Rehabilitation after traumatic injury
Consultation on draft scope
Stakeholder comments table

15/08/2018 to 12/09/2018

Stakeholder	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
Association for Family Therapy and Systemic Practice (UK)	5	21	Inpatient settings does not include 'Burns units' when burns were previously specified within the scope. It may be that you are including Burns Units under Trauma centres, but this was not clear.	Thank you for your comment. Burns per se will be excluded but will be included if combined with complex trauma. We will not look at how specialist centres work etc., only as burns as one component of the complex trauma. This was clarified in the scope.
Association for Family Therapy and Systemic Practice (UK)	5	26	In community settings, schools are included, where workplaces are not. Rehabilitation which includes employers and workplace adaptations may be as relevant to adults as school interventions are to children.	Thank you for your comment. To make this clearer we have removed the list of included settings (as it was getting too long) and instead replaced with "All inpatient, outpatient and community settings in which rehabilitation services following traumatic injury are provided".

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Association for Family Therapy and Systemic Practice (UK)	6	24-28	The inclusion of traumatic brain injury here is somewhat confusing, since this group appeared to be excluded from the scope.	Thank you for your comment. Rehabilitation following traumatic brain injury will be covered in another NICE guideline due to begin development in 2019. Where complex rehabilitation needs result primarily from traumatic brain injury this will be explicitly excluded from the guideline. This guideline will, however, cover assessment and coordination of services for people with complex traumatic injuries, one of which may be traumatic brain jury. We have tried to make this clearer in the scope. We also recognise that people with traumatic injuries may suffer from delirium and other assorted issues that although not classed as TBI will have an effect on assessment and rehabilitation. So although specific treatments for traumatic brain injury will not be covered by this guideline, the programmes included for our population will be likely to include some cognitive and communication therapy components. These will be determined in more detail in the protocols for the appropriate review questions.

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Association for Family Therapy and Systemic Practice (UK)	10	2	In considering what should be included it is important to recognise that standalone talking therapies, which are likely to be based on a mental health model, will be different to talking therapies which are integrated with a specialist rehabilitation team. For people with complex trauma-related needs, the psychological needs do not neatly fit into diagnostic categories used, for example, by IAPT services. Whilst there will be some rehabilitation needs that represent a closer fit (for example PTSD, depression, specific anxieties) there are some which are very context specific, including adjustment to loss, adjustment to changed future life, impact of medical and surgical treatments, which would be enhanced by a psychological therapist who was integrated into the rehabilitation team, and who both understands the context of rehabilitation and has developed working relationships with other professionals in the team, including co-working, consultation, development of psychological skills in the team,	Thank you for your comment. The Guideline Committee is comprised of experts in this field who will decide what specifically each review question will include. The Guideline Committee will then consider the relevant evidence and make recommendations on that basis.

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Association for Family Therapy and Systemic Practice (UK)	10	2	It is also important to consider both the impact upon and the resources available from the person's relationships, whether that be couple relationships or family and parental relationships. The Burn Care review, several years ago, recognised the importance of recognising the impact of burn trauma on families, and how psychological assessment and support for families could improve care and outcomes for paediatric burns survivors. We consider this to be equally applicable to other complex trauma experiences. The skills of a systemic family therapist, or other professional trained in family therapy / systemic practice are useful in considering both the relational and the systemic psychological aspects of complex trauma. Supporting the development of peer support systems is also important, both as a unique form of support, but also to facilitate trauma survivors taking on a valued and useful role to others going through similar experiences.	Thank you for Guideline Committee your comment. The Guideline Committee is comprised of experts in this field who will decide what specifically each review question will include. The Guideline Committee will then consider the relevant evidence and make recommendations on that basis.

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Association for Family Therapy and Systemic Practice (UK)	10	34	In considering co-ordination of rehabilitation services, both inpatient and community-based, we believe it is important that a team has access to all forms of professional expertise necessary. This would be best facilitated by including a professional who has expertise in psychosocial aspects of complex trauma within the core team making rehabilitation decisions, rather than as a separate resource.	Thank you for your comment. The Guideline Committee will consider the relevant evidence and make recommendations on that basis.
Association for Family Therapy and Systemic Practice (UK)	11	21	We think that the person's experience of the quality of their relationships and social roles (including school / occupation / other community involvement) should be included in the main outcomes, as these are central to a person's capacity to perform their identity, and therefore valid areas to include in rehabilitation.	Thank you for your comment. The outcomes listed in the scope are only examples of outcomes that are likely to be considered in the guideline. For each clinical question the most relevant outcomes will be decided by the Guideline Committee and evidence for those outcomes will then be used to develop recommendations.

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Association of Trauma and Orthopaedics Chartered Physiotherapists	1	18	Burns rehabilitation has its own network and requires specialist skills. Should these injuries be separated out into their own guidelines?	Thank you for your comment. Burns per se will be excluded but will be included if combined with complex trauma. We will not look at how specialist centres work etc., only as burns as one component of the complex trauma. This was clarified in the scope.
Association of Trauma and Orthopaedics Chartered Physiotherapists	1	19	Injuries need not be the most severe in nature e.g. fracture pattern to have a severe impact on functional and rehabilitation need. Also, it can be the multiplicity and combination of injuries of less severe trauma that lead to complex rehabilitation needs.	Thank you for your comment. We agree and this is why we have defined complex rehabilitation needs as we have in section 1 of the scope e.g. reflecting the fact that less severe trauma can lead to hospital admissions i.e. complex rehabilitation needs.
Association of Trauma and Orthopaedics Chartered Physiotherapists	1	21	Hospital admission after less severe trauma may not be due to pre-existing conditions, but because of functional impact of injuries and environmental factors that mean they will not be able to manage in their own home	Thank you for your comment. We have amended section 1 of the scope with these suggestions.
Association of Trauma and Orthopaedics Chartered Physiotherapists	2	3	Many people experience negative impact on QOL after trauma, but there are also recognised positives such as post traumatic growth, different life choices	Thank you for your comment. This statement was revised.

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Association of Trauma and Orthopaedics Chartered Physiotherapists	2	9	People may not have access to at least 2 AHPs for the longer duration of recovery. Some people continue with outpatient physiotherapy for many months after hospital discharge, but do not have involvement from other AHPs.	Thank you for your comment. The focus of the guideline is on effective assessments and treatments across a broad population as well as on the coordination of care particularly in the move from inpatient to outpatient/community services for people with complex rehabilitation needs. Due to limits on the size of this scope and the need to prioritise the guideline will not be covering long-term care and rehabilitation packages.
Association of Trauma and Orthopaedics Chartered Physiotherapists	2	18	Rehabilitation prescription is only completed for those who meet Major Trauma criteria, which is a subset of those with traumatic injuries and complex rehabilitation needs, by definitions used in this document.	Thank you for your comment. This was amended to reflect the fact that only patients who meet Major Trauma criteria should have a rehabilitation assessment and prescription carried out during the hospital admission.
Association of Trauma and Orthopaedics Chartered Physiotherapists	2	22	Limitations in access also result from changes in commissioning and variations in what equipment can be provided from loan equipment services, including small aids, walking aids and wheelchairs. This is compounded by the Major Trauma Networks, where many patients are in hospitals out of area.	Thank you for your comment. Whilst we agree that these are all factors that theoretically contribute to variation in practice we do need to keep the introduction to the scope quite brief so wanted to avoid adding further examples. However, we note your points and will consider, where appropriate, in the context of the Guideline Committees work to develop the guideline.

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Association of Trauma and Orthopaedics Chartered Physiotherapists	3	28	Please be clear that this will include rehabilitation services in outpatient settings	Thank you for your comment. This was clarified in the Settings section.
Association of Trauma and Orthopaedics Chartered Physiotherapists	3 5	14 12	People with mild to moderate head injuries may not meet the 'traumatic brain injury pathway' and be managed by musculoskeletal or trauma hospital teams. These head injuries may require some input but not be the primary rehabilitation need. Does this guideline include these people?	Thank you for your comment. We recognise that people with traumatic injuries may suffer from delirium and other assorted issues that although not classed as TBI will have an effect on assessment and rehabilitation. So although specific treatments for traumatic brain injury will not be covered by this guideline, the programmes included for our population will be likely to include some cognitive and communication therapy components. These will be determined in more detail in the protocols for the appropriate review questions. Interventions related to traumatic brain injury will be covered in the new NICE guideline on 'Rehabilitation following traumatic brain injury' due to begin development in 2019.
Association of Trauma and Orthopaedics Chartered Physiotherapists	4	19	The draft scope only refers to inequalities in access to inpatient rehabilitation. There are significant inequalities and variations in CCG funding for outpatient and community service, and local authority funding for social services. In addition, people who rely on public transport can have difficulty attending outpatient appointments for e.g. physiotherapy, fracture clinic and cannot afford taxi	Thank you for your comment. The focus of this guideline is on rehabilitation services and although we intend to look at the interface with social care services we will be primarily looking at equalities issues in relation to rehabilitation services only. We have however amended the equalities impact assessment to say that we

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				will be looking at the impact of geography on inpatient, outpatient and community rehabilitation services.
Association of Trauma and Orthopaedics Chartered Physiotherapists	4	22	Homeless is an important factor not just from a discharge perspective. Often these patients do not have NHS numbers and this has implications for what services they can access and what rehabilitation they are entitled to.	Thank you for your comment. We have changed this from not just being about discharge but access to services more generally. Also this group of people are included in our equality considerations and where relevant special considerations will be given to this group of patients when developing guideline and making recommendations.
Association of Trauma and Orthopaedics Chartered Physiotherapists	5	4-16	People with minor injuries who have complex rehabilitation needs (2 or more AHPs) and require admission are included. This is very broad scope	Thank you for your comment. Yes this part of the guidelines population broadens the scope but they are still using similar resources to the rest of the guidelines population so have been included and the focus of the guideline is on the complexity of the rehabilitation need rather than on the severity of the injury.
Association of Trauma and Orthopaedics Chartered Physiotherapists	5 6 7	11 27 6	On reading the scope it is unclear whether spinal cord injury is being included or not. This is a complex patient group and needs to be clarified.	Thank you for your comment. Spinal cord injury is already covered in relation to the coordination of services and identification and assessment. We have also included a new review question specifically aimed at identifying rehabilitation packages and programmes that are effective and acceptable for people with spinal cord injury and there will now be a

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				section in the guideline specifically focused on this population. We have made changes across the scope and hope it is now clearer.
Association of Trauma and Orthopaedics Chartered Physiotherapists	6	11	Including functional and vocational would increase relevance to patient	Thank you for your comment. Functional and vocational terms have been added where relevant in the scope.
Association of Trauma and Orthopaedics Chartered Physiotherapists	6	2	Including outpatient AHP services e.g. physio, OT, dietician, SLT, psychology, podiatry, orthotics	Thank you for your comment. We have included outpatient services in the scope.
Association of Trauma and Orthopaedics Chartered Physiotherapists	6	20	Specific packages should include complex musculoskeletal. This is a very significant group with complex rehabilitation needs who currently get no services commissioned to address their needs.	Thank you for your comment. Although our specific packages questions do not cover musculoskeletal trauma, we do have a broad rehabilitation packages review question in the scope (Q2.1) which should cover this group and allows the opportunity to make recommendations related to this group should the Guideline Committee decide to do so.

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Association of Trauma and Orthopaedics Chartered Physiotherapists	7	10	What is the definition of long-term? There is a significant issue in not being able to access some services e.g. equipment, adaptations from social care/local authority because of the decision on whether a person's needs are 'classified' as long term or short term.	Thank you for your comment. The scope excludes long-term care and rehabilitation packages for people with long-term care needs. However, the review questions in the scope looking at care packages will consider the effectiveness and acceptability of different rehabilitation programmes as well as their content, timing, intensity, frequency and setting. So there are currently no details on things such as time span of rehabilitation packages. The Guideline Committee will need to agree in the committee meetings definitions in these areas and what can sensibly be included or excluded.
Association of Trauma and Orthopaedics Chartered Physiotherapists	7	14	Nutritional support should be included. These patients have high nutritional needs which impact on healing/recovery e.g. fractures, complex soft tissue injuries/plastics. This is a topic patients have requested more information about to support their recovery.	Thank you for your comment. Nutritional support is no longer excluded. This guideline will consider nutrition as part of rehabilitation packages or programmes.
Association of Trauma and Orthopaedics Chartered Physiotherapists	7	8	Social care interventions are significant in this population and barriers between health and social care have a major impact on discharge and the ability to manage patients in the community.	Thank you for your comment. The guideline will look at the optimal methods of coordinating and delivering rehabilitation services and social care services for people with complex rehabilitation needs after traumatic injury when they transfer from being inpatients to being outpatients. This is the time point in the pathway where the connection between these two sets of services has been identified to be of

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				the highest priority. Due to resource limitations, the guideline will not consider specific social care interventions or the explicit assessment of social care needs.
Association of Trauma and Orthopaedics Chartered Physiotherapists	9	21	The draft scope plans to cover adults and children. Children have significantly different rehabilitation needs and rehabilitation services to adults. We would suggest that this is a separate guideline as otherwise the scope will be huge.	Thank you for your comment. We will be separating out the evidence reviews for children and adults.
Association of Trauma and Orthopaedics Chartered Physiotherapists	10	15	We agree with this question but would like clarification on what specialist settings refer to. We do not think groups should be excluded e.g. complex musculoskeletal because they are not admitted to a specialist setting e.g. burns unit, peripheral nerve unit, SCIU.	Thank you for your comment. Both patients in specialist and non-specialist settings (with complex rehabilitation needs after traumatic injury) are included in the populations to be considered in questions 2.1 and 2.2. The original question 2.2 has been deleted as the main issues it was trying to capture are considered to be captured by the other questions.
Association of Trauma and Orthopaedics Chartered Physiotherapists	10	19	Limb loss or amputation: does this only include immediate / index admission amputation? Some people proceed to amputation several months after injury as they have tried to preserve the limb but this is unsuccessful	Thank you for your comment. Question 3.1 is not currently limited to immediate/index admission amputation. The Guideline Committee will decide on the exact parameters of the review protocol for this question, consider the relevant evidence and make recommendations on that basis.

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Association of Trauma and Orthopaedics Chartered Physiotherapists	10	24	Define extent of nerve injury to be included within scope	Thank you for your comment. In the scope complex rehabilitation needs are defined as multiple needs that will always at least involve coordinated multidisciplinary input from 2 or more allied health professional disciplines. Question 3.2 further refines this population by requiring those needs to partly arise from nerve injury resulting from traumatic injury. Any potential further refinement of this definition of the population for question 3.2 will be done by the Guideline Committee when they agree the review protocol for this question.
Association of Trauma and Orthopaedics Chartered Physiotherapists	13	1	As comment 16. Specific packages should include complex musculoskeletal	Thank you for your comment. Complex muscular skeletal injuries will be considered as part of question 2.1 as this is a very diverse population. We will be adding further detail within the protocol for this question in discussion with the Guideline Committee. We have also included limb reconstruction within the specific packages, which is a type of complex musculoskeletal injury.
Association of Trauma and Orthopaedics Chartered Physiotherapists	General	General	Driving: car adaptations, assessment. Is this part of the scope?	Thank you for your comment. Programmes and packages in the guideline may also consider equipment for rehabilitation.

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Association of Trauma and Orthopaedics Chartered Physiotherapists	General	General	People are discharged from hospitals after MSK injuries before their injuries are healed. They often require multiple visits to fracture clinic and/or multiple admissions to see orthopaedic teams and may need changes in cast, walking aids, weight bearing status. This is often a stressful time point for patients, as their ability to progress with their functional recovery depends upon the assessment of healing at these clinics. How this service is delivered and communicated to AHPs is an important component in delivering effective rehabilitation. This can be complicated when patients live out of area from the MTC, which may still keep responsibility for following up orthopaedic injuries	Thank you for your comment. The coordination with different care services following hospital discharge will be considered in the coordination of care aspect of the guideline. Particular considerations will be given to patients living out of area from MTC when drafting recommendations.
Association of Trauma and Orthopaedics Chartered Physiotherapists	General	General	Will this include involvement of Orthogeriatricians and fracture liaison services, or is this not within the scope?	Thank you for your comment. We will consider the involvement of Orthogeriatricians and fracture liaison services in the coordination of care aspect of the guideline and have now made this explicit in the guideline.
Association of Trauma and Orthopaedics Chartered Physiotherapists	General	General	How will the guidelines address important operational deficits for which there is unlikely to be evidence, such as provision of loan wheelchairs for 'short term' e.g. 3-6 months for someone unable to take weight on both legs due to their injuries	Thank you for your comment. Programmes and packages in the guideline may also consider equipment for rehabilitation. The guideline will be developed following methodology set out in the NICE manual.

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British Dietetic Association	General	General	We would like to see the importance of nutritional care to be highlighted in this guideline due to the following: Physiological stress following major trauma leads to rapid malnutrition, associated with increased metabolic rate, impaired utilisation of nutrition and protein catabolism. As a result clinically, profound weight loss and severe muscle depletion is seen in this patient group. Attached is a paper from 2006 that outlines The metabolic changes are outlined in the following report: Hasenboehler. E, et al (2006) Metabolic changes after polytrauma: an imperative for early nutritional support. World Journal of Emergency Surgery 2006, 1:29 Accessed at: http://www.wjes.org/content/1/1/29 Patients are often underfed due to interruptions to feeding - particularly those fed via the oral or enteral route. This is normally due to fasting for procedures resulting in insufficient feed delivery. This happens on the ward and in critical care. Early feeding in trauma patients has been reported beneficial since 1981. More recently a meta-analysis revealed a statistically significant reduction in mortality attributable to early EN within 24 hours of traumatic injury: Doig. G.S, et al. (2011). Early enteral nutrition reduces mortality in trauma patients requiring intensive care: A meta-analysis of randomised controlled trials. Injury , Volume 42 , Issue 1 , 50 – 56 Accessed at: https://www.ncbi.nlm.nih.gov/pubmed/20619408	Thank you for your comment. This guideline will consider the nutritional needs of patients with complex rehabilitation needs as part of rehabilitation package or programme.

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British Orthopaedic Association	General	General	The BOA Trauma Group is in broad agreement with the content of the guideline scope. The physiotherapy sprint audit undertaken by the NHFD in 2017 demonstrates the lack of community rehabilitation facilities available for frail, elderly patients once discharged from acute hospitals and this should be highlighted by NICE and made a priority area for improvement. The economic benefits demonstrated by effective rehabilitation programmes generally should be highlighted as a driver for improving services generally.	Thank you for your comment and information on lack of community rehabilitation facilities available for frail, elderly patients. We will take into account of your information while drafting the recommendations related to coordination or rehabilitation care. The economic priorities for de-novo economic modelling will be discussed with the Guideline Committee. Where possible cost-effectiveness information will be used to support recommendations for people with complex rehabilitation needs.
Cruse Bereavement Care	2	4	The draft scope currently doesn't state the need for emotional bereavement support, as part of the rehabilitation following a traumatic injury. In some cases bereavement support may be needed, as some may have also had a bereavement at the time of the traumatic injury.	Thank you for your comment. This was revised to include more explicit reference to emotional, psychological and psychosocial support.
Cruse Bereavement Care	6	18-19	The draft scope could be more specific around the potential need for emotional bereavement support.	Thank you for your comment. To make the scope succinct general terms for physical, functional, vocational, psychological and psychosocial etc. support are generally used with a few examples where necessary. The protocols and evidence reports will go into more detail and comprehensively list all forms of support that will be looked at.

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Department of Health and Social Care	General	General	Thank you for the opportunity to comment on the draft scope for the above guideline. I wish to confirm that the Department of Health and Social Care has no substantive comments to make, regarding this consultation.	Thank you for your comment.
Manchester Foundation Trusts	General	General	There is no mention of dental and Orofacial reconstruction after traumatic injury. I have read the scope of practice and can see no inclusion or exclusion of this aspect of care but I see no reason why it should lie outside a document of this calibre.	Thank you for your comment. Please see our definition of complex rehabilitation needs in section 1 of the scope. The scope is not explicitly excluding rehabilitation related to facial injuries or dental injuries but reconstructive surgery would not be covered in this scope as it is not rehabilitation. Muscular skeletal and nerve injuries to the face would be included in the context of rehabilitation needs.
Remedy Healthcare Ltd	9	27	The following should be included in a rehabilitation needs assessment: MDT involvement (Consultant in Rehabilitation Medicine, Physiotherapist, Occupational Therapist and Clinical Psychologist), access to background medical information, assessment of current symptoms, impairments, limitations, participation restrictions, environmental factors, co-morbidities (psychiatric, neurological, cardio-respiratory, gastrointestinal), medication, on-going / outstanding treatment plans, patient's desired outcomes, goal setting. The WHO International Classification of Functioning, Disability & Health is a useful framework for this.	Thank you for your comment and the useful information included about rehabilitation needs assessment. The Guideline Committee will consider the relevant evidence and make recommendations on that basis.
Remedy Healthcare Ltd	10	1	Ongoing assessments should be managed under the lead of a Consultant in Rehabilitation Medicine. The Consultant will receive input from the MDT and make ongoing recommendations regarding the patient's ongoing rehabilitation needs.	Thank you for your comment. The Guideline Committee will consider the relevant evidence and make recommendations on that basis.

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Remedy Healthcare Ltd	10	12	Access to early MDT rehabilitation needs assessment should be equally accessible to those in specialist units, such as burns units, to ensure rehabilitation planning is initiated and delivery can begin as soon as is clinically feasible.	Thank you for your comment. Patients in specialist units are included in the population to be considered in the assessment question (1.1). The Guideline Committee will consider the relevant evidence and make recommendations on that basis.
Remedy Healthcare Ltd	10	16	Optimal initiation and provision of rehabilitation is as soon as possible, with ongoing follow up thereafter. The rehabilitation team must be allowed to assess and put in place all rehabilitation requirements as soon as the patient is deemed medically fit to start rehabilitation and then enabled to regularly review rehabilitation progress and further needs. Current service provision within the private sector is often fragmented, with multiple agencies/providers delivering care in isolation and without effective case management and coordination. Follow-up is irregular and clinical direction and goal setting can lack direction. Effective follow-up should ensure continuity of care, maintenance of clear objectives and regular, MDT progress review and programme refinement.	Thank you for your comment. The Guideline Committee will consider the relevant evidence and make recommendations on that basis.

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Remedy Healthcare Ltd	10	18	The military model has again demonstrated exceptional outcomes for patients following limb loss. All above elements noted in previous comments should be included for packages for patients following limb loss. Additionally, all referrals should include combined assessments by a skilled MDT, including Physiotherapy, Occupational Therapy, Psychology and Prosthetic intervention. This team should work together from the beginning (i.e. the initial combined MDT assessment), communicate regularly and recommend clinical decisions based on the full team's involvement. For example, when a prosthesis is being considered, input from the Prosthetist is vital to ensure the full range of potentially suitable products are considered, for socket fitting, adjustments, etc. The Physiotherapist will address the biomechanical elements, including gait and limb control; the OT will address the functional considerations, including the home environment, driving or returning to work/education and the Psychologist will address the individual's psychological wellbeing. Access to additional services is also vital, including exercise rehabilitation instruction, pain management, etc. To ensure a tailored and client focused approach.	Thank you for your comment. The Guideline Committee will consider the relevant evidence and make recommendations on that basis.

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Remedy Healthcare Ltd	10	3-7	The Military Model of Rehabilitation has demonstrated excellent clinical outcomes. This model has recently been adapted and trialled in the private sector by Remedy Healthcare on a small number of civilians with similar clinical outcomes shown. The Remedy Healthcare model is based on the military model used at DMRC Headley Court. It delivers high intensity, MDT, Consultant-led programmes throughout a full pathway of rehabilitation, including access to both intensive, residential rehabilitation and community based rehabilitation. This programme delivers continuity of fully integrated care 'from ward to work', enabling the patient to access the same treating team throughout their rehabilitation journey. The key elements of successful rehabilitation following complex traumatic musculoskeletal injury are contained within the military model. These include: Early intervention; Integrated care from a Consultant-led MDT; Variable & appropriate intensity – determined by clinical need, rather than by resource availability; Aspirational – rehabilitation objectives and final outcomes determined by clinical potential, rather than constrained by limited resource availability.	Thank you for your comment. The Guideline Committee will consider the relevant evidence and make recommendations on that basis.

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Remedy Healthcare Ltd	11	4	Most people with complex rehabilitation needs after traumatic injury are able to commence meaningful rehabilitation before they are fit to discharge home from hospital. These individuals should be enabled to begin MDT rehabilitation in a post-acute setting, such as a bespoke rehabilitation unit (typically, such patients will 'block' an acute bed in a trauma unit or on a general ward where the provision of such rehabilitation is not feasible). The significant gap in current clinical service delivery between acute hospital care and community / home-based care (i.e. post-acute care) must be addressed if any effective rehabilitation programmes are to be delivered for this group of patients.	Thank you for your comment. The Guideline Committee will consider the relevant evidence and make recommendations on that basis. The guideline will have a particular focus on the coordination of services at the point of discharge from inpatient to outpatient and community services.
Remedy Healthcare Ltd	11	7	The best way to coordinate community and outpatient rehabilitation is by using a Consultant led service.	Thank you for your comment. The Guideline Committee will consider the relevant evidence and make recommendations on that basis.
Remedy Healthcare Ltd	13	1	A further 'specific package' should be considered in addition to those listed – 'multiple fractures'. These individuals have complex and specific needs with the combination of multiple limb fractures (as well as pelvic fractures & soft tissue, skin loss injuries) presenting significant challenges to the progression of rehabilitation and the return to function and mobility.	Thank you for your comment. Where people with multiple fractures fall under the scope definition of complex rehabilitation needs they will be included within the guideline and treatments/interventions will be considered as part of question 2.1. We will be adding further detail within the protocol for this question in discussion with the Guideline Committee. We have not included a specific question about multiple fractures as other areas were seen as a higher priority for NICE guidance.

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Restorative Dentistry UK	General	General	The draft scope should include severe facial injuries such as those that can arise from MVC or ballistic injuries or burns. Facial trauma resulting in disfigurement can result in severe psychological problems. Oral, dental and facial rehabilitation is a highly specialised service provided in many Hospitals through joint working between Consultant maxillofacial surgeons and Consultants in Restorative Dentistry. Titanium implants, 3d printing and computer designed prostheses can all contribute to reinstating facial appearance, masticatory function and speech.	Thank you for your comment. Please see our definition of complex rehabilitation needs in section 1 of the scope. The scope is not explicitly excluding rehabilitation related to facial injuries but reconstructive surgery would not be covered in this scope as it is not rehabilitation. Muscular skeletal and nerve injuries to be face would be included in the context of rehabilitation needs.
Royal College of General Practitioners	General	General	'The role of the multidisciplinary team is vital and within it need to delineate roles and responsibility in particular social care'	Thank you for your comment. The role of multidisciplinary team will be considered as part of coordination of rehabilitation care.
Royal College of Nursing	2	1	It would be helpful to be more specific about the classification of age for example what do we mean by “younger” and “older” ages? This would assist in the service planning and requirements.	Thank you for your comment. At this stage, the definitions were left broad. We will be working with the Guideline Committee to define the exact ages during the protocol development stages. We will also be working with the Guideline Committee to ensure that evidence related to different age ranges is included and sub-group analyses are undertaken (where possible) to inform the recommendations to the specific age groups to assist with the service planning and requirements.

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Royal College of Nursing	2	18-20	This is an area of vital importance and although would be expected to happen, we are not sure that it can be said that this assessment of rehabilitation requirement is currently carried out by all. Suggest rewording the statement to reflect the variation in current practice.	Thank you for your comment. This was amended to reflect that currently, this is not a standard practice and that patients ***should*** have rehabilitation assessment and prescription carried out during the hospital admission.
Royal College of Nursing	6	5-6	Would it be beneficial to link to the existence of the rehabilitation guidance in critical care? Some patients stay a long time in acute area and early consideration of rehabilitation would reduce the longer term care. This could be physical or psychological and should not be over looked.	Thank you for your comment. This guideline will cross reference to the guideline on rehabilitation in critical care where necessary.
Royal College of Nursing	General	General	The Royal College of Nursing (RCN) welcomes proposals to develop NICE guidelines about rehabilitation after traumatic injury. The RCN invited members who care for people in emergency, critical care and those with traumatic injuries to review the document on its behalf. The comments below reflect the views of our reviewers.	Thank you for your comment.
Royal College of Nursing	General	General	The draft scope seems comprehensive.	Thank you for your comment.

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Royal College of Nursing	General	General	The psychosocial aspects of rehabilitation should be considered and equal consideration should be given to the physical impact and both should be highlighted in this work. A recommended stream should be highlighted surrounding the aspects and effects of post-traumatic stress disorder (PTSD) on such patients and the implication for rehabilitation to them and their families. A close link between the physical and mental health pathway is required here.	Thank you for your comment. Although psychosocial aspects of rehabilitation will be considered as part of rehabilitation programmes or packages. This guideline will also refer to NICE guideline on posttraumatic stress disorder.
Royal College of Paediatrics and Child Health	General	General	Thank you for inviting the Royal College of Paediatrics and Child Health to comment on the draft scope consultation on rehabilitation after traumatic injury. We have not received any responses for this consultation.	Thank you for your comment.
Royal College of Speech and Language Therapists	2	4	In complex rehabilitation communication problems must be considered as communication problems affects a person's ability to understand others and be understood and is frequently affected post trauma. We recommend that communication and cognitive problems are added. Many people with complex rehabilitation needs will require speech and language therapy input due to specific conditions which increase their risk of communication problems. These patients often have complex communication difficulties of multiple aetiologies. More generally, patients are at risk of communication problems as a result of muscle weakness, prolonged intubation and procedures such as tracheostomy. There are three main causes of communication in people with complex rehabilitation needs: Organic communication such as those caused by stroke, major trauma, head injury, Guillain –	Thank you for your comment. This was revised to include communication problems and cognitive function.

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			Barré syndrome, post-surgery to the oral cavity/pharynx or larynx, chronic obstructive pulmonary disorder (Martin-Harris-B 2001), Adult Respiratory Distress Syndrome (ARDS), spinal cord injury, tumours, etc. Concomitant communication such as the effects of critical care neuropathy (due to disuse atrophy of striated muscle) or the effects of technologies to prolong life/enable clinical management of the illness such as mechanical ventilation, tracheostomy tubes, nasogastric tubes and Nasopharyngeal airways (Conlan and Kopec 2000; Pannunzio 1996). Psychogenic communication such as those resulting from critical care psychosis, delirium or clinical depression.	
Royal College of Speech and Language Therapists	2	5	After a traumatic incident people can experience problems eating, drinking and swallowing. The draft scope lists eating and drinking only. These are different from swallowing problems and we recommend that swallowing is added.	Thank you for your comment. This was revised to include swallowing.
Royal College of Speech and Language Therapists	2	11	Whilst we agree with the definition of complex needs including 2 or more allied health professional disciplines we are concerned that your examples are all physically based. There is no mention of nutrition, swallowing, communication or mood/depression.	Thank you for your comment. This was revised to include some non-physical examples.
Royal College of Speech and Language Therapists	6	19	Please would you explain what you are referring to in “talking therapies”	Thank you for your comment. Talking therapies has been removed from the scope to avoid confusion. To make the scope succinct general terms for physical, functional, vocational, psychological and psychosocial etc. therapies are generally used with a few examples where necessary. The protocols and evidence reports will go into more detail and comprehensively list all therapies that will be looked at.

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Royal College of Speech and Language Therapists	7	7	Please explain why you have excluded rehabilitation for speech loss. The equality impact assessment states that this is less of a priority than other rehabilitation areas. We disagree with this statement and feel that speech, language and communication should be included in the scope of the guideline. In complex rehabilitation speech and language is frequently affected. Evidence shows that many people with complex rehabilitation needs resulting from traumatic injury will have complex communication problems of multiple aetiologies. Unidentified and unmet communication problems have significant implications. Mechanically-ventilated people report high levels of frustration when trying to communicate their needs and the inability to speak and associated communication difficulties are a major source of stress for people who are or have been intubated (Pathak et al, 2004).Establishing communication for people with complex needs is largely too often overlooked in these settings. Loss of speech whilst a tracheostomy is in place could cause great distress to the patient even if the patient is warned beforehand (National Tracheotomy Safety Project 2013). Nurses often report feeling frustrated and incompetent when they are unable to understand and meet people's needs (Bergbom-Engberg and Haljamae, 1989).An inability to communicate effectively leads to the risk of clinical pain needs being unmet and has implications for consent or opinions regarding treatment and hospital management. Clinical risks: Many people in ICU describe feelings of disempowerment and social isolation due to their inability to communicate effectively and because they are unable to express how they feel (Hemsley et al, 2001).	Thank you for your comment. Speech loss has now been included.

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Royal College of Speech and Language Therapists	General	General	The RCSLT is pleased that this guideline will apply to children, young people and adults.	Thank you for your comment.

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Spinal Injuries Association	4	18	Despite not focusing on the care delivered in specialist Spinal Cord Injury Centres (see comment page 7, line 7), the pathway for Spinal Cord Injured (SCI) people nonetheless begins in the Trauma network for those with traumatic injuries (and often those with non-traumatic injuries.) The national NHS Database demonstrates geographic inequalities for access to these centres (72 days in the south of England vs nearly half that in the north.) This in turn can lead to Spinal Cord Injured people being treated in the trauma network for large periods of time whilst they await transfer. The treatment SCI people receive during in non-specialist settings should be included in this scope, even if their eventual rehabilitation is delivered by specialist centres beyond the scope of these guidelines. Outreach from the SCI Centres to MTCs etc. During this time should be a part of this scope.	Thank you for your comment. Spinal cord injury is already covered in relation to the coordination of services and identification and assessment. We have also included a new review question specifically aimed at identifying rehabilitation packages and programmes that are effective and acceptable for people with spinal cord injury and there will now be a section in the guideline specifically focused on this population.

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Spinal Injuries Association	5	27	In keeping with the previous comments, the whole pathway for a Spinal Cord Injured (SCI) person must be considered in this scope, even if their treatment in specialist SCI Centres is not. SCI people may present at GP surgeries as well as the trauma network and are particularly at risk of being incorrectly identified as SCI, or being referred to specialist services, in this setting. Not only can SCI people experience delays of several months waiting for treatment in one of these centres (during which time they may well be treated in a MTC etc), but the NHS SCI Database shows that up to two thirds of SCI people may never be admitted to a centre. The scope must consider the needs of this cohort of SCI people and work to ensure that SCI is correctly identified during the acute phase (including conditions such as Cauda Equine Syndrome) such referrals are appropriately made to the specialist SCI service All SCI people who are not admitted to a specialist SCI Centre still have their rehabilitation delivered with input from the SCI Centres – i.e. through outreach or outpatient appointments.	Thank you for your comment. The scope has been amended so that one of the review questions specifically covers rehabilitation following spinal cord injury. The scope also has a broad existing review question covering assessment, which would cover spinal cord injury assessment.

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Spinal Injuries Association	6	14	This is particularly pertinent for Spinal Cord Injury (SCI). In many cases – for instance Cauda Equina Syndrome – SCI is incorrectly identified. As a result, people may not be correctly referred to the specialist SCI services. If the specialist SCI service falls outside of this scope, then correct referral to the service must still be a critical part of the scope of these guidelines to ensure best treatment for SCI people.	Thank you for your comment. We will be including assessment for spinal cord injury in the guideline.
Spinal Injuries Association	6	24	As discussed previously in this response, assessment of Spinal Cord Injury (SCI) and co-ordination of the services they receive whilst SCI people await (often lengthy) transfers to specialist services must be included in this scope. Such a scope must consider the role of the SCI Centre as specialists and refer to their input throughout the pathway, such as referrals and outreach services from SCI Centres to other settings, such as MTCs.	Thank you for your comment. Spinal cord injury is already covered in relation to the coordination of services and identification and assessment. We have also included a new review question specifically aimed at identifying rehabilitation packages and programmes that are effective and acceptable for people with spinal cord injury and there will now be a section in the guideline specifically focused on this population. We have made changes across the scope and hope it is now clearer.

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Spinal Injuries Association	7	1	As well as Social Care the scope must cover NHS Continuing Healthcare (CHC). CHC is responsible for the largest number of lost bed days due to delayed discharge in the specialist SCI Centres. CHC will also be a significant cause of lost days in other rehabilitation services. In Spinal Cord Injury it is our belief that better, multi-disciplinary assessments carried out by or with the MDT in the SCI Centre, rather than non-specialist assessors in the community, would go some way to relieving the blockages CHC causes in the wider pathway. More importantly, assessments involving the specialist MDT would ensure that after a period of intensive, specialist (and expensive) SCI rehabilitation, a SCI person is discharged with a suitable care package which enables them to live independently and put into practice the skills which they have learnt during this rehabilitation. Failure to provide suitable CHC care packages as a result of poor assessment can lead to regression as the SCI person is unable to put their new skills into practice. This is unacceptable and failure to provide suitable, on-going support makes a mockery of the rehabilitation process. Please note that considering CHC assessments as part of the scope may lead to significant cost savings across the patient pathway, including outside of specialist SCI Centres. Delayed discharge from an SCI Centre may lead to blockages elsewhere in the system – notably in MTCs. The cost of a CHC care package per week is negligible when compared to what a bed in a MTC would cost per day.	Thank you for your comment. We will consider these issues in our assessment and coordination of rehabilitation services review questions Thank you for making us aware of these specific issues.

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Spinal Injuries Association	7	7	"Specialist rehabilitation programmes" for spinal cord injury presumably refer to the rehabilitation received in Spinal Cord Injury Centres. If so, it is disappointing that the rehabilitation received in these centres is not also being assessed in this consultation. Page 3, line 15 refers to plans to assess Traumatic Brain Injury guidelines in 2019. The Spinal Injuries Association would like to call for guidance for SCI to also be addressed by NICE in the near future, in recognition of the wider pathway for SCI people injured through both trauma and non-trauma.	Thank you for your comment. There are no confirmed plans for a full guideline on Spinal cord injury. However, a question on rehabilitation programmes and packages specifically for spinal cord injury has now been included in this guideline.
Spinal Injuries Association	9	29	Add "and NHS Continuing Healthcare."	Thank you for your comment. The question (2.1) has now been slightly revised so instead of including examples of therapies they are now referred to as "physical and non-physical therapies". The Guideline Committee will then decide on the specific therapies that will be considered in this question.
Spinal Services CRG	6	20	Major MSK trauma e.g. pelvic fracture / multiple fractures are a group currently poorly resourced and at risk of significant long term limitations and consideration should be given to explicitly make recommendations for this group	Thank you for your comment. We have a broad rehabilitation review question in the scope (Q2.1) which should cover this group and allows the opportunity to make recommendations related to this group should the Guideline Committee decide to do so.

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Spinal Services CRG	6	7	It is unclear why critical care units excluded – the rehabilitation pathway will often start there. There should be common recommendations to the critical care guidance	Thank you for your comment. . This guideline will cross reference to the guideline on rehabilitation in critical care where necessary.
Spinal Services CRG	7	6	Although the "specialist rehabilitation programmes" will not be addressed, there should be recommendations for the required early interventions to minimise complications and begin rehabilitation interventions for these groups. Outreach from the SCI Centres to MTCs during this time should be a part of this scope.	Thank you for your comment. The types of interventions covered will be detailed in the protocols and agreed with the Guideline Committee. This will include with for the new question which has now been included specifically about spinal cord injury.
Spinal Services CRG	9	12	This should include vocational services	Thank you for your comment. The questions prioritised for economic modelling have not been decided yet, and it is therefore too early to say to what extent vocational services will feature in such analyses.
Spinal Services CRG	11	13	Continuing health care should also be included (not only social care)	Thank you for your comment. Due to resource limitations, the guideline cannot consider all aspects of this area and has therefore focused on priority areas based on current variation or uncertainty in practice.
Spinal Services CRG	11	21	Secondary health conditions / complications should be included in outcome measures	Thank you for your comment. The outcomes listed in the scope are only examples of outcomes that are likely to be considered in the guideline. For each clinical question the most relevant outcomes will be decided by the

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				Guideline Committee and evidence for those outcomes will then be used to develop recommendations.
Spinal Services CRG	11	29-30	Is this PROM / PREM? If not they should be included	Thank you for your comment. The outcomes listed in the scope are only examples of outcomes that are likely to be considered in the guideline. For each clinical question the most relevant outcomes will be decided by the Guideline Committee and evidence for those outcomes will then be used to develop recommendations.
Spinal Services CRG	General	General	Initially the scope included children and young people and adults, now it states “people”. There should be separate recommendations for children / young people as the pathways and considerations are different to the adult population	Thank you for your comment. This guideline will look at both children and young people and adults. Separate recommendations will be considered for children/ young people where relevant.

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The Disabilities Trust	2	18	The scope states that "*Currently, patients have a rehabilitation assessment and prescription carried out during the hospital admission*". We are not aware of evidence that this is the case and suggest that: 1) An audit is conducted to determine how many people admitted to hospital for traumatic injuries receive a rehabilitation assessment and prescription; 2) The wording of this sentence is changed to "*Currently, **it is recommended** that patients have a rehabilitation assessment and prescription carried out during hospital admission*" to account for any discrepancies that may happen in practice.	Thank you for your comment. This was amended to reflect that currently, this is not a standard practice and that patients ***should*** have rehabilitation assessment and prescription carried out during the hospital admission.
The Disabilities Trust	2	12-13	We and other participants present in the guideline development workshop, feel that the scope of the guideline should make explicit reference to the biopsychosocial impact of traumatic injuries, and of the need for support within all aspects of functioning, including psychological adjustment after the injury. The current wording of the scope focuses on occupational performance and misses out the psychological aspects of recovering from trauma, which may nevertheless affect occupational performance and outcomes of traumatic injury rehabilitation more generally.	Thank you for your comment. This was revised to include emotional, psychological and psychosocial support.

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The Disabilities Trust	3	15-17	While we understand the rationale for excluding "complex rehabilitation needs resulting primarily from traumatic brain injury", which will be covered in a separate guideline, the scope of the present guideline should include the provision of clear guidance on how to screen for needs that may result primarily from traumatic brain injury (TBI) and guidance to ensure that TBI related needs that are not the primary need (e. g. in cases of polytrauma) are also identified and monitored.	Thank you for your comment. Rehabilitation following traumatic brain injury will be covered in another NICE guideline due to begin development in 2019. Where complex rehabilitation needs result primarily from traumatic brain injury this will be explicitly excluded from the guideline. This guideline will, however, cover assessment and coordination of services for people with complex traumatic injuries, one of which may be traumatic brain jury. We recognise that people with traumatic injuries may suffer from delirium and other assorted issues that although not classed as TBI will have an effect on assessment and rehabilitation. So although specific treatments for traumatic brain injury will not be covered by this guideline, the programmes included for our population will be likely to include some cognitive and communication therapy components. These will be determined in more detail in the protocols for the appropriate review questions.

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The Disabilities Trust	3	4-5	The scope rightly refers to the "*wider costs to the community if people are unable to work return to work or education*" but it does not explicitly mention that these may take the form of loss of productivity for informal carers (e. g. carers unable to return to full-time work), as well as the potential health risks associated with being a carer (e. g. mental health).	Thank you for your comment. (1) This is only the acknowledgement of potential economic consequences. However, as per NICE guidelines manual productivity costs and costs borne by people using services and carers that are not reimbursed by the NHS or personal social services should usually be excluded. Regarding the (2) the potential health risks associated with being a carer will be captured by the impact on family and carers outcome.
The Disabilities Trust	5	8-9	The scope accounts for consideration of those "with pre-existing physical and/or mental health conditions, physical and learning disability or frailty". We suggest that there the functional impact of these pre-existing conditions should be also be given consideration.	Thank you for your comment. We will be considering functional impact in the guideline.

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The Disabilities Trust	6	10-12	The scope makes reference to physical, psychological and psychosocial interventions, although some problems may be improved by alterations to the environment, which often require input from a multidisciplinary team. Acknowledgment that interventions may be of an environmental nature should be within the scope of the guideline.	Thank you for your comment. Programmes and packages in the guideline may also consider equipment for rehabilitation in the home.

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The Disabilities Trust	6	6	The scope of the guideline does not cover accident and emergency (A&E) departments. However, significant aspects of screening and assessment of traumatic injuries and traumatic brain injuries that enable identification of the most appropriate pathway for each individual, should begin at the point of admission to hospital. Paramedics and A&E departments will have the first contact with the patient, and will be knowing and able to record key information, such as whether there was loss of consciousness or not, whether the patient was under the influence of drugs or alcohol, etc. This information is important to identify whether a traumatic brain injury may have occurred in the context of a traumatic injury, and therefore enable referral to the appropriate pathway, and application of the most relevant guidelines. Excluding the A&E settings will miss the opportunity of integrating the delivery of care.	Thank you for your comment. Whilst we recognise the important role of A&E more generally in relation to traumatic injury, we believe the focus for this guideline needs to be on the admitting team regarding the consideration and assessment of rehabilitation needs.
The Royal College of Ophthalmologists	10	24	There should be mention of how to access help for sight loss with special mention of Eye Clinic Liaison Officers and sight loss charities e.g. the RNIB, Macular Society. Losing sight is devastating and has enormous impact on a person's quality of life and independent living.	Thank you for your comment. Due to the limited size of the scope, and the very specific nature of rehabilitation interventions in this area, sight loss will only be covered in the context of assessment of rehabilitation needs and coordination of services.

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The Disabilities Trust	10	34	The scope makes reference to “coordination of rehabilitation services”, but it is unclear whether this includes coordination prior to admission into rehabilitation services. However, this pre-admission coordination seems essential to ensure that people are referred to the most appropriate service, and that no significant needs are missed.	Thank you for your comment. It is not possible to coordinate rehabilitation prior to admission to the acute hospital, as the extent of injury has not yet been diagnosed. If what is meant is preadmission to a rehabilitation facility then this will be covered by the coordination of services on leaving the acute hospital.
The Disabilities Trust	11	33	Length of stay is listed as a “main outcome”. While we agree that length of stay is an important aspect to consider, it should not be taken as an indicator of clinical outcome. People with more severe problems tend to require longer stays in service, and often, better outcomes are achieved in those with longer stays. However, we agree that this is an important variable to explore, as it may help further understand the process of rehabilitation such as, for example, if there are recommended minimum periods of stay in rehabilitation.	Thank you for your comment. The outcomes listed in the scope are only examples of outcomes that are likely to be considered in the guideline. For each clinical question the most relevant outcomes will be decided by the Guideline Committee and evidence for those outcomes will then be used to develop recommendations.
The Disabilities Trust	13	1 (flowchart)	“Coordination of services”, which is listed at the end of the process, should be considered at an earlier stage. For example, following “identification and assessment of needs”. Coordination of (and between) services is closely related to the assessment and identification of rehabilitation needs, as ensuring that patients are referred to the most appropriate service is key to achieve the best outcomes.	Thank you for your comment. Although questions on "Coordination of services" is listed at the end, recommendations related to other sections (e.g. Identification and assessment needs) will take into account of evidence from "Coordination of services".
The Royal College of Ophthalmologists	General	General	The focus is on major trauma and rehabilitation. It would be helpful to have a section on loss of major senses including sight and hearing.	Thank you for your comment. Due to resource limitations, loss of major senses including sight and hearing will only be covered in the context of assessment of rehabilitation needs and coordination of services.

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UHS NHS Foundation Trust	2	10	Complex needs will cover multiple needs, and will always involve coordinated multidisciplinary input from 2 or more allied health professional disciplines. I'm concerned that simple injuries still require 2 disciplines e.g. Fractured ankle requires Dr and Physiotherapist so 2 or more disciplines does not equate to complex rehabilitation	Thank you for your comment. The definition refers to 2 allied health professionals so this is in addition to role of doctors and physicians. We have however made some minor amends to the definition which now reads "Complex needs will cover multiple needs, and will always involve coordinated multidisciplinary input from 2 or more allied health professional disciplines, and could also include the following: (1) vocational or educational social support for the person to return to their previous functional level, including return to work, school or college; (2) emotional, psychological and psychosocial support; (3) equipment or adaptations; (4) ongoing recovery from injury that may change the person's rehabilitation needs (for example, restrictions of weight bearing, cast immobilisation in fracture clinic); (5) further surgery and readmissions to hospital."
UHS NHS Foundation Trust	2	17	Lots of complex rehabilitation patients require further surgery and readmissions to hospital, this should be included in the examples	Thank you for your comment. This was revised to include further surgery and readmissions to hospital.
UHS NHS Foundation Trust	4	22	Equality considerations – should this include patients with mental health issues	Thank you for your comment. We have included people with mental health issues as a sub-group for specific consideration in section 3.1 of the scope so it was agreed there was no need to also include them as equality consideration.
UHS NHS Foundation Trust	5	4	Would the guideline be able to define complex more clearly	Thank you for your comment. Section 1 of the scope contains our definition of complex.

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UHS NHS Foundation Trust	6	7	This states that the guidance will not cover critical care units. Elsewhere in the document e.g. page 5, line 19 and 2, reference is made to the guidance covering all settings in which rehabilitation services are provided after traumatic injury. Depending on length of stay in a critical care, some of the early rehabilitation needs of the patient may be appropriate to start assessing and treating within the critical care setting and therefore whether some recognition of this should be addressed by the guideline rather than stating the guidance is not within scope of critical care. Reference could be made to the early mobilisation literature, indicating that rehabilitation can start in critical care to justify the above points?	Thank you for your comment. The scope has been amended to cover critical care units and rehabilitation in relation to the coordination of care.
UHS NHS Foundation Trust	6	7	If the NICE guideline is not to cover rehabilitation which starts on critical for lots of patients this new guideline should link in with the principles of rehabilitation and goal setting that is advised in Rehabilitation following critical illness NICE Guideline	Thank you for your comment. The scope has been amended to cover critical care units and rehabilitation in relation to the coordination of care. This guideline will also cross reference to the guideline on rehabilitation in critical care where necessary.

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UHS NHS Foundation Trust	6	27	In keys areas that will be covered you include those with traumatic brain injury, spinal cord injury, sight loss, hearing loss and speech loss but these are then included in the areas that will not be covered.	Thank you for your comment. We have amended the scope and hope the following is now clearer a. the definition of complex rehabilitation needs, b. the areas of injury that are likely to be included in both the assessment and coordination questions, c. the areas of injury that are specifically excluded from our treatment questions and the reasons for that, d. some specific rehabilitation treatment questions for some specific injury areas.
UHS NHS Foundation Trust	7	10	Concern was raised that patients with long term care and rehabilitation packages also experience trauma. Plus patients with lower limb reconstruction can have frames on for over 2 years. Do we need to define long term rehabilitation packages	Thank you for your comment. The scope excludes long-term care and rehabilitation packages for people with long-term care needs. However, the review questions in the scope looking at care packages will consider the effectiveness and acceptability of different rehabilitation programmes as well as their content, timing, intensity, frequency and setting. So there are currently no details on things such as time span of rehabilitation packages. The Guideline Committee will need to agree in the committee meetings definitions in these areas and what can sensibly be included or excluded.

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UHS NHS Foundation Trust	11	21	Good list of outcome measures, not sure length of stay is an indicator of good or poor rehabilitation following trauma	Thank you for your comment. The outcomes listed in the scope are only examples of outcomes that are likely to be considered in the guideline. For each clinical question the most relevant outcomes will be decided by the Guideline Committee and evidence for those outcomes will then be used to develop recommendations.
UK Acquired Brain Injury Forum (UKABIF)	1	6-7	This seems to suggest NICE are only looking at musculoskeletal injury – in which case why not rename it as such? This does not follow NHSE policy of not focusing on separate diagnoses. As above it does not make sense to separate this out – many people with traumatic injuries also have a brain injury. Would suggest the following be inserted "1.3 million people in the UK live with the consequences of ABI, and each year approximately half a million patients attend UK emergency departments for traumatic brain injury. That is nearly 1,500 patients with traumatic brain injury attending A&E departments in the UK each day"	Thank you for your comment. We have made revisions throughout the scope to clarify what type of injuries we will be looking at i.e. not only musculoskeletal injuries. We hope this is now clearer.

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UK Acquired Brain Injury Forum (UKABIF)	2	18-19	The Rehabilitation Prescription (RP) is not included in any NICE Guidance - we challenge the statement that patients have a rehabilitation assessment and prescription Our research shows that only 40% have an RP initiated and only 4% are completed	Thank you for your comment. This was amended to reflect that currently, this is not a standard practice and that patients ***should*** have rehabilitation assessment and prescription carried out during the hospital admission.
UK Acquired Brain Injury Forum (UKABIF)	2	1-2	The big peak is young male adults, the two smaller peaks are children under 2 and older people	Thank you for your comment. The wording was kept as it is. The suggested peak in young male adults is more relevant from the traumatic brain injury perspective. Where complex rehabilitation needs result primarily from traumatic brain injury this will be explicitly excluded from the guideline so it would be misleading to include TBI data and statistics within section 1 of the guideline. This guideline will however cover assessment and coordination of services for people with complex traumatic injuries, one of which may be traumatic brain jury.
UK Acquired Brain Injury Forum (UKABIF)	2	5-6	There is an Underplay of Post-Traumatic Stress Disorder and an overlap between PTSD and acquired brain injury. We also wish to highlight mental health conditions such as suicide and depression.	Thank you for your comment. This was revised to include depression, anxiety and other psychological difficulties.

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UK Acquired Brain Injury Forum (UKABIF)	6	24-28	We acknowledge there is a head injury review coming up but of the 45,000 in rehabilitation after traumatic injury at least 50% will have had a brain injury. There is therefore a strong argument not to provide documents for individual conditions. It is not best use of specialist neurorehabilitation resources and complex rehabilitation across all diagnoses. If papers are joined together this will result in joint responsibility rather than transfer of care. Co-morbidities are the rule rather than the exception in this area.	Thank you for your comment. Rehabilitation following traumatic brain injury will be covered in another NICE guideline due to begin development in 2019. Where complex rehabilitation needs result primarily from traumatic brain injury this will be explicitly excluded from the guideline. This guideline will, however, cover assessment and coordination of services for people with complex traumatic injuries, one of which may be traumatic brain jury. We have tried to make this clearer in the scope. We also recognise that people with traumatic injuries may suffer from delirium and other assorted issues that although not classed as TBI will have an effect on assessment and rehabilitation. So although specific treatments for traumatic brain injury will not be covered by this guideline, the programmes included for our population will be likely to include some cognitive and communication therapy components. These will be determined in more detail in the protocols for the appropriate review questions.

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UK Acquired Brain Injury Forum (UKABIF)	7	1-4	This contradicts page 7 line 8/9Is this relationship being considered or not? Social care does not work like this. Social care is needs led not led by diagnosis	Thank you for your comment. We have clarified this in the scope. We will consider the relationship between rehabilitation services and social care services (for example, home care) when people transfer from inpatient to outpatient rehabilitation services including the support needs and preferences of those people. But we will not be looking at specific social care interventions as part of our questions about rehabilitation packages and programmes (for example, home care or personal assistance).
UK Acquired Brain Injury Forum (UKABIF)	General	General	We are disappointed to note that much relevant work is stated in the National Service Framework which was published in 2005 is once again not being used to develop NICE Guidance. This work was completed after lengthy consultation with many relevant parties and would save enormous time and effort if utilised.	Thank you for your comment. The development of this NICE guideline will follow the methodology as set out in the NICE manual.

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University Hospital Birmingham	1 2	15-18 4-18	The draft scope currently excludes those patients who have had a Traumatic Brain Injury (TBI) due to a separate TBI guideline being produced in 2019. We feel that reference should be made to those presenting with a TBI within this guideline as many of our patients with multiple injuries or poly-trauma also require screening to exclude additional TBI or concussion. Many have significant traumatic injuries and an additional TBI and this further supports the need for coordinated and comprehensive specialist rehabilitation. TBI cannot be regarded as a separate entity and should not be excluded from the remit of this document. The draft scope currently excludes "Cognitive function" as a problem / consequence of trauma. Cognitive deficits are not exclusive to TBI and may be as a result of delirium, etc. and therefore should be taken into consideration. The draft scope states that input from 2 or more allied health professional (AHP) disciplines must be involved to qualify as complex rehabilitation needs. We feel that some people within this group may not be able to access two or more AHP disciplines due to their geographic or local provision but should not be excluded from this guideline as a consequence. Therefore could the following statement be changed to where 2 or more AHP disciplines should be involved? The draft scope currently indicates that patients should have a rehabilitation assessment and prescription carried out during the hospital admission. Is there a need to indicate the preferred timing for a rehabilitation assessment, i.e. Acute?	Thank you for your comment. The scope already includes patients with traumatic brain injury in relation to identifying and assessing needs and coordinating services but where complex rehabilitation needs result primarily from traumatic brain injury this will be explicitly excluded from the guideline. We have made some amendments to the scope so we hope this is now clearer.

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University Hospital Birmingham	6	16	The draft scope currently mentions Community rehabilitation facilities. Do the guidelines allow this to be outpatient services e.g. Physiotherapy within an acute hospital setting such as a Major Trauma Centre (MTC) or Trauma unit (TU)? The draft scope, only includes MTC and TU settings under the subheading of inpatient settings (page 5, line 22). The majority of outpatient physiotherapy rehabilitation after traumatic injuries takes place at present within MTC and TU settings and so we feel these settings shouldn't be excluded from the discussion as to where best provide outpatient rehabilitations services for people with complex rehabilitation needs.	Thank you for your comment. We have amended to make it clearer that outpatient settings are included.
University Hospital Birmingham	7	14	The draft scope indicates that Nutritional support will not be covered in the NICE guideline. Patients following Major Trauma have significant nutritional support requirements and timely, proactive assessment and intervention from Nutrition and Dietetic colleagues is essential for this patient cohort.	Thank you for your comment. Nutritional support is now no longer specifically excluded.

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University Hospital Birmingham	7	1-4	The draft scope suggests that the relationship between rehabilitation services and social care will be addressed. Will the guideline also look to include how social care needs will be assessed and services accessed? Accessing the necessary social input / services remains a challenge to meet the needs of complex trauma patients. A significant number of patients following major trauma require social care interventions to support their rehabilitation and recovery. This should feature in the guidelines produced.	Thank you for your comment. The guideline will look at the optimal methods of coordinating and delivering rehabilitation services and social care services for people with complex rehabilitation needs after traumatic injury when they transfer from being inpatients to being outpatients. This is the time point in the pathway where the connection between these two sets of services has been identified to be of the highest priority. Due to resource limitations, the guideline will not consider specific social care interventions or the explicit assessment of social care needs.
University Hospital Birmingham	7	10-11	The draft scope currently is excluding examination of long-term care and rehabilitation packages for people with long-term care needs. Whilst long-term care may be outside the scope of this guidelines would the guideline consider including and discussing 'top-up' rehabilitation needs that the patient may need beyond their initial rehabilitation phase to maintain their quality of life and ability to remain in employment?	Thank you for your comment. The scope excludes long-term care and rehabilitation packages for people with long-term care needs. However, the review questions in the scope looking at care packages will consider the effectiveness and acceptability of different rehabilitation programmes as well as their content, timing, intensity, frequency and setting. So there are currently no details on things such as time span of rehabilitation packages. The Guideline Committee will need to agree in the committee meetings definitions in these areas and what can sensibly be included or excluded.

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University Hospital Birmingham	10	23	Specialist equipment needs should be highlighted and addressed as part of the guideline, i.e. Access to communication technology, Eye Gaze, Wheelchair and Specialist seating provision, etc.	Thank you for your comment. Programmes and packages in the guideline may also consider equipment for rehabilitation.
University Hospital Birmingham	10	7-11	Within the scope of the guideline, we need to consider the complete timeline of rehabilitative input. This should include days following the trauma to years' post-injury. The scope should also include guidance and consideration of staffing resources (numbers / profession / experience) and timely accessibility to these services.	Thank you for your comment. NICE guidelines cannot and are not intended to cover every aspect of a pathway, but rather to focus on priority areas that are marked by uncertainty or variation in practice. The included questions represent these priority areas and they cover assessment, treatments, follow-up and different aspects of coordination.

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University Hospital Birmingham	11	1-3	Within the scope of the guideline, it may be beneficial to differentiate between the rehabilitation provided in the acute setting and that provided in a Specialist in-patient rehabilitation setting.	Thank you for your comment. "Setting" is an implicit part of the questions that the Guideline Committee will consider when making recommendations.
University Hospital Birmingham	11	7-9	Will the guidelines examine whether it would be a more clinically effective and cost-effective to have regional outpatient rehabilitation centres and/or a national rehabilitation centre for this group of patients? Presently, the pathway for outpatient rehabilitation seems ad hoc, as the draft scope alludes to (page 2, line 21-23), with many seen at their local provider irrespective of skill mix, experience and resources. Furthermore, more often than not, if problems and / or limitations with the local provider arises, the regional multi-trauma centre (in our experience) then steps in to provide the care.	Thank you for your comment. The guideline does not currently include any explicit questions about service configuration, but "setting" is an implicit part of the questions that the Guideline Committee will consider when making recommendations.

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University Hospitals Coventry and Warwickshire NHS Trust (UHCW)	2	10	Should three or more AHPs (can include Psychology) be the measure of complex needs as the documented standard of 2 or more AHPs will be achieved by the most straightforward rehabilitation cases in the acute setting if they have PT and OT needs.	Thank you for your comment. The definition refers to 2 allied health professionals so this is in addition to role of doctors and physicians. We have however made some minor amends to the definition which now reads "Complex needs will cover multiple needs, and will always involve coordinated multidisciplinary input from 2 or more allied health professional disciplines, and could also include the following: (1) vocational or educational social support for the person to return to their previous functional level, including return to work, school or college; (2) emotional, psychological and psychosocial support; (3) equipment or adaptations; (4) ongoing recovery from injury that may change the person's rehabilitation needs (for example, restrictions of weight bearing, cast immobilisation in fracture clinic); (5) further surgery and readmissions to hospital."
University Hospitals Coventry and Warwickshire NHS Trust (UHCW)	4	21	Homeless patients require consideration from an adjuncts to management point of view as well as hospital discharge. Without an NHS number this group of patients cannot access specialist rehabilitation such as spinal cord injury units, non-emergency ambulance transfers or equipment provision such as orthoses.	Thank you for your comment. We have changed this from not just being about discharge but access to services more generally. Also this group of people are included in our equality considerations and where relevant special considerations will be given to this group of patients when developing guideline and making recommendations.

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University Hospitals Coventry and Warwickshire NHS Trust (UHCW)	5	8	Also need to consider addiction. Spinal cord injury units in particular are reluctant to admit patients with mental health issues or addiction	Thank you for your comment. The scope has a specific consideration section which includes people with pre-existing mental health conditions (including substance abuse)..This will also include addiction.
University Hospitals Coventry and Warwickshire NHS Trust (UHCW)	5	16	Should read 'and/or do not require admission to hospital'	Thank you for your comment. This was rephrased.
University Hospitals Coventry and Warwickshire NHS Trust (UHCW)	6	19	Having looked it up blood flow occlusion therapy is a very niche and aspirational adjunct. Including something like this is likely to lessen the impact of the argument when trying to get agreement with commissioners around the need for core interventions.	Thank you for your comment. Blood flow occlusion therapy has been removed as an example from the scope.
University Hospitals Coventry and Warwickshire NHS Trust (UHCW)	7	14	I strongly disagree with this exclusion. Nutritional delivery and dietetics should be a key area covered as it is essential for surgical recovery, wound management, muscle regeneration and rehabilitation engagement. For further clarity engagement with the BDA Trauma sub group of the Critical Care specialist interest group is advised. Current chair is Janet Brewer at Janet.Brewer@nhs.net	Thank you for your comment. Nutritional support is no longer excluded. This guideline will consider nutrition as part of rehabilitation packages or programmes.

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Registered stakeholders