for short term support at school and for funded support through an education, health and social care plan (if appropriate).'.
Royal Manchester Children's Hospital	Guideline	033	023	Legal, financial advice etc-should this not be given out early in admission to advise families on how to pay bills, claim sickness benefits, access food banks etc	Thank you for your comment. The first recommendation in the 'Discharge planning and a multidisciplinary approach' section reads 'Consider early, multidisciplinary, discharge planning to ensure appropriate and smooth discharge and transition to outpatient and community services.' to emphasise the importance of beginning discharge planning early. This will include information on legal and financial advice, among others.

Royal Manchester Children's Hospital	Guideline	034	022	Most children will not be eligible for an EHCP but would benefit from emergency education funding for short term support in the school.	Thank you for your suggestion. We have made an addition to the recommendation to cover this.
Royal Manchester Children's Hospital	Guideline	034	024	add consider applying for individual funding requests if local services unable to meet the rehabilitation needs of the patient	Thank you for your comment. The committee was of the view that this is a very specific and unusual scenario and that it would be covered by the points already included in this recommendation.
Royal Manchester Children's Hospital	Guideline	035	013	Add education, safeguarding leads	Thank you for your comment. The community practitioners listed as attending the pre-discharge planning meeting are only provided as examples. The exact composition of these meetings will depend on the rehabilitation needs and goals of the person being discharged. Therefore, no change has been made.
Royal Manchester Children's Hospital	Guideline	037	002	1.8.19 Children and families often develop new needs further into recovery, particularly as they begin to reintegrate into their usual lives and may need contact with a key worker beyond 3 months post discharge. A single point of contact, key worker Evidence shows it is important for the key worker (central point of contact) to	Thank you for your comment. We agree that people undergoing rehabilitation after traumatic injury might need to have contact with a key worker for longer than 3 months. This was given as a single point of contact example for people being discharged from hospital, which is not the same as a key worker (both are clearly defined in the glossary). The committee included 'limited time' to highlight that care

				be someone the injured children and their family's trust. It may be worthwhile to consider their shared decision making in the selection of a key worker. (1,3) There should be sufficient flexibility to ensure that the selection of the most appropriate key worker is based on individual patient needs.	should be transferred to community practitioners rather than remaining with the hospital team. The committee discussed the suggestion of recommending shared-decision making when appointing a key worker. However, they thought it was implied in the wording 'professional ... with knowledge and expertise' and that this specification could cause resource pressure for smaller settings. Therefore, they have not added this to the recommendation wording.
Royal Manchester Children's Hospital	Guideline	037	011	add community paediatrician, family support worker (not all children in trauma TBI)	Thank you for your comment. We have added this example.
Royal Manchester Children's Hospital	Guideline	037	018	Identify most appropriate service to take over their rehabilitation programme whether adults or children's and ensure they are accepted into that service.	Thank you for your comment. Because NICE already has guidance about young people transitioning between services we are simply directing readers to those rather than writing any additional ones. These points are already covered within this guideline.
Royal Manchester Children's Hospital	Guideline	040	All	We would recommend that education warrants a separate section, as there are many considerations for school return.	Thank you for your comment. The committee agree that education is a very important consideration for children and young people returning to school or

				Children who are transitioning schools when their injury occurs may require additional support to integrate into a new school including access to a school reintegration facilitator. Healthcare professionals need to provide specific advice to the school/teachers about specific environmental and educational adjustments to support the child's return. These may include, leaving lessons early to avoid crowds, a flexible timetable, a graduated return, the symptoms the child may experience as a result of their injury and how these may impact their learning. This can be provided by the school fit note. All adjustments need to ensure that the injured child remains socially integrated. The referenced manuscript shows that this was a key priority for the injured children's return to education. Children often experience friendship challenges as a result of their injury, which may become pronounced on their return to school.	college. Unfortunately, as no evidence was found for return to education, they were unable to make such detailed recommendations as in your comment. However, the committee have made a number of recommendations in 'Supporting access and participation in education, work and community' that cover access to education for children and young people as well as information exchange between healthcare professionals, education settings and parents/carers. Additionally, we have included a new recommendation in the 'Discharge planning and a multidisciplinary approach' section about arranging a meeting between healthcare professionals, education setting and parents/carers to discuss a child or young person's return to school (including transport arrangements).

				Psychologists/health professionals/teachers may need to provide them with support/strategies to cope with such strategies. Specific support needs to be provided to help children catch-up with their curriculum as a result of their absence from school including. • Advice around school transport and applying to the local authority. • Emergency funding applications for short term support. • May require consideration of reasonable adjustments for exams. • Specific advice needs to be given about involvement in physical activity at school. • Children and families may benefit from a central point of contact at school (School nurse, school rehabilitation facilitator). Reference: A qualitative study of the educational support needs of injured children and their families after a child's traumatic injury. Under review with the journal of rehabilitation medicine.	

				I have more suggestions- but this is why I think education/school return needs a separate section. Most young people with MT injuries do not qualify for EHCP's.	
Royal Manchester Children's Hospital	Guideline	041	001	1.10 Needs to be a section of gaps in services provision and how to overcome the gaps. Escalation procedures and individual funding requests.	Thank you for your comment. The committee discussed that gaps in service provision would be reduced if the recommendations in the 'Commissioning' and 'Organisation' sections were implemented successfully. Therefore, no additions have been made regarding gaps in service. The committee also did not make any new recommendations in escalation procedures and individual funding requests as this is too detailed given the broad scope of the guideline.
Royal Manchester Children's Hospital	Guideline	043	001	If professionals identify an unmet need on discharge how will the patient be able to navigate the system to bridge this gap. This should be raised with the local commissioners by the discharging service.	Thank you for your comment. This recommendation was based on identified evidence that people undergoing rehabilitation after traumatic injury would prefer to be informed about possible delays to rehabilitation when returning to the community, so that they could set their expectations and arrange alternative services if needed. It is not placing pressure on inpatient healthcare

					professionals or community services to bridge the gap.
Royal Manchester Children's Hospital	Guideline	043	009	Consider technology enabled follow up. The trauma population is associated with low socioeconomic status and not all patients may have access to technology (digital poverty). We may need to consider how this would be offered to patients without this type of resource.	Thank you for your comment. The recommendation is part of the section 1.10 about commissioning and organisation of services. The committee recognises that a diverse population needs a diverse range of service models and channels by which rehabilitation can be delivered to meet the needs of the local population as well as the urban/rural environment. This is about having the infrastructure in place so that different needs can be responded to. The committee considered this issue also in the context of guided self-managed rehabilitation and have included the line "For people who cannot access the internet, explore alternative ways to provide these materials." as part of recommendation 1.5.7.
Royal Manchester Children's Hospital	Guideline	044	003	1.10.13 Rehabilitation consultants may play an important role in leading rehabilitation training across the major trauma networks to support hospitals to develop specialist knowledge in the management of rehabilitation of	Thank you for your comment. Given that various practitioners could deliver training, the committee was of the view that it would be better to keep this open and leave it to individual services to decide who would be providing and delivering such training.

				traumatic injuries.(5) Often therapists/nurses have skills and expertise in one particular field: Musculoskeletal injuries, traumatic brain injury. Rehabilitation consultant led training needs to address care relevant to all types of injuries to facilitate holistic patient management. Training within the major trauma networks needs to address return to exercise/activity after injury. Exercise Medicine Consultants and Registrars would be well placed to deliver this training to healthcare professionals.	
Royal Manchester Children's Hospital	Guideline	045	General	Add section on pain management and another section on maintaining ADL's and independence	Thank you for your comment. As suggested, we have added new recommendations on pain management to the general principles, physical rehabilitation, and discharge planning sections. We also added a new recommendation to the physical rehabilitation section on promoting independence with activities of daily living.
Royal Manchester Children's Hospital	Guideline	045	003	??? add positive impact on wellbeing. There is a large body of evidence to support the psychological benefits of exercise, especially early in recovery.	Thank you for your comment. The committee were particularly concerned about people losing muscle function, strength and function after traumatic injury,

					as many have considerably reduced physical functioning. This would have a large impact on subsequent physical rehabilitation (for example, delays or preventing completion of certain exercises). While they agree that exercise can have a positive effect on well-being after trauma, this is not the main reasoning for the recommendation. Therefore, no amendments have been made.
Royal Manchester Children's Hospital	Guideline	046	002	Early weight-bearing. The surgical team should define the person's weight-bearing status at the earliest opportunity after a traumatic injury, and inform the rehabilitation multidisciplinary team, explaining the reasons for restricted weight bearing, what limits should be put in place and for how long. Add documentation of weight bearing status should be documented in the notes. This paragraph could emphasise the importance of documenting the weight bearing status, especially given the large multi-disciplinary teams involved in the treatment and management of trauma patients.	Thank you for your comment. We have slightly amended the recommendation so that it now reads 'define and document'. The committee think the importance of communicating the reason behind weight-bearing status to such a large team is adequately covered in the second sentence.

Royal Manchester Children's Hospital	Guideline	049	014	may also need to incorporate patient education on use/application of splints.	Thank you for your comment. As suggested, we have added a new recommendation to cover this.
Royal Manchester Children's Hospital	Guideline	051	General	In addition to scars evidence shows that injured children are self-conscious about other forms of visible differences, such as an external limb fixator, altered mobility etc. (3) Therefore other forms of visible difference should be addressed in this section. Education of peers through school reintegration programmes is important for children whose injury results in scars or another form of visible difference.	Thank you for your comment. The committee was of the view that visible differences would be covered by the term 'injuries'. Also, the education of peers is outside of the scope, and we could not make any recommendations on that.
Royal Manchester Children's Hospital	Guideline	052	General	It would be beneficial to add about abdominal injuries including bowel and pancreatic injuries here due to nil by mouth status to include TPN, introducing feeds.	Thank you for your comment. Unless otherwise specified in the recommendation wording, recommendations throughout the guideline are applicable to the general trauma population (excluding traumatic brain injury). Therefore, this recommendation is covered by the recommendation that states 'Involve a dietitian and nutrition team for treatments to maintain nutritional supply, for example, a nasogastric tube, percutaneous

					endoscopic gastrostomy (PEG), radiologically inserted percutaneous gastrostomy (RIG) or parenteral nutrition (PN).'.
Royal Manchester Children's Hospital	Guideline	053	008	??	Thank you for your comment. Unfortunately, due to the uncertain nature of your comment, we are unable to provide a reply.
Royal Manchester Children's Hospital	Guideline	055	General	People with pre existing or previous mental health difficulties more at risk of psychological difficulties following trauma does this need to be highlighted	Thank you for your comment. The consideration of psychological risk factors is covered in the 'Assessing psychological functioning', and includes pre-existing and past mental health difficulties.
Royal Manchester Children's Hospital	Guideline	028 – 029	All	1.6 Add - information sharing needs to consider age appropriate language and communication	Thank you for your comment. Communication with patients is covered in the additional NICE guidelines referenced in the 'Principles for sharing information and involving family and carers' section. Both CG138 'Patient experience in adult NHS services: improving the experience of care for people using adult NHS services' and NG204 'Babies, children and young people's experience of healthcare' have recommendations regarding developmentally-appropriate language and communication styles. Therefore, no changes have been made.

Royal Manchester Children's Hospital	Guideline	066	003	Add-refer children to National Specialist Centre for Children with SCI Refer to peer support charity with consent from child and family MTC to jointly care for child with local SCI centre advising if no beds are available and / or family prefer to stay in MTC	Thank you for your comment. This is covered in the first recommendation of this section, regarding communication with tertiary services as per the NICE guideline on spinal injury. Therefore, no change has been made.
Royal Manchester Children's Hospital	Guideline	066	010	Add MDT from both hospital and community and regional SCI centre	Thank you for your comment. We have made reference to MDTs in the plural in this recommendations to cover more than one and also because not everyone will have an ongoing relationship with the regional SCI centre and these recommendations do not cover people based in or discharging from a regional specialist spinal cord injury centre
UK Major Trauma Psychology Network	Evidence Review A1 and A2	General	General	There is evidence about the use of specific screening measures for risk of PTSD and depression in traumatic injury namely the Post Traumatic Assessment Scale (PAS), which is used some in UK Major Trauma Centres by major trauma psychologists. A second measure has been developed in the US (Injured Trauma Survivor Screen, ITSS).	Thank you for your comment. Due to the breadth of the population included in this guideline, the identification and assessment evidence review focused on an initial holistic assessment of any rehabilitation needs after traumatic injury. We did not look at specific tools (validated or unvalidated). For this reason, the papers referred to in your comment do not meet out eligibility criteria. We are also

				Available measures require further validation in the UK but may be suitable to include in the initial assessment protocol of rehabilitation needs after traumatic injury. These measures need to researched in UK major trauma populations potentially alongside more commonly used UK measures (e.g. CORE 10) that are not specific to traumatic injury. PAS: O'Donnell, M. L., Creamer, M. C., Parslow, R., Elliott, P., Holmes, A. C., Ellen, S., Judson, R., McFarlane, A. C., Silove, D., & Bryant, R. A. (2008). A predictive screening index for posttraumatic stress disorder and depression following traumatic injury. *Journal of consulting and clinical psychology*, *76*(6), 923–932. https://doi.org/10.1037/a0012918 ITSS: Hunt, J. C., Sapp, M., Walker, C., Warren, A. M., Brasel, K., & deRoon-Cassini, T. A. (2017). Utility of the injured trauma survivor screen to predict PTSD and depression during	unable to make research recommendations into areas where evidence was not searched for. However, we have highlighted the importance of identifying indicators of psychological problems beyond that of an acute stress response, and referred readers to NICE guidelines on PTSD and depression where appropriate.

				hospital admission. *The journal of trauma and acute care surgery*, *82*(1), 93–101. https://doi.org/10.1097/TA.0000000000001306 Hunt, J. C., Chesney, S. A., Brasel, K., & deRoon-Cassini, T. A. (2018). Six-month follow-up of the injured trauma survivor screen: Clinical implications and future directions. *The journal of trauma and acute care surgery*, *85*(2), 263–270. https://doi.org/10.1097/TA.0000000000001944	
UK Major Trauma Psychology Network	Evidence Review A1 and A2	General	General	Practitioner Psychologist staffing within the major trauma centre should be sufficient to implement and oversee the psychological screening protocol, provide intervention, to contribute to rehabilitation prescriptions and discharge plans and to provide a level of on going monitoring and intervention to outpatients as appropriate as well as guidance and handover to rehabilitation teams. The size of the psychology team in the major trauma centre or a rehabilitation team should be based on	Thank you for your comment. There was no evidence on the psychology practitioner staffing levels/representation. As a result, the committee was only able to make generic recommendations in this area to highlight the importance of continued psychological assessment and management at all stages of rehabilitation. However, as you state, the need will be variable and depend on local demand and service configuration. We would therefore expect providers to make any appropriate adjustments.

				appropriate demand and capacity analysis.	
UK Major Trauma Psychology Network	Evidence Review A1 and A2	General	General	Major trauma psychology screening protocols should include screening for mild traumatic brain injury and pain. There is diagnostic overlap between mild traumatic brain injury and PTSD but these conditions can also present comorbidly (see Bryant). Mild traumatic brain injury is not routinely identified as part of initial major trauma medical work ups. Major trauma practitioner psychologists and neuropsychologists should work closely with the consultant in rehabilitation medicine/neurologist as well as other members of the MDT around the screening, early management and signposting advice provided to patients with mild traumatic brain injury particularly those with comorbid psychological distress. If patients enter their rehabilitation programme unclear about their diagnosis (i.e. MTBI or PTSD), this has the potential to adversely affect their rehabilitation, lead to confusion with the	Thank you for your comment. Traumatic brain injury was included in our protocol population for our assessment and identification evidence reviews. Recommendations regarding traumatic brain injury screening and assessment have been included in the guideline section 'Multidisciplinary team rehabilitation needs assessment'. The screening and treatment of pain following traumatic injury is covered by existing NICE guidance, and therefore specific recommendations are out of scope for this guideline. However, the committee are aware of the importance of effective pain management in successful rehabilitation after traumatic injury, and have included references to pain assessment, possible interventions and referral to specialist services where appropriate. We have also included a link to the NICE guideline on the assessment and management of chronic pain.

				team and potentially mismanagement due to inappropriate treatments being offered. Screening around pain should also occur given the links between pain and PTSD and the links between pain, PTSD and MTBI (polytrauma clinical triad e.g. Peixoto, C., Hyland, L., Buchanan, D. M., Langille, E., & Nahas, R. (2018). The polytrauma clinical triad in patients with chronic pain after motor vehicle collision. *Journal of pain research*, *11*, 1927–1936. https://doi.org/10.2147/JPR.S165077	
UK Major Trauma Psychology Network	Evidence Review A1 and A2	General	General	In addition to screening, there is some evidence for early intervention approaches after traumatic injury for PTSD using a stepped care format based on screening. Zatzick, D., Jurkovich, G., Heagerty, P., Russo, J., Darnell, D., Parker, L., Roberts, M. K., Moodliar, R., Engstrom, A., Wang, J., Bulger, E., Whiteside, L., Nehra, D., Palinkas, L. A., Moloney, K., & Maier, R. (2021). Stepped Collaborative Care Targeting	Thank you for your comment. The treatment of PTSD is covered by the existing NICE PTSD guideline and therefore is out of scope for this guideline. However, the committee are aware of the increased risk for psychological sequelae after traumatic injury and have included recommendations regarding early and continued psychological support, awareness of PTSD symptoms, and referral to psychological services if needed. Links to the NICE PTSD and

				Posttraumatic Stress Disorder Symptoms and Comorbidity for US Trauma Care Systems: A Randomized Clinical Trial. *JAMA surgery*, *156*(5), 462–470. https://doi.org/10.1001/jamasurg.2021.0131 It includes integrated care and provision of flexible interventions based on identified need. Intervention is normally CBT-based, but may also include other psychological approaches (e.g. motivational interviewing), components of case management, and psychopharmacotherapy.	depression guidelines have also be given where further information is appropriate. In particular, the NICE guideline on depression in adults with a chronic physical health problem: recognition and management includes recommendations on the stepped care model referred to in your comment.
UK Major Trauma Psychology Network	Evidence Review A1 and A2	General	General	Psychology staffing within major trauma centres should be sufficient to provide appropriate intervention to major trauma patients in a stepped/matched care format and to provide training to other members of the MDT on psychological approaches. The size of the psychology team in the MTC or a rehabilitation team should be based on appropriate demand and capacity analysis.	Thank you for your comment. Although a systematic review of the economic literature was conducted, no studies were identified that were relevant to this question. Therefore, no recommendations resulting in significant financial impact (in this case, staffing levels) were able to be made. However, a holistic approach towards rehabilitation after traumatic injury has been stressed throughout the guideline, with recommendations including families, carers and external support

				Demand capacity analysis needs to be differentiated upwards for paediatric traumatic injury patients whereby one has to consider the system around the child or young person including the family, education setting, social care setting etc and thus requires a lot more consultation, support and liaison within the paediatric population	networks where appropriate. Specifically, the questions relating to co-ordination of rehabilitation care were designed to include social care organisations to ensure this important aspect was not overlooked. Children and young people have a specific recommendation aimed at co-ordination with education providers.
UK Major Trauma Psychology Network	Guideline	General	General	We note that patients with traumatic injury who required an intensive care admission were excluded in the literature search criteria. This may entail some of the papers cited above cannot be included. We wondered if this exclusion criteria risks mis or underrepresenting patients' needs after traumatic injury given the research in major trauma/traumatic injury tends to cluster patients together for the most part. The exclusion criteria should be made explicit to avoid confusion or inappropriate application.	Thank you for your comment. Patients with traumatic injury requiring intensive care admission are covered by NICE guideline NG39 Major trauma: assessment and initial management, and therefore out of scope for this guideline. However, critical care management has been referred to where appropriate.
UK Major Trauma Psychology Network	Guideline	General	General	Separating guidelines into defined subgroups (e.g. critical care, traumatic brain injury (TBI) and traumatic injury	Thank you for your comment. We have included a number of cross references to other NICE guidelines within this one.

	And Evidence Reviews A1 and A2			excluding critical care and TBI patient groups) may be pragmatic and appropriate from a research summation perspective. However, there is a risk that the guidelines may be interpreted as reflecting a reality on the ground that there is a clear separation of patient presentations and pathways when there is not. In reality, there is huge overlap in terms of presentations, symptoms and needs. There is also great discrepancy in terms of how and where and who takes care of patients or how patients are grouped together both at the MTC and in rehabilitation pathways (e.g. orthopaedic, vascular, neuro) based on local resources. It would be helpful if the guidelines highlighted this discrepancy if possible. For major trauma to rehabilitation pathways, the relevant guidelines need to be read and applied collectively and rehabilitation teams may need to apply guidelines to mixed groups of patients in practice.	NICE is aware that guidelines may overlap and seeks not to duplicate recommendations in different guidelines, but instead to provide links to common principles across care. The aim of this guideline was to cover a very broad population, not just patients with a high injury severity score who would meet major trauma criteria but also those with lesser injuries but still complex needs, due to pre-existing conditions, frailty or mental health difficulties etc. NICE is also working hard to improve the accessibility and join up between its guidance and to work with partners, especially on implementation of recommendations. Also it is important to note that specialist assessment and specific rehabilitation interventions for traumatic brain injury are not covered by this guideline but will be covered by a new NICE guideline about Rehabilitation for chronic neurological disorders including traumatic brain injury. We have made a number of additions to the guideline including changes to recommendation 1.2.3 which now reads

				A further reality is that patients may be on a rehabilitation pathway but their needs have not been fully determined by that point. Even if early identification and assessment processes can be improved (e.g. rehabilitation consultant and psychology input at MTC), some of the most basic clinical decisions are not possible to make for quite a while (e.g. if a traumatic brain injury is a significant factor). For this reason, it's important that rehabilitation teams have a working knowledge and skills to apply the larger group of relevant guidelines and ideally are supported with sufficient resources to do so.	"Always think about the mechanism of injury and whether the person may have had a head injury. Be aware that the symptoms of traumatic brain injury can be subtle and regular screening may be necessary. If there are clinical symptoms, refer the person for a specialist assessment with healthcare professionals with expertise in traumatic brain injury rehabilitation. See also the NICE guideline on head injury.". We have also added information at the start of the cognitive assessment section to explain more clearly that assessment of traumatic brain injury is not covered in that section.
UK Major Trauma Psychology Network	Guideline recommend ations	108 / general		1.13 We agree with the committee's views that psychological support should be 'tailored' to the patients rehabilitation goals, needs and preferences and treatment should form part of a 'complete rehabilitation package'. Consistent with this and appropriate to the number of admissions to the team, a psychologist should be embedded within rehabilitation MDT's to provide	Thank you for your comment. We are not able to mandate which healthcare professionals form part of the multidisciplinary team because this will differ with patients, trauma type and setting. However, we have included a psychological practitioner as an example member of the multidisciplinary team. Additionally, there is a recommendation that community rehabilitation professionals should have access to training and peer

				training and consultation to staff and psychological intervention to patients'. The recommendation to have 'access' to a psychologist is not sufficient depending on how this is interpreted (i.e. more broadly as access to other statutory services that are non specific to the injury or more specifically as direct access to a dedicated psychologist with experience and knowledge of the injury trajectory and psychological impact/sequelae).	support from specialist services once people are discharged from hospital. Psychology services are given here as an example. Regarding the last point, there are no recommendations in the 'Psychological rehabilitation ' section that teams 'have access to' a psychologist. They recommend careful monitoring and referral as soon as possible if psychological conditions worsen or affect engagement in rehabilitation. There is a recommendation in the 'Psychological support after limb loss, amputation or limb reconstruction' which recommends to 'continue psychological support and ensure that the multidisciplinary team has access to a practitioner psychologist with appropriate expertise in physical trauma and rehabilitation'. This is because not all settings providing rehabilitation after limb loss or reconstruction will have a dedicated psychologist within the service, especially not one with experience in physical trauma. The wording you suggest would have a resource impact for these services, and there was no evidence

					identified to support the strength of that wording.
UK Major Trauma Psychology Network	Guideline	054 - 056	All	1.13 Rehabilitation teams should receive regular training around understanding, identifying and monitoring, responding to and signposting patients as to their psychological needs. The rehabilitation team should receive training on psychological approaches relevant to physical rehabilitation such as psychological first aid, motivational interviewing and aspects of CBT pertaining to common clinical issues such as pain/chronic pain. As major trauma psychologists, we have been asked to provide training, such as psychological approaches when working with chronic pain, to rehabilitation teams. The rehabilitation team should receive training in supporting patients at higher risk for PTSD/depression in their rehabilitation programmes (e.g. patients with traumatic injuries due to interpersonal violence or a history of trauma).	Thank you for your comment. The need for training for hospital and community rehabilitation professionals is covered in the section 'Rehabilitation skills, knowledge and expertise in the workforce'.

UK Major Trauma Psychology Network	Guideline	016	023 - 026	1.2.19 A clinical neuropsychologist is qualified to provide standardised, gold standard, diagnostic assessments to quantify and clarify the nature of cognitive dysfunction, which sets their role apart from an OT or SALT. A clinical neuropsychologist can provide specialist differential diagnosis such as PTSD or depression versus cognitive impairment. This is an important professional distinction, which should be recognised in the guidance. We would argue that best practice is that if concerns persist about the patients cognition then an assessment should be sought be a clinical neuropsychologist ideally situated within a service with links to neurology to support diagnosis of any neurological condition as needed.	Thank you for your comment. Firstly, we have made it clearer at the start of this set of recommendations that this section does not cover assessment or specific cognitive interventions for people with a traumatic brain injury. Because the indicators of problems with cognitive functioning may be varied the committee agreed it was appropriate to list a number of different practitioners who may be involved in initial assessments for issues with cognitive functioning and included the phrase "as appropriate" to indicate this.
UK Major Trauma Psychology Network	Guideline	016	012 - 014	1.2.15 This could potentially be reworded to avoid misleading. Acute stress, shock and psychological distress can present in many ways	Thank you for your comment. We have made it clearer at the start of this set of recommendations that this section does not cover assessment or specific cognitive interventions for people with a traumatic brain injury.

				including difficulty taking on board information. Problems with cognitive functioning due to acute stress will usually be transient and short term. Where available, an assessment by a clinical neuropsychologist or practitioner psychologist will provide the rehabilitation team with further information on the factors underpinning the patient's presentation and how to support.	It is important for NICE guidelines to present in a consistent style, which is not consistent with your suggestions. Also, the committee agreed the sequence of recommendations as they stand after careful consideration and there is a clear rationale for this order and sequence, based on ruling out other possible causes of problems with cognitive functioning which are not related to the traumatic injuries.
UK Major Trauma Psychology Network	Guideline	054	018	1.13.1 We are concerned that this recommendation is too simplistic and not matched to the clinical need. The current wording is 'reassure people that short-term psychological problems in the form of an acute stress response are common after a traumatic injury'. The 'normalising message' for acute stress is important as most people who experience a traumatic event will not go on to develop PTSD but it is not sufficient in isolation as per the evidence. We recommend that patients are provided with 1. screening, 2.	Thank you for your comment. The committee discussed that, in their experience, unless people are reassured that psychological symptoms after traumatic injury might be temporary they can end up self-diagnosing with PTSD which causes more stress and more harm. This recommendation is placed at the start of the 'Psychological section' because it is meant to be applied in combination with the subsequent recommendations. These go on to describe assessment, monitoring and referral to specialist psychological services if symptoms last longer than expected, get worse or start to adversely

				psychoeducation and 3. brief psychological intervention (psychological first aid/CBT) as appropriate. See https://istss.org/public-resources/trauma-basics/adult-prevention-and-early-treatment-for-ptsd-%E2%80%8E Reassurance in and of itself has the potential to be unhelpful or even harmful and should not be recommended.	affect engagement in rehabilitation. There is already NICE guidance on the early treatment of PTSD, and it is therefore out of scope for this guideline. Instead, the committee have signposted to other NICE guidelines for further information.
UK Major Trauma Psychology Network	Guideline	108	023 - 026	"Most team members specialising in the management of major trauma are equipped to provide psychological and emotional support" We do not consider this statement to have any supporting evidence. In the contrary, our experience, as a large group of major trauma psychologists, is that major trauma colleagues seek out and benefit from regular training on the provision of psychological and emotional support such as psychological first aid, motivational interviewing, trauma informed care, aspects of cognitive behavioural therapy, psychological	Thank you for your comment. The wording of the rationale is psychological and emotional support' rather than psychological and emotional treatment or interventions. In the committee's experience, healthcare professionals may not feel comfortable in offering emotional and psychological support to people following traumatic injury if they are not psychologically trained. However, the committee wanted to highlight that this support is invaluable to people following traumatic injury, and can be as simple as listening to concerns. Regarding your point about training, this is covered in the 'Rehabilitation skills,

				approaches to pain management, positive behaviour support, de-escalation and conflict resolution. A programme of training should be provided by major trauma psychologists, as well as other professionals as appropriate, at the major trauma centre. Ideally, there would be opportunities for staff across trauma and rehabilitation networks to join training sessions or to access training from psychologists within their teams. In addition, there should be access to staff support services for staff working within major trauma and rehabilitation services.	knowledge and expertise in the workforce', which has recommendations regarding the provision of supervision and training for both hospital and community rehabilitation professionals to develop specialist knowledge in rehabilitation after trauma. Access to practitioner psychologists for community-based rehabilitation staff is a specific example given.
United Kingdom Acquired Brain Injury Forum	Guideline	General	General	I welcome the report structure and layout, the frequent "no research found" comment is a serious concern for the field. I welcome the mention of remote consultations - the acceptance of remote/video consultation has increased hugely during covid. More research is clearly needed on how to optimise this, for whom.	Thank you for your comments. We agree that more research is needed in the field of rehabilitation after traumatic injury and how the flexibility of rehabilitation care can be increased. The committee discussed the lack of evidence identified throughout the guideline, and decided to prioritise research recommendations in areas where they feel additional research would have the most impact (for example, allowing

					new or stronger recommendations to be made in future guidelines).
United Kingdom Acquired Brain Injury Forum	Guideline	053 - 054	007	1.12 One of our members wrote to us about the guideline and we support this view: I have some concerns about it. I don't think there is enough information in there about cognitive rehabilitation methods. For example there are a few links below that revise a lot more advice on what should be done for rehabilitation- what is recommended for the rehabilitation of memory problems. Attention problems, executive problems etc. I worry that is this is not out in the guidelines it will not be properly funded. The nice guidelines state of cognitive problems persist an assessment should be carried out- but what about the what afterwards? Also while I acknowledge reassurance and a message of hope should be transmitted, I also think that it should be acknowledged that some people with severe traumatic injuries may have longer term cognitive problems that	Thank you for your comment. The guidelines referenced in your comment are both on traumatic brain injury, which is excluded from the scope of the current guideline. As such, the cognitive rehabilitation section does not include recommendations on traumatic brain injury beyond referring people with a head injury for a specialist assessment with healthcare professionals with expertise in traumatic brain injury rehabilitation. Cognitive rehabilitation after traumatic brain injury will be included in an upcoming NICE guideline on Rehabilitation for chronic neurological disorders.

				they need to adapt t and be supported with. Information like this is listed in SIGN guidelines here: https://www.sign.ac.uk/media/1068/sign130.pdf The INCOG guidelines produced by a committee of experts are useful **specific guidelines** available here: https://pubmed.ncbi.nlm.nih.gov/24984093/	
United Kingdom Acquired Brain Injury Forum	Evidence review 2	015	026	It is surprising that the committee perceive a lack of controversy when debates continue about the role of assistive technology, compensatory strategies or cognitive retraining approaches	Thank you for your comment. Due to the lack of evidence found in this systematic review, the committee discussed that their clinical experience showed no particular intervention had evidence of significant harms or significant benefits. Therefore, they were content to allow rehabilitation professionals to use their own knowledge and clinical judgement in this area.
United Kingdom Acquired Brain Injury Forum	Guideline	053	016	1.12.4 I would also like to see more detail on the p**rofessions** recommended in an MDT and the use of neuropsychology when patients are struggling with cognitive problems to assist with	Thank you for your comment. The committee did not agree that it was necessary to add reference to more specialist practitioners given that specialist assessment and specific rehabilitation interventions for traumatic brain injury are not covered by this guideline but will be

				assessment and rehabilitation. Such as the guidelines here: https://www.bsrm.org.uk/downloads/2021-v9.3-22-3-21-speccommunitystandards-summary-fortheweb-clean.pdf This member's comment is shown as a stark contrast to 1.13.4 "refer them urgently to psychology services for 22 psychological assessment and treatment," The implication here is that cognition is left as a free-for-all with no expectation of specialist practitioner qualification (albeit possibly attended to by neuropsychologist, OT, SALT, psychiatrist or other mdt member. This is risky.	covered by a new NICE guideline about Rehabilitation for chronic neurological disorders including traumatic brain injury. We have made a number of additions to the guideline including changes to recommendation 1.2.3 which now reads "Always think about the mechanism of injury and whether the person may have had a head injury. Be aware that the symptoms of traumatic brain injury can be subtle and regular screening may be necessary. If there are clinical symptoms, refer the person for a specialist assessment with healthcare professionals with expertise in traumatic brain injury rehabilitation. See also the NICE guideline on head injury." We have also added information at the start of the cognitive assessment section to explain more clearly that assessment of traumatic brain injury is not covered in that section.
University Hospitals Birmingham NHS Foundation Trust Peripheral Nerve Injury Service	Guideline	057	009	There is no mention of a nerve surgeon in the limb salvage / rehabilitation team. This is an important omissio that should be corrected. Neuropathic pain and functional loss (sensory / motor) are	Thank you for your comment. There is no mention of any specific healthcare professional in this recommendation, simply the teams that will be involved. A surgeon would form part of these teams if appropriate. Neuropathic pain and

				challenges to limb rehabilitation and must be considered in the discussions.	functional loss would be covered by discussions about pain management, long-term expectations and impact on daily life. Therefore, no changes have been made.
University Hospitals Birmingham NHS Foundation Trust Peripheral Nerve Injury Service	Guideline	057	015	No mention here of the role of prophylaxis of phantom pain with targetted muscle reinnervation. This is an important omission that should be corrected with the emerging evidence base in this field.	Thank you for your comment. The committee were aware of targeted muscle reinnervation in military studies, but no evidence was identified that met our inclusion criteria. They discussed that this is not routinely offered, so a recommendation on this intervention would have a resource impact for many settings. Given these 2 considerations, the committee decided not to make a recommendation on targeted muscle reinnervation.
University Hospitals Birmingham NHS Foundation Trust Peripheral Nerve Injury Service	Guideline	059	015	Consideration should be given t referral to a specialist surgical unit for management of phantom and residual limb pain. Early managemet provides more favourable outcomes for neuroma management, resurfacing scarred nerves, neurolysis and for targetted muscle reinnervation. These techniques are essential to surgical rehabilitation in	Thank you for your comment. The committee discussed that the referral to surgery would not be the first referral made for people with phantom and residual limb pain, and would only be considered if other interventions have failed. Due to the large scope of the guideline, we were unable to go into detail of all the ways to manage pain after limb loss. Instead the committee recommended

				the polytrauma patient and the amputee.	referral to a specialist pain team if needed, with the expectation that they would further refer for surgery if needed.
University Hospitals Birmingham NHS Foundation Trust Peripheral Nerve Injury Service	Guideline	064	001	Section 1.15 Rehabilitation after spinal cord injury: We are concerned that this section does not provide comment on the role of surgical rehabilitation for upper limb function in tetraplegic spinal cord injury with guidance on access to and timing of tendon transfer surgery and nere transfer surgery for improving upper limb motor function and sensory nerve transfer for improving sensation for prehension. There has been a specific NICE consultation in this area.	Thank you for your comment. Surgical rehabilitation in tetraplegic spinal cord injury is a very specific intervention, that will be considered once other, less-invasive interventions have been. No evidence was found regarding this intervention, and it is not widely available due to its specialist nature, so the committee did not make any recommendation on the use of surgical rehabilitation. We have looked at the NICE consultation referenced in your comment but we are unable to include it in our systematic review as it is based on a rapid review of medical literature and specialist opinion, rather than primary research or a systematic review.

University Hospitals Birmingham NHS Foundation Trust Peripheral Nerve Injury Service	Guideline	071	014	Section 1.16.6 Rehabilitation after nerve injury Many nerve injuries require prompt exploration and we would advise referral and exposure of a nerve in cases with clinical evidence of complete loss of function with displaced fractures, delayed reduction of joint dislocation, neuropathic pain, deteriorating function and post surgery nerve injury. The concept of sequential assessment is useful as long as the modalities of the nerve tested are complete. Neurophysiology has a very limited role in the acute setting and the guidance you provide is helpful in determining axonopathy that may have otherwise been underestimated and misdiagnosed as neurapraxia, however delay to referral by waiting for neurophysiology results after 6 weeks is not advised for many injuries and will worsen the outcome through delaying appropriate treatment. Suggets major rephrase of this section to reflect the risk of previously undiagnosed injury and to describ ethe red flag features of	Thank you for your comment. The committee agreed that there are cases where you might want to explore or image the nerve further. They re-worded an earlier recommendation in the 'Rehabilitation after nerve injury - general principles' section to include assessing the peripheral nerves of the affected limb and communication with the surgical team to decide whether early surgical intervention is necessary. The recommendation referenced in your comment refers to people that have not had this surgical intervention, which has now been added to the text.

				injuries needing referral in line with the boast 5 guidelines on peripheral nerve injury.	
University Hospitals Birmingham NHS Foundation Trust Peripheral Nerve Injury Service	Guideline	072	018	Should advice be provided on trophic muscle stimulation in complete nerve injuries and functional muscle stimulation in partial nerve injuries	Thank you for your comment. No evidence was identified for trophic muscle stimulation in complete nerve injuries or functional muscle stimulation in partial nerve injuries. Therefore, the committee decided to leave these discussions and decisions to the members of the specialist peripheral nerve injury service.
University Hospitals Birmingham NHS Foundation Trust Peripheral Nerve Injury Service	Guideline	072	021	Suggest include pain here. It would also be helpful to have a section on managemet of nerve pain other than therapy as detailed in 1.16.4 line 7. There are psychological, pharmacological and cognitive techniques that may be of great benefit.	Thank you for your comment. The committee was unable to be more specific about the management of nerve pain in relation to rehabilitation in this section, as no evidence was identified. Due to the complexity of this area of rehabilitation, they instead recommended referral to a specialist pain team as needed to ensure appropriate treatment is received. There are also recommendations about pain management in the general section about physical rehabilitation interventions (1.11) Sections 1.12 (cognitive interventions) and 1.1.3 (psychological interventions) also relate to people with nerve pain from nerve injury

University Hospitals Birmingham NHS Foundation Trust - Trauma rehab	Guideline recommendations	008	024 - 026	Section 1.1.9 “Ensure prompt referral to Speech & Language Therapy (SLT) for swallow assessment if concerns re. swallow safety”.	Thank you for your comment. At this stage, we are only at a screening stage, and a nurse practitioner or other professional could do this basic assessment as to, for example, whether an individual can have a glass of water. Also, there are recommendations later on with more detail on swallowing, for instance, in the section on nutritional supplementation. Plus there are links to other related NICE guidance.
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	General		Document is unnecessarily “wordy” with notable repetition across sections.	Thank you for your comment. As the guideline covers a range of individual rehabilitation areas and specific injuries, there may repetition where the committee has agreed a recommendation is important for several populations. We have tried to minimise this by including general principle sections where possible.
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	General		There is not equal representation and consideration given across Therapy disciplines. Predominantly reads as a document focussed on Physiotherapy.	Thank you for your comment. The evidence reviews were designed to examine effectiveness of interventions around physical, psychological and cognitive rehabilitation needs as well as interventions that supported people's inclusion into work, education, leisure and other core aspects of daily life. However

					interventions specific to traumatic brain injury were not included, as these will be covered by another guideline about rehabilitation for chronic neurological disorders. As the focus of this guideline is largely on rehabilitation needs resulting from physical injuries there were a lot of recommendations the committee wanted to make about different aspects of physical rehabilitation, however it is clearly acknowledged throughout the guideline that rehabilitation plans and programmes should be based on the holistic needs of the person and should always consider psychological and cognitive rehabilitation as well.
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	General		Reconsider some of the terminology used throughout the document and ensure that the terminology used represents terms that are used clinically or recommended nationally or in other NHS-E Major Trauma related guidelines or requirements. Examples: Rehabilitation Prescription not Rehabilitation Plan; Clinical Psychologist not Practitioner	Thank you for your comment. The population covered in the guideline includes those with an injury severity score (ISS) under 9 as well as those currently defined within NHS England commissioning arrangements as suffering from major trauma (ISS>15) or moderately severe trauma (ISS>8). The committee wrote the guideline to cover all these groups and some of the terms used are explained in the 'terms

				Psychologist, Post-traumatic Amnesia not Traumatic amnesia, etc	used in this guideline' section. For example when the guideline uses the term rehabilitation plan it also means rehabilitation prescription for those entitled to one, but is clear that this can come in many forms. The term practitioner psychologist is based on the definition of this AHP within the HCPC. We have removed the reference to traumatic amnesia to make it clear that the guideline does not cover interventions for people with traumatic brain injury.
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	General		Sections seem to jump around	Thank you for your comment. The committee discussed the best way to organise the guideline to make it accessible and logical. As much as possible, the sections are organised in the same rehabilitation timeline of people after traumatic injury, with signposting to corresponding sections as appropriate.
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	015 - 016	011 - 004	Section 1.2.15/16: How are they defining brain injury – based on nothing on scan? Patients can experience neurological insult/trauma without presence of findings on scan. Screening in relation to symptoms of concussion is excluded from the draft	Thank you for your comment. Specialist assessment and specific rehabilitation interventions for traumatic brain injury are not covered by this guideline but will be covered by a new NICE guideline about Rehabilitation for chronic neurological disorders including traumatic brain injury.

				guidelines & should be included. These guidelines were never destined to include TBI but we feel there may be a population who will between guidelines. This cohort may not have true “TBI” (based on scan findings) but do present with symptoms of a traumatic brain injury. A person may have had no brain injury or trauma on scan but still have LOC at scene or dropped GCS.. This may still be defined as a brain injury. We need to be clear that we have ruled out post concussive symptoms and post traumatic amnesia to then direct appropriate assessment in cognitive functioning. Please can the term: post traumatic amnesia be adopted throughout this document as this is the common terminology used amongst those of us who assess this. To ensure flow, 1.2.16 and 1.2.17 need to be reversed so that you are	We have made a number of additions to the guideline including changes to recommendation 1.2.3 which now reads "Always think about the mechanism of injury and whether the person may have had a head injury. Be aware that the symptoms of traumatic brain injury can be subtle and regular screening may be necessary. If there are clinical symptoms, refer the person for a specialist assessment with healthcare professionals with expertise in traumatic brain injury rehabilitation. See also the NICE guideline on head injury.". There is also a new paragraph at the start of the cognitive assessment section, which explains more clearly that assessment of traumatic brain injury is not covered in that section. We have removed reference to traumatic amnesia in the section about assessment cognitive functioning.

				investigating and ruling out pre-existing factors prior to then asking about any cognitive problems. The term “ask” should be “assess” as a number of people will be unable to communicate their cognitive problems. Surely a baseline is needed before assessing cognitive functioning?	
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	014 - 015	029 - 003	Section 1.2.13 – Unnecessarily wordy – consider re-wording	Thank you for your comment. The committee believe that, although the recommendation is more comprehensive than others, it is necessary to clearly describe the clinical scenario. As such, no change has been made.
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	007	018 - 021	Section 1.1.3: Should it be worded that psychological support should be readily available in timely manner, rather than “request additional support and/or advice from psychology services as needed” as driver for improved psychology service provision.	Thank you for your comment. The recommendation that you have referenced was worded to encourage all practitioners to feel comfortable supporting people in their care after traumatic injury (for example, listening to their story or worries), especially early on after a traumatic injury. The committee discussed that people sometimes just need to talk to someone, and this does not require a referral to specialist psychologists. However, the committee also did not want

					to discourage referral to psychology services if distress went beyond generalised support, and therefore included a recommendation to refer to psychology services if needed. Recommendations on the availability of psychological services can be found in the 'Psychological rehabilitation' section.
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	008	009 - 012	Section 1.1.5: Should it be phrased, before and 'during' surgery (as a number of therapy practitioners are in theatres during surgery to provide splinting & casting in order to maintain anatomical structures for function.	Thank you for your comment. The committee did not want to confuse the message that rehabilitation therapies should be available as soon as possible before and after surgery and whilst they recognise that sometimes therapy practitioners may be present while surgery is taking place this guideline is covering a very broad population and this point would only be relevant for quite small numbers so the committee decided to keep the recommendation as it is.
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	008	015 - 017	Section 1.1.6 – Occupational Therapy intervention involves significantly more than just referral for aids & equipment / adaptations. Our suggestion would be to use a broader term not just specific to OT….	Thank you for your comment. This section relates to immediate and initial assessment. A more detailed set of recommendations about a full multidisciplinary needs assessment, involving all the relevant practitioners is set out in section 1.2 (Multidisciplinary

				As soon as possible after the traumatic injury a person with physical impairments should be assessed by all relevant therapies - including PT,OT , SALT, dietetics, orthotics	team rehabilitation needs assessment). In particular the people who may form part of the MDT are set out in recommendation 1.2.4.
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	008	021 - 023	Section 1.1.8: Should also ask about alcohol intake and recreational drug use?	Thank you for your comment. Alcohol intake and recreational drug use are covered in subsequent recommendations on the rehabilitation needs assessment, and therefore does not need to be added here.
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	008	021 - 023	Section 1.1.8 Ask about patients oral intake prior to admission and are they able to tolerate oral diet, fluids and medication. Do they have any allergies or intolerances, underlying medical requirements that will impact on patients nutritional requirements (malabsorption IBD, liver disease, renal problems). Ask about Health supplements and oral nutritional supplements (note not all are high calorie, could be high protein.) What is their appetite and food intake like currently? Is the patient limited with their positioning that will affect their intake, flat bed rest, only allowed to sit	Thank you for your comment. This guideline has a very broad scope and as such the committee had to prioritise the areas where recommendations were most needed across the population and the key areas. This did not allow the evidence reviews to drill down into specific evidence about particular health supplements, BMI factors or allergies. It is expected that healthcare professionals will use their experience and expertise to implement guidelines in the best way for their patients and healthcare setting. There is already a recommendation regarding referral to dietician in this section (' Monitor the person's nutritional intake and weight

				to 30 degree's etc. What is their weight, BMI and weight history. Have they lost more than 10% of their body weight? Do they have a feeding tube from this admission or a previous admission (NG/PEG/RIG/JEJ)? Ensure a prompt referral to the specialist dietitian is made. (MUST and ESPEN recommendations)	throughout their hospital stay, provide nutrition support in line with the NICE guideline on nutrition support for adults, and refer for a specialist dietitian review if needed.'), as well as several others in the 'Nutritional supplementation' section. Therefore, no amendments have been made to the nutritional assessment recommendations.
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	009	005	Section 1.1.11 ….monitor weight weekly or alternative measurements such as mid arm circumference, skinfold thickness, hand grip etc if unable to weigh pt.	Thank you for your comment. The committee agreed that this level of detail was not needed in this recommendation, and that other guidelines and clinical expertise about how such things are monitored would be available to practitioners elsewhere. It is expected that healthcare professionals will use their experience and expertise to implement guidelines in the best way for their patients.
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	010	009 - 010	Section 1.2.2 – Should Pelvic injuries be considered separately or are they included under limb injuries?	Thank you for your comment. The key areas and review questions for the guideline to cover were included in the published scope for the guideline, which in turn was based on stakeholder feedback about the most important things for the guideline to cover. Pelvic injuries were not

					included as an area for specific intervention evidence reviews but clearly the guideline as a whole does cover people with pelvic injuries who also have complex rehabilitation needs.
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	010	025 - 026	Section 1.2.4: When discussing medical specialities, should a Consultant Psychiatrist also be included recognising that this is currently a significant role absent from designated Major Trauma MDT? Also worth considering the role of an acute case manager from a medico legal perspective.	Thank you for your comment. In this section, we detail the potential constituency of the core MDT. The committee was of a view that consultant psychiatrists would only be involved at the initial stages and in other high-risk situations where very specific psychiatric input will be needed (for example, if an individual is sectioned). In addition, only some people will need psychological and neuropsychological support at this stage (for example, if they are a risk to themselves or for self-harm). In these cases, rehabilitation services would refer them to the liaison psychiatric service. This was clarified in the section on 'Assessing psychological functioning'.
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	010	027 - 028	Section 1.2.4: Why only list 4 AHPs, either list all or none. Orthotists would be obvious choice missing from this list if naming specific AHPs	Thank you for your comment. The examples given in this list are only examples of allied healthcare practitioners. It is not meant to be an exhaustive list. However, the committee have added

					several more examples to this list in order for it to be more inclusive, 1 of which is orthotists.
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	010	015	Section 1.2.3 – important to include note / detail re. mechanism of injury when considering if an individual is at risk of TBI. Reconsider wording of this section. Rewording as follows: Always think about whether the person may have had a head injury (see 15 the section on assessing cognitive functioning). Consider mechanism of injury, GCS and LOC at scene. If this is a possibility, involve professionals with expertise in traumatic brain injury for specialist assessment.	Thank you for your comment. Specialist assessment and specific rehabilitation interventions for traumatic brain injury are not covered by this guideline but will be covered by a new NICE guideline about Rehabilitation for chronic neurological disorders including traumatic brain injury. We have made a number of additions to the guideline including changes to recommendation 1.2.3 which now reads "Always think about the mechanism of injury and whether the person may have had a head injury. Be aware that the symptoms of traumatic brain injury can be subtle and regular screening may be necessary. If there are clinical symptoms, refer the person for a specialist assessment with healthcare professionals with expertise in traumatic brain injury rehabilitation. See also the NICE guideline on head injury.". We have also added information at the start of the cognitive assessment section to explain more

					clearly that assessment of traumatic brain injury is not covered in that section.
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	010	029	Section 1.2.4 – is “practitioner psychologist” the correct term? i.e. Clinical psychologist and Neuropsychologist	Thank you for your comment. Practitioner psychologist is a term that HCPC Professional Standards Authority uses. We are aware of health psychologists, counselling psychologists, etc.; however, the recommendation was worded as practitioner psychologists to make it inclusive of all these sub-specialities.
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	011	019 - 021	Section 1.2.6 – It may be beneficial to include a statement on whose responsibility it is to make an assessment / document mental capacity.	Thank you for your comment. Because the circumstances will differ so much with regards to hospital setting and those forming part of the MDT it was not possible to suggest one particular role who would be responsible for this. This is also why we have referred to the NICE guideline on decision making and mental capacity which provides more detailed guidance on the topic.
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	011	024 - 025	1.2.7: Background needs to include drug and alcohol history and educational attainment	Thank you for your comment. The committee did not want to list every aspect of the persons background that would be relevant to this exercise as this will depend on the circumstances and indicators. There is also already reference to drug

					and alcohol history in recommendations 1.2.5, 1.2.18 and 1.2.21.
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	011	004	Consider also adding in “Case Manager”	Thank you for your comment. The components of the multidisciplinary team noted in the recommendation are only examples of professionals that may be included. It is not meant to be an exhaustive list, and will change depending on setting, trauma type and rehabilitation needs. Therefore, the committee decided not to add case manager to the list. However, they noted that case manager has been given as an example of a key worker in the ‘A single point of contact, key contact and key worker after discharge’ section of the guideline.
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	011	011	Section 1.2.5 – Note – there may not be resolution of delirium There may not be resolution of confusion or delirium if a person is in Post traumatic amnesia	Thank you for your comment. We have removed the reference to post traumatic amnesia because it was causing confusion. A new statement has been included at the beginning of the section: "Please note this guideline does not cover assessment or specific rehabilitation interventions for people with traumatic brain injuries. See recommendation 1.2.3 in the section on multidisciplinary team rehabilitation needs assessment.". We

					have also added more detail to 1.2.3 about early screening for traumatic brain injury.
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	011	015	'Access to assistive and environmental adaptations e.g. call buzzer, phone, lights'	Thank you for your comment. The committee wanted to be succinct in this instance and focus on communication aids and didn't believe it was necessary to include examples of these, which are numerous depending on the particular needs of the person.
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	014	003 - 005	Section 1.2.12 – Is it necessary to note specifically that a physiotherapist with appropriate skills and competencies is required? Could be re-worded as follows: the multidisciplinary team including a therapist with appropriate skills..	Thank you for your comment. We have amended the recommendation stem to read 'As part of the rehabilitation needs assessment after a traumatic injury, the multidisciplinary team with appropriate skills and competencies, should assess the person's pre-injury and current physical functioning, which should include:...'.
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	014	014	Consider re-wording – "identifying any problems with balance or dizziness and consider whether any specific vestibular symptoms". Assess for BPPV as indicated / required. Consider symptoms of concussion / post-concussion syndrome.	Thank you for your comment. The committee discussed the suggested amendment but agreed that the original wording was clearer within the context of the original stem and the rest of the bullet points. Therefore, no change has been made.

				"Head Injury" should be noted in a separate bullet point and not added to the end of the sentence.	
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	016	025 - 026	1.2.19: It is likely that the professionals in this paragraph will have been the ones who will have completed the rehabilitation needs for cognitive functioning in the first instance. Can we avoid the term "practitioner psychologist" and use the terms Neuropsychologist &/or Clinical Psychologist. A Speech and language therapist is not the appropriate professional to provide "specialist cognitive assessment". Rephrase if concerns regarding language and cognition, but unlikely to be the case if no TBI.	Thank you for your comment. Practitioner psychologist is a term that HCPC Professional Standards Authority uses, which encompasses all psychology sub-specialities (including neuropsychologist and clinical psychologist). Speech and language therapy is the appropriate speciality for people with communication difficulties after traumatic injury. As per the rehabilitation needs assessment, these issues can be present both pre- and post-trauma. Therefore, the committee decided to keep the recommendation wording as it is.
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	017	021 - 022	1.2.21: …..look for indicators of psychological problems (including lack of engagement with rehabilitation) beyond that of an acute stress response 'or post traumatic amnesia (it must be noted that many people who are in PTA frequently lack ability to	Thank you for your comment. After discussion with the committee, we have removed references to 'post-traumatic amnesia' and 'traumatic amnesia' throughout the guideline, replacing them with memory problems where appropriate. Regarding psychosocial risk factors and

				engage in rehabilitation especially if they are agitated as well. It is important to acknowledge that here.	subsequent engagement with rehabilitation, the recommendation referenced in your comment is part of the assessment section and including information on engagement with rehabilitation would not be suitable here. However, there is another recommendation in the main 'Psychological rehabilitation' section that covers this point, which recommends urgent referral to psychological services if psychological problems affect a person's engagement with rehabilitation.
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	018	009 - 010	1.3.1: Combine lines 9 and 10 as they are one and the same. Suggest: activities that are meaningful and purposeful	Thank you for your comment. The committee wanted to keep these two lines separate because the first asks what is important to them in relation to the entirety of their life and the second is particularly around rehab activities that relate to those things that are important. The committee have slightly amended the first two bullets to read: • what is most important to the person and what they most value • activities that are meaningful for the person and relate to what is important

University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	018	012 - 013	1.3.1: “a strengths based approach” – what does this mean???? This is not common terminology. Suggest: Goals should be SMART (specific, measurable, achievable, relevant and time bound) This covers a more holistic approach to goal setting, be it physical, cognitive or psychosocial functioning.	Thank you for your comment. The committee explained that using SMART goals is implied in the recommendation, and that the descriptive wording is more useful to an individual and therapist. However, we have now included a definition of a "strengths-based approach” in the glossary.
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	018	019 - 020	1.3.2: When setting ‘SMART’ long term rehabilitation goals…..	Thank you for your comment. The committee explained that using SMART goals is implied in the recommendation, and that the descriptive wording is more useful to an individual and therapist. However, we have now included a definition of a "strengths-based approach” in the glossary.
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	018	020	1.3.2: include purposeful in this sentence	Thank you for your comment. The committee thought that the terms 'meaningful' and 'motivational' already conveyed the word 'purposeful' and no further edits were made.
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	019	010 - 011	1.4.1 – NHS-E requirement is that the patient should have a “Rehabilitation Prescription” and that the Rehabilitation Plan should be documented within this document. Use the term “Rehabilitation	Thank you for your comment. Due to the differences in terminology throughout rehabilitation healthcare, the committee decided to use the term 'rehabilitation plan' throughout the guideline to describe a

				Plan" with caution. Often confusion between the "Rehabilitation Prescription" & the "Rehabilitation Plan". Agree terminology needs to be defined here as it is confusing. Use references from TARN regarding rehabilitation prescriptions as should be aiming for consistency with RPs.	general patient-held document which assists communication when people transfer. This is further defined in the glossary, which notes rehabilitation prescription as a possible format for this document. Therefore, no change has been made. The population covered in the guideline includes those with an injury severity score (ISS) under 9 as well as those currently defined within NHS England commissioning arrangements as suffering from major trauma (ISS>15) or moderately severe trauma (ISS>8). The committee wrote the guideline to cover all these groups and some of the terms used are explained in the 'terms used in this guideline' section. When the guideline uses the term rehabilitation plan it also means rehabilitation prescription for those entitled to one.
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	019	011 - 012	1.4.1: Information should also include: pre-morbid baseline (incl. drug/alcohol history if any) , home circumstances, family, previous support services, driving, previous education, employment,	Thank you for your comment. The committee extensively discussed the wording of this recommendation, in order to ensure that the rehabilitation plan included all relevant information without being too prescriptive for individual

				First language (interpreter required?), capacity, consent	settings and practitioners. Pre-morbid baseline and previous education would be included in the 'information about the person's needs and preferences'. Details on home circumstances, family and previous support services would be covered between 'how the rehabilitation programme of therapies and treatments will be delivered' and 'any follow-up arrangements'. Consent is covered by 'who the rehabilitation plan should be shared with (with the person's consent) and details about any information that the person wants to remain confidential'. Language and capacity are covered in a separate guideline section title 'Principles for sharing information and involving family and carers'. We have added 'information about associated risks, responsibilities and possible legal issues about returning to driving and where they might receive specific advice' to cover your point about driving. We also added 'information and sources of further information about returning to vocational or leisure activities'

					to cover your point about employment and education.
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	020	013	1.4.2: written in clear English – It needs to be acknowledged that a group of people will be unable to read an English version if it is not their first language and therefore accommodation needs to made for this to be translated into a 'first language' where required and should be included as such here. Also need to include no use of abbreviations or medical jargon	Thank you for your comment. Communication with patients is covered in the additional NICE guidelines referenced in the 'Principles for sharing information and involving family and carers' section. Both CG138 'Patient experience in adult NHS services: improving the experience of care for people using adult NHS services' and NG204 'Babies, children and young people's experience of healthcare' have recommendations regarding people who do not have English as their first language.
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	021	022 - 027	1.4.11: criminal activity does not just include violence – it may include victims of modern slavery, financial or emotional abuse and therefore as part of the prevention programme, we need to include 'safeguarding referral/involvement' May be worth considering an alternative term other than 'violence' prevention programme	Thank you for your comment. The evidence was specifically concerning a violence prevention programme which is why the committee included this recommendation.
University Hospitals Birmingham NHS	Guideline	022	001	1.5.1: Could this be re-phrased as 'Rehabilitation programmes of therapies and interventions' as treatments is a	Thank you for your comment. The committee discussed this at length and preferred the phrase 'treatments' in the

Foundation Trust – Trauma rehab				very misleading term as it suggest doing something to a person rather than necessarily with a person If so can this term be adopted throughout and the flow of this section will read a little better.	context of talking about both therapies and treatments to give the reader a little more information about all the various interventions that may be covered within this broad heading.
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	022	007	1.5.1: poor examples of focusing on outcomes as these are likely to be longer term goals. Outcomes for some patients may be moving from a puree to normal diet or being able to sit out into a specialist wheelchair, don/doff their own limb post amputation. Is it better to refrain from giving examples here??	Thank you for your comment. The committee chose the included outcome examples based on their experience, as these tend to be what people want to achieve after traumatic injury. We have also included a link to the section 'Setting Rehabilitation Goals', which includes a recommendation on smaller, motivational goals. Therefore, no change has been made.
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	022	010	1.5.1: Poor examples - the professionals involved will know what materials they to provide for educational purposes and this may be in a number of different formats . Hence do we need examples here at all??? Refrain from giving.	Thank you for your comment. The committee was of the view that education materials may mean different things to different people, and examples are helpful to clarify the meaning.
University Hospitals Birmingham NHS	Guideline	023	001 - 004	1.5.1: Either all examples are needed of therapies that could be involved or none at all. Many AHPs have been missed such as SALT, Dietetics,	Thank you for your comment. As stated, this is not an exhaustive list and only some examples. Thank you for spotting the typo, this was corrected to say "and treatments

Foundation Trust – Trauma rehab				Podiatry, Neuropsychology and Neuropsychiatry. Also we have never come across the term ‘exercise Occupational therapy’ – please can this be removed and simply say Occupational Therapy.	such as physiotherapy, exercise, occupational therapy".
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	024	002	1.5.3 This recommendation will be challenging for many orthopaedic trauma patients including amputees as there are no intensive residential rehabilitation facilities. In some clinical areas x3 a week would be deemed a minimal service for patients with ongoing needs and not an intensive service. Suggest not giving examples of what an intensive service looks like. This only refers to residential or outpatient settings. What about in-patients settings – intensive rehabilitation starts at the point of receiving in-patient therapy care in an acute MTC? Where is the section for intensive rehabilitation for in-patients and where are the benchmarks for in-patient services? This would be	Thank you for your comment. It seems that the recommendation was misinterpreted. As a result, we reworded the recommendation to clarify that we mean intensive rehabilitation programme that, for example, is 3-weeks duration and not 3-times per week. We have also added additional wording to capture the different settings where services could deliver such rehabilitation programmes, including in-patient settings. We further clarified that immediate acute rehabilitation is not covered in this guideline by adding a 'post-acute period' definition to the glossary. It has to be noted that intensive rehabilitation provided over three weeks is only an example for which we had supporting economic evidence, and there is some flexibility as to how such intensive rehabilitation will be delivered in practice.

				hugely beneficial from a commissioning perspective.	
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	031	008	1.7.7 – Change “rehabilitation plan” to “Rehabilitation Prescription” as this is the document that should be used for the purpose of a written handover.	Thank you for your comment. Due to the differences in terminology throughout rehabilitation healthcare, the committee decided to use the term 'rehabilitation plan' throughout the guideline to describe a general patient-held document which assists communication when people transfer. This is further defined in the glossary, which notes rehabilitation prescription as a possible format for this document. Therefore, no change has been made. The population covered in the guideline includes those with an injury severity score (ISS) under 9 as well as those currently defined within NHS England commissioning arrangements as suffering from major trauma (ISS>15) or moderately severe trauma (ISS>8). The committee wrote the guideline to cover all these groups and some of the terms used are explained in the 'terms used in this guideline' section. When the guideline uses the term rehabilitation plan it also

					means rehabilitation prescription for those entitled to one.
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	035	003	1.8.13 – Change wording to: "Document in the Rehabilitation Prescription"…	Thank you for your comment. Due to the differences in terminology throughout rehabilitation healthcare, the committee decided to use the term 'rehabilitation plan' throughout the guideline to describe a general patient-held document which assists communication when people transfer. This is further defined in the glossary, which notes rehabilitation prescription as a possible format for this document. Therefore, no change has been made. The population covered in the guideline includes those with an injury severity score (ISS) under 9 as well as those currently defined within NHS England commissioning arrangements as suffering from major trauma (ISS>15) or moderately severe trauma (ISS>8). The committee wrote the guideline to cover all these groups and some of the terms used are explained in the 'terms used in this guideline' section. When the guideline uses the term rehabilitation plan it also

					means rehabilitation prescription for those entitled to one.
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	044	010	1.10.14 – Avoid term “practitioner psychologists”	Thank you for your comment. Practitioner psychologist is a term that HCPC Professional Standards Authority uses. We are aware of health psychologists, counselling psychologists, etc.; however, the recommendation was worded as practitioner psychologists to make it inclusive of all these sub-specialities.
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	052	008 - 012	1.11.41 – 1.11.42 These 2 points can be combined. Change wording to oral nutritional supplement / food fortification and dietary manipulation will be used to ensure that patients are meeting their nutritional requirements for rehabilitation. Patients vary from frail, normal BMI to morbidly obese, young to older adults. All of these patients will have increased nutritional requirements including protein, vitamins and minerals depending on injuries, wound healing and pre and post injury nutrition which may not be met by the hospital menu alone. Patients with pre existing conditions may be at increased risk of malnutrition	Thank you for your comment. The committee disagreed with your suggestion of combining the 2 recommendations, as they refer to 2 separate populations. Each of them have their own reasons for involving specialist dieticians, and should be considered individually. The committee agree that all patients will have increased nutritional requirements after traumatic injury, due to the increased energy needed by the body for healing. Protein was specifically identified due to its importance in this healing after traumatic injury. Finally, the committee thought that including 'oral' in the recommendation would be too restrictive for healthcare professionals, as not everyone will receive

				e.g IMD, liver disease, renal cardiac, IMD, eating disorder patients.	nutrition through this route. Therefore, no changes have been made.
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	052	020 - 023	1.11.45 'If there are concerns regarding swallow safety discuss with medical team. Place NBM and refer to SLT for comprehensive swallow assessment as soon as possible'	Thank you for your comment. The committee discussed your suggested wording, but decided that the original wording was clearer. Therefore, no changes have been made.
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	052	017	Please confirm if Burns patients are included in this guideline – If so, would need to include gold standard for SLT management in burns e.g. inhalation injuries and ENT	Thank you for your comment. Burn patients have been included in the scope for this guideline in so much as people with multiple injuries may also have burns. However, the committee discussed that burn rehabilitation is a very specialised service, and is organised very differently from other trauma rehabilitation pathways. Therefore, evidence was included from burn patients when identified, but recommendations were designed to be applicable to the general trauma population. SLT management in burns would be considered too specific given the content of the rest of the guideline.
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	052	017 – 019	1.11.44 For people with severe burns, they need to be referred on admission to a dietitian specialising in burns. (Burns midlands network guidelines). All burns covering over a 20% BSA	Thank you for your comment. We have removed the phrase 'severe burns' so the recommendation now reads 'For people with burns in combination with other traumatic injuries, regularly monitor their

				should be referred to a are likely to need enteral feeding to support healing of the burn. Smaller burns can be managed by oral nutritional support and additional vitamin and mineral supplementation under the dietitians supervision.	weight and involve a dietitian with experience of burns, for example, if the person's weight fluctuates or they are at risk of losing muscle mass and strength.'.
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	053	010 - 013	In relation to non-brain injured patients, cognitive rehabilitation should be referred to the appropriate practitioner. Does "motor development and neurodevelopmental conditions" need to be addressed in "cognitive rehab" where there is not TBI?	Thank you for your comment. The committee have made it clearer at the beginning of this section that the guideline does not cover assessment and specific rehabilitation interventions for people with traumatic brain injury. Recommendation 1.2.3 has also been expanded to make it clearer that screening and referral for traumatic brain injury should be done early. The committee felt that cognitive rehabilitation therapies would still be needed in many instances where there were cognition problems related to the shock of the trauma and where there were already co-existing neurodevelopment issues, which may also have been adversely affected by the trauma.
University Hospitals Birmingham NHS	Guideline	053	018 - 021	Include 'if any pre-morbid communication impairment consider referral to SLT	Thank you for your comment. This is covered by a recommendation in the 'Initial assessment and early interventions'

Foundation Trust – Trauma rehab					section which states to involve speech and language therapy for people with new or existing communication impairments. Therefore, no change has been made.
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	053	003	1.11.46 Dietitian, nutrition nurses, nutrition team will be involved in supporting the patients nutritional treatment throughout their admission as required. Patients requiring long term enteral nutrition will be referred for consideration or PEG/RIG/JEJ feeding Total parenteral nutrition is now referred to as parenteral nutrition (PN)	Thank you for your comment. We have changed the wording to simply parenteral nutrition as per your comment. However, after reviewing the suggested amendments, the committee thought their current wording implied the continued support of the nutritional team
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	053	008	1.12.1: “Reassure people that most trauma reacted problems with cognitive functioning are temporary” I don’t think we can state this as we simply do not know. What ‘cognitive’ problems are we talking about here as this guideline was not meant to include brain injury?	Thank you for your comment. The committee have made it clearer at the beginning of this section that the guideline does not cover assessment and specific rehabilitation interventions for people with traumatic brain injury. Recommendation 1.2.3 has also been expanded to make it clearer that screening and referral for traumatic brain injury should be done early. The committee thought that cognitive rehabilitation therapies would still be needed in many instances where there was cognition problems related to the shock of the trauma and where there were

					already co-existing neurodevelopment issues, which may also have been adversely affected by the trauma.
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	055	022 - 023	1.13.4 – Avoid “practitioner psychologist” as not commonly used – consider term “Clinical Psychologist”	Thank you for your comment. Practitioner psychologist is a term that HCPC Professional Standards Authority uses. We are aware of clinical psychologists, counselling psychologists, etc.; however, the recommendation was worded as practitioner psychologist to make it inclusive of all these sub-specialities. We have added this definition to the 'terms used in this guideline' section.
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	060	006	Does this recommendation mean do not use a walking aid? (the limb would be in a dependent position when mobilising). Agree – very unclear re “limb in a dependent position”	Thank you for your comment. The committee felt that the recommendation clearly states to avoid residual limb swelling when using walk aids by using walking aids where the limb can be put in a dependent position. The committee could not come up with a clearer way of putting this.
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	071	001 - 020	Question – is this recommendation specific to limb nerves or inclusive of other nerve damage e.g. laryngeal/facial nerve, or is this implied in “multiple injuries”, “head injury” “complex fracture”?	Thank you for your comment. We have separated these points as you suggested.

				Learning disability should not be classed as an example of a cognitive impairment. Suggest “has a cognitive impairment or learning disability”	
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	072	005 - 011	? include ‘ENT /OMFS and concurrent SLT involvement‘	Thank you for your comment. This recommendation gives an example list of techniques and treatments that could be used to maintain range of movement and function after nerve injury. It is expected that the appropriate rehabilitation professional will deliver these interventions. Therefore, no change has been made.
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	074	025 - 026	Amend to ‘communication, swallow function and tracheostomy wean, consider….’	Thank you for your comment. The committee wanted to focus this recommendation on communication and swallowing and have not included the additional example you have suggested
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	077	003 - 008	Review the description in relation to the “Rehabilitation Plan” particularly in relation to the NHS-E / TARN guidance & requirements of the Rehabilitation Prescription.	Thank you for your comment. Due to the differences in terminology throughout rehabilitation healthcare, the committee decided to use the term 'rehabilitation plan' throughout the guideline to describe a general patient-held document which assists communication when people transfer. This is further defined in the

					glossary, which notes rehabilitation prescription as a possible format for this document. Therefore, no change has been made. The population covered in the guideline includes those with an injury severity score (ISS) under 9 as well as those currently defined within NHS England commissioning arrangements as suffering from major trauma (ISS>15) or moderately severe trauma (ISS>8). The committee wrote the guideline to cover all these groups and some of the terms used are explained in the 'terms used in this guideline' section. When the guideline uses the term rehabilitation plan it also means rehabilitation prescription for those entitled to one.
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	078	001	Revise to: “Post-Traumatic Amnesia”	Thank you for your comment. Following discussion with the committee, it was decided that both 'traumatic amnesia' and 'post-traumatic amnesia' will not appear in the guideline.
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	081	005	Amend – Nutritional assessment (including early identification or swallowing difficulties and assessment by SLT)…..	Thank you for your comment. We have not made this change or addition to the recommendation or the rationale and impact section because the committee did

					not agree that this task always needed to be completed by an SLT at this stage.
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	106	020 - 029	Agree low quality evidence around trauma patients. Can it state that evidence has been taken and extrapolated from similar patient populations However there is evidence for evidence for malnutrition in older adults, patients that remain in hospital, BAPEN/ESPEN. Evidence for nutritional supplementation in patients with #NOF, head injuries, wound healing, burns, liver. Line 25 – can this state people have altered nutritional requirements after a traumatic injury (not just calories, also not always higher…. Some patients will have lowering of activity from admission)	Thank you for your comment. There was evidence identified in the trauma population, which was judged to be of very low quality. The recommendations were not necessarily extrapolated from similar patient populations, as they were based on the committee experience and expertise. Line 25 refers to the increase caloric need for healing after traumatic injury, due to the hyper metabolic response. It does not take into account other factors that might affect nutritional need while in hospital (for example, decreased activity).
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	107	001 - 004	Add trauma and head injury patients to burns	Thank you for your comment. This rationale is relating to a recommendation that highlights the effect of the hyper metabolic response on weight loss in burn patients, which the committee discussed was important enough to warrant a separate recommendation. Therefore, we have not added the examples you have

					suggested. but we have clarified the language in both the recommendation and rationale to say 'people with burns in combination with other traumatic injuries'.
University Hospitals Birmingham NHS Foundation Trust – Trauma rehab	Guideline	122	022 - 024	Amend - 'that affect communication, swallow function and tracheostomy wean to SLT to assess, diagnose and manage communication and swallowing difficulties'	Thank you for your comment. We have not added the reference to a tracheostomy wean as this is one of many possible specific issues and cannot go into detail to cover all the possible clinical circumstances someone may be in relation to communication and swallowing following a chest injury. Also weaning from a tracheostomy may be performed by a number of health people not just SLTs. We have already made reference to communication at the start of the recommendation.
University Hospitals Bristol and Weston NHS Foundation Trust	Guideline	002	002	The trauma population is rapidly changing with increasing evidence that the elderly population are projected to quickly overtake the working age group and become the demographic most affected. Is it useful to focus on working age adults in the opening paragraph?	Thank you for your comment. The opening paragraph sets out the importance of the guideline, and does not contain information that is not currently correct. It also does not focus solely on working age adults. We do make reference to the importance of rehabilitation after traumatic injury in the older population later on in the 'Context' section.

University Hospitals Bristol and Weston NHS Foundation Trust	Guideline	007	020	Please could it be specified that all patients who have complex rehabilitation needs should have access to psychological services as needed? Many patients do not have access to this service as there is a lack of established referral pathways/acknowledgment of the need for this – particularly in acute settings	Thank you for your comment. The committee was unable to make this recommendation, in part because they were unable to be specific about which were the most effective psychological interventions for people with complex rehabilitation needs. Although evidence of effectiveness was identified, it was mainly judged to be low and very low quality. Additionally, no cost-effectiveness evidence was identified. As your suggested recommendation would undoubtedly have a resource impact, the committee decided that it would not be appropriate. However, the committee have written recommendations about access and referral to psychological services in sections 1.1 assessing psychological functioning and 1.13 psychological rehabilitation. The aim of these recommendations is to ensure that those in need of psychological support do get referred for a psychological assessment with a practitioner psychologist or by a member of the liaison psychiatry team to inform their rehabilitation plan and goals.

University Hospitals Bristol and Weston NHS Foundation Trust	Guideline	023	002	Is 'exercise occupational therapy' an intentional phrase? Perhaps there is a typo and a comma has been omitted after exercise? Given the non-specific nature of the term 'exercise' perhaps this should come further down the list of 'therapies' if it needs to be included.	Thank you for your comment. This was a typo and was meant to read 'exercise, occupational therapist'. We have amended the text as such.
University Hospitals Bristol and Weston NHS Foundation Trust	Guideline	024	014	Could an adjustment to this recommendation be considered to specify 5 days of rehab / 2 rest days rather than weekdays and weekends? In a climate where many services are striving for 7 day/week service delivery this seems overly prescriptive and restrictive which may not be in the patients best interest	Thank you for your comment. We have made an edit here and included the weekday/weekend scenario only as an example
University Hospitals Bristol and Weston NHS Foundation Trust	Guideline	055	028	Please could it be clarified what is meant by 'regularly check for signs and symptoms of anxiety, depression and PTSD' for example is a screening tool recommended?	Thank you for your comment. Screening of anxiety, depression and PTSD is covered in existing NICE guidance, and therefore out of scope for this guideline. Instead, we have signposted all relevant guideline for further information if needed.
University Hospitals Bristol and Weston NHS Foundation Trust	Guideline	056	012	Does this section just relate to the acute scenario or does it also include delayed/later access to limb reconstruction/amputation e.g. when primary treatment has failed?	Thank you for your comment. This section applies to both scenarios.

University Hospitals Bristol and Weston NHS Foundation Trust	Guideline	072	015	Suggest add ‘studies’ in after ‘nerve conduction’	Thank you for your comment. We aim to keep the recommendations succinct and did not think this addition was needed.
University Hospitals Bristol and Weston NHS Foundation Trust	Guideline	072	018	Please could it be clarified what the determinates are of a ‘poor prognosis for recovery after rehab therapy and nerve conduction studies’?	Thank you for your comment. The nerve conduction study should drive the prognosis, and therefore poor prognosis refers to people with a poor response on nerve conduction studies. After discussion, the committee did not think this needed further clarification in the recommendation. Therefore, no change has been made.
University Hospitals Bristol and Weston NHS Foundation Trust	Guideline	073	010	Suggest include recommendation to utilise pain assessment techniques such as Abbey Pain Scale for those who have communication difficulties, are cognitively impaired or otherwise not able to report pain reliably.	Thank you for your comment. We have added a new recommendation as 1.11.3: Choose a pain scale appropriate for the person, taking into account a range of factors such as their developmental age, cognitive ability, any communication difficulties, and their first language".
University Hospitals Bristol and Weston NHS Foundation Trust	Guideline	077	025	The ‘trauma coordinator’ role is described using the major trauma centre model. Trauma units also have ‘trauma coordinators’ who carry out a similar role but will usually be responsible for different tasks than those listed here. This could be confusing. Could the ‘in major trauma	Thank you for your comment. We have made some changes to the terms ‘trauma coordinator’ and 'rehabilitation coordinator'. The committee wanted to recognise that the role may mean slightly different things in the context of different settings, but the recommendations should be consistent regardless of setting.

				centres' part be removed and could more of the roles (e.g. coordinate rehabilitation) be included as 'this role may also include…'	
University of the West of England	Evidence Review B3	General	General	We are concerned that very little mention is given to the impact of traumatic injury on body image and appearance. For example, literature on disfiguring injuries, particularly burns and those due to military conflict, is very relevant to these guidelines.	Thank you for your comment. We agree that the psychosocial impact of changes to appearance following traumatic injury can be large. The guideline includes several recommendations regarding the importance of psychological support after limb loss, limb reconstruction and scaring, and referral to psychological services where appropriate. The committee believe that this adequately covers issues such as body image and appearance.
University of the West of England	Evidence Review B3	General	General	Many traumatic injuries will result in permanent or temporary changes to appearance, including scarring and limb loss. The psychosocial impact can be extensive and enduring. Research conducted at the Centre for Appearance Research (www.uwe.ac.uk/car) has included the development and evaluation of online interventions to support people with visible differences of any sort, including traumatic injuries such as burns.	Thank you for your comment. We agree that the psychosocial impact of changes to appearance following traumatic injury can be large. The guideline includes several recommendations regarding the importance of psychological support after limb loss, limb reconstruction and scaring. Unfortunately, after reviewing the research articles mentioned in your comment, we are unable to include them in the evidence reviews as they did not meet the protocol inclusion criteria for the review for the

				For example: **Face IT** (https://www.faceitonline.org.uk/) is an evidence-based online intervention for adults (aged 18 years and over), based on cognitive behavioural therapy and social interaction skills training.A small RCT has been published on this, see: • Bessell, A., Brough, V., Clarke, A., Harcourt, D., Moss, T.P & Rumsey, N. (2012). Evaluation of the effectiveness of Face IT, a computer-based psychosocial intervention for disfigurement-related distress, *Psychology, Health & Medicine. 17*, 5, 565-577. • Bessell, A., Clarke, A., Harcourt, D., Moss, T.P. & Rumsey, N. (2010). Incorporating User Perspectives in the Design of an Online Intervention Tool for People with Visible Differences: Face IT, *Behavioural and Cognitive Psychotherapy, 38*, 577–596 **YP Face IT** (www.ypfaceit.co.uk) is an evidence-based online intervention for	following reasons: * Bessell et al (2012) Evaluation of the effectiveness of Face IT, a computer-based psychosocial intervention for disfigurement-related distress Mixed population – Traumatic and non-traumatic participants with results not presented separately for traumatic injuries. * Bessell et al. (2010) Incorporating User Perspectives in the Design of an Online Intervention Tool for People with Visible Differences: Face IT Study design – Qualitative study. * Zelihić et al. A randomised control trial (RCT) of Young Person's Face IT: A web-based psychosocial intervention for adolescents distressed by a visible difference Unable to locate for review as revisions are being submitted. * Williamson et al. (2019) Young Persons' Face IT (YP Face IT), a web-based self-help psychosocial intervention for adolescents distressed by appearance-altering conditions and injuries: a feasibility study for a parallel randomized controlled trial

				young people (aged 12-17 years), based on CBT and social interaction skills training. See: • Zelihić, D. et al (revisions submitted). A randomised control trial (RCT) of Young Person's Face IT: A web-based psychosocial intervention for adolescents distressed by a visible difference Under review *Body Image* • Williamson H, Hamlet C, White P, Marques EMR, Palin T, Cadogan J, Perera R, Rumsey N, Hayward L, Harcourt D (2019) Young Persons' Face IT (YP Face IT), a web-based self-help psychosocial intervention for adolescents distressed by appearance-altering conditions and injuries: a feasibility study for a parallel randomized controlled trial. *Journal of Medical Internet Research – Mental Health* DOI: 10.2196/14776	Mixed population – Traumatic and non-traumatic participants with results not presented separately for traumatic injuries. * Riobueno-Naylor et al. (2021). Appearance concerns, psychosocial outcomes, and the feasibility of implementing an online intervention for adolescents receiving outpatient burn care Study design – No comparison group.

				Riobueno-Naylor, A., Williamson, H., Canenguez, K., Kogosov, A., Drexler, A., Sadeq, F., …Sheridan, R. L. (2021). Appearance concerns, psychosocial outcomes, and the feasibility of implementing an online intervention for adolescents receiving outpatient burn care. *Journal of Burn Care and Research, 42*(1), 32-40. https://doi.org/10.1093/jbcr/iraa108	
University of the West of England	Guideline	General	General	We are concerned that very little mention is given to the impact of traumatic injury on body image and appearance. For example, literature on disfiguring injuries, particularly burns and those due to military conflict, is very relevant to these guidelines.	Thank you for your comment. We agree that the psychosocial impact of changes to appearance following traumatic injury can be large. The guideline includes several recommendations regarding the importance of psychological support after limb loss, limb reconstruction and scaring, and referral to psychological services where appropriate. The committee believe that this adequately covers issues such as body image and appearance.
University of the West of England	Guideline	General	General	We are concerned that the specific needs of military veterans who have sustained traumatic injuries are not highlighted in the guidelines. Our research with military veterans and personnel with appearance-altering	Thank you for your comment. Unfortunately, the reference included in your comment does not meet our study design criteria for inclusion in our evidence reviews (review included 1 qualitative paper, 1 case study and 2 cross-sectional

				injuries (Keeling et al, under review) has shown the specific support needs of this group, which are nuanced to those of civilians with appearance-altering injuries. • Keeling, M., Williamson, H., Williams, V., Kiff, J., & Harcourt, D. (2021). Body image concerns and psychological wellbeing among injured combat veterans with scars and limb loss: A review of the literature. Military Behavioral Health, 9(1), 1-10. https://doi.org/10.1080/21635781.2020.1792013	studies). However, the committee agreed that the psychosocial impact of changes to appearance following traumatic injury can be large. As such, the committee made several recommendations regarding the importance of psychological support after limb loss, limb reconstruction and scaring, and referral to psychological services where appropriate. The committee believe that this adequately covers issues such as body image and appearance.
University of the West of England	Guideline	027	003	Section 1.5.10 We are pleased to see the use of PROMS being recommended. In our experience and based on our research and systematic reviews, PROMS that are specific to a particular situation/injury are preferable to general PROMS (or a combination of general and specific PROMS). With regards to burn injuries for example, the CARe Burn Scales	Thank you for your comment. None of the protocols cover monitoring progress, therefore these papers do not meet inclusion criteria.

				(www.careburnscales.org.uk) are a suite of burn-specific PROMS for adults, young people, children and parents affected by burn injuries: For example: • Griffiths. C., Guest, E., White P., Gaskin E, Rumsey N, Pleat J & Harcourt D. (2017). A systematic review of patient reported outcome measures (PROMs) used in adult burn research, *Journal of Burn Care & Research*, 38(2):e521-e545. • Griffiths, C., Guest, E., Pickles, T., Hollen, L., Gerada, M., White, P., Tollow, P., & Harcourt, D. (2019). The development and validation of the CARe Burn Scale - Adult Form: a patient reported outcome measure (PROM) to assess quality of life for adults living with a burn injury. *Journal of Burn Care and Research*, 40, 3, 312–326. • Griffiths, C., Guest, E., Pickles, T., Hollen, L., Grzeda, M.,	

				Tollow, P. & Harcourt, D. (2020). The development and validation of the CARe Burn Scale: Child Form: a parent-proxy reported outcome measure assessing quality of life for children aged 8 years and under living with a burn injury, *Quality of Life Research,* https://doi.org/10.1007/s11136-020-02627-x	
University of the West of England	Guideline	044	003	Section 1.10.13 Training for health professionals and others working with people with traumatic injuries should include training to support them with changes to appearance as a consequence of their injury. Some training resources are available and work is in progress to develop specific ACT-based training for professionals working with military personnel with appearance-altering injuries, adapted from training based on civilians' needs. This has received very positive feedback in acceptability work with leading support organisations that work with military veterans.	Thank you for your comment. However, specific training interventions for practitioners to support people with disfigurement were beyond the scope of this guideline.

University of the West of England	Guideline	113	015	We suggest there is evidence of the value of psychological support in managing changes to appearance – this evidence is of interventions that are generic to disfiguring conditions, not specific to traumatic injury. Research evidence shows that many challenges faced by people with an altered or unusual appearance are similar, irrespective of whether the change to appearance is due to injury or other cause (eg. health condition, treatment etc). This support can be provided online (e.g. Face IT and YP Face IT – important considerations during lockdown). In addition to the publications regarding evaluated interventions (detailed below), work in progress at www.uwe.ac.uk/car is developing: • evidence-based interventions to meet the specific needs of military veterans and personnel with appearance-altering injuries (based on findings from the UNITS study)	Thank you for your comment. Unfortunately, if studies are not in the traumatic injury population, it would not have met the inclusion criteria for our systematic reviews and therefore would not have been evidence considered by the committee. The committee agree that people with altered or unusual appearances do experience psychological problems as a direct results of their appearance, and recommended healthcare practitioners be aware of the long-term psychological impact of change in body image as a result of injury. Additionally, they highlighted the extra psychological impact for children and young people as they grow (for example, when going through puberty).

				• ACT-based interventions for adults with appearance-altering conditions (including traumatic injuries) (Zucchelli, F., Donnelly, O., Rush, E., Smith, H,. Williamson, H., & the VTCT Foundation Research Team at the Centre for Appearance Research. (2021). Designing an mHealth intervention based on Acceptance and Commitment Therapy for people with visible differences: A participatory study involving stakeholders with clinical and lived experience. JMIR Formative Research. doi:10.2196/26355) • an intervention to support people with visible difference faced with challenges regarding intimate relationships. see: **Face IT** (https://www.faceitonline.org.uk/) is an evidence-based online intervention for adults (aged 18 years and over), based	

				on cognitive behavioural therapy and social interaction skills training. See: • Bessell, A., Brough, V., Clarke, A., Harcourt, D., Moss, T.P & Rumsey, N. (2012). Evaluation of the effectiveness of Face IT, a computer-based psychosocial intervention for disfigurement-related distress, *Psychology, Health & Medicine. 17*, 5, 565-577. • Bessell, A., Clarke, A., Harcourt, D., Moss, T.P. & Rumsey, N. (2010). Incorporating User Perspectives in the Design of an Online Intervention Tool for People with Visible Differences: Face IT, *Behavioural and Cognitive Psychotherapy, 38*, 577–596 **YP Face IT** (www.ypfaceit.co.uk) is an evidence-based online intervention for young people (aged 12-17 years), based on CBT and social interaction skills training. See: • Williamson H, Hamlet C, White P, Marques EMR, Palin T, Cadogan J, Perera R, Rumsey N, Hayward L, Harcourt D	

				(2019) Young Persons' Face IT (YP Face IT), a web-based self-help psychosocial intervention for adolescents distressed by appearance-altering conditions and injuries: a feasibility study for a parallel randomized controlled trial. *Journal of Medical Internet Research – Mental Health* DOI: 10.2196/14776 Riobueno-Naylor, A., Williamson, H., Canenguez, K., Kogosov, A., Drexler, A., Sadeq, F., …Sheridan, R. L. (2021). Appearance concerns, psychosocial outcomes, and the feasibility of implementing an online intervention for adolescents receiving outpatient burn care. *Journal of Burn Care and Research, 42*(1), 32-40. https://doi.org/10.1093/jbcr/iraa108	