NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1 Quality standard title

Rehabilitation after critical illness.

Date of quality standards advisory committee post-consultation meeting:
17 May 2017.

2 Introduction

The draft quality standard for rehabilitation after critical illness was made available on the NICE website for a 4-week public consultation period between 27th March and 21st April 2017. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 22 registered stakeholders, which included service providers, national organisations, professional bodies and others.

This report provides the quality standards advisory committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the committee as part of the final meeting where the committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the committee should read this summary alongside the full set of consultation comments, which are provided in appendices 1 and 2.

3 Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be to be for these to be put in place?

3. Do you have an example from practice of implementing the NICE guideline(s) that underpins this quality standard? If so, please submit your example to the NICE local practice collection on the NICE website. Examples of using NICE quality standards can also be submitted.

4. Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.

Stakeholders were also invited to respond to the following statement specific questions:

5. For draft quality statement 1: we suggest that adults in critical care who are at risk of physical and non-physical morbidity should have short- and medium-term rehabilitation goals agreed within 4 days of being admitted or before discharge from critical care. This timescale is based on expert opinion. Is this timescale appropriate and feasible?

4 General comments

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

- General support for the quality standard.
- Concern that the statements are too weak and the quality standard will have a limited impact.
- Concern about some areas not being sufficiently covered or addressed
- Suggestion that term ‘rehabilitation prescription’ should be used throughout the document as used by The Trauma Audit & Research Network (TARN) for national audit.

Consultation comments on data collection

- Mixed response regarding data collection:
    - data collection perceived as feasible without the need for local financial investment
    - currently no structures in place for data collection even though some evidence could be found in patient’s notes.
- Suggestion that data collection could be done via Intensive Care National Audit & Research Centre (ICNARC) and local patient management systems such as Wardwatcher - highlighted caveat that ICNARC does not collect rehab data at present.

Consultation comments on resource impact

- Mixed response from the stakeholders:

    - quality standard would be achievable by local services without the need for significant local financial investment
    - concern that there is currently a lot of variation in funding and resources available within critical care making implementation difficult without additional resources
- Potential cost savings from early identification of individualised rehab goals and starting of rehab which can reduce length of ICU and hospital stay, reduce readmissions and GP referrals.
- Financial investment needed for the provision of follow-up which is low nationally and does not include key professionals such as speech and language therapists and clinical psychologists.
- Additional human resources needed to collect the information from the bedside as well as data collection systems to be set up.
- Need for clear guidance on commissioning and tariffs for critical care follow-up services/clinics.

5 Summary of consultation feedback by draft statement

5.1 Draft statement 1

Adults in critical care who are at risk of physical and non-physical morbidity have short- and medium-term rehabilitation goals agreed within 4 days of being admitted to and before discharge from critical care.

Consultation comments

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

- Support for the statement and the timeframe – an assessment form that includes short and medium term goals, and an outcome measure which is completed daily can be easily implemented and audited.
- Having an assessment and a co-ordinated plan in place is more important than having rehabilitation goals - co-ordinated rehabilitation plan encompasses both needs and goals and is likely to facilitate better patient care – the assessment and plan should be carried out by a MDT including physiotherapy, psychology, occupational therapy, speech and language therapy and rehab physicians.
- Accomplishing goals needs to be monitored and followed-up, not just agreed.
- Suggestion to use “psychological morbidity” as opposed to “non-physical morbidity” as it is not well understood.

- Various suggestions to change definitions of goals:
    - Short term goals:
        - small goals to be achieved within a few days/a week
        - goals for the patient to achieve before they are discharged from critical care
        - apply to rehabilitation within ICU (e.g. sit to stand with assistance of two and a rollator frame in 3 days)
    - Medium term goals:
        - what people need to achieve for discharge

    - goals for the patient to achieve before they are discharged from hospital
    - goals relevant just prior to hospital discharge
  - Long term goals:
    - goals to help them return to their normal functional ability on discharge
    - goals to help the patient return to their normal activities of daily living after they are discharged from hospital [including vocational rehabilitation needs/return to work, if applicable
    - goals relevant to full recovery/baseline function/employment.

- Additional suggestion highlighting psychological needs:
  - Short term - within hospital:
    - to have a reasonable method for communication
    - to have access to personal items
    - to enable a good sleep/wake cycle to minimise delirium risk
    - for family to be involved with care
  - Medium term - towards and post discharge:
    - to have access to information
    - to be offered a post critical care review
    - to have access to psychological support from a trained professional
- Concerns about malnutrition or weight loss not being included under the definition of risks of morbidity - as they are likely to impact on short and medium term rehabilitation goals.

Consultation question 5

We suggested that adults in critical care who were at risk of physical and non-physical morbidity should have short- and medium-term rehabilitation goals agreed within 4 days of being admitted or before discharge from critical care. This timescale is based on expert opinion. Is this timescale appropriate and feasible?

Stakeholders made the following comments in relation to consultation question 5:

- 4 days seems an appropriate and feasible timescale - all specialities will have had time to review and assess and develop medical plans.
- Concern that the goal setting will not be realistic for many patients at this stage – especially the patients who are still sedated and ventilated at 4 days - the statement should be around having a comprehensive assessment by this stage.
- Defining medium term goals within 4 days of admission to critical care was not perceived as the right focus:
    - too early for the patients to predict goals on their return home – may be more appropriate at discharge from critical care
    - discussing medium-term goals with the patient or family / carers may not be appropriate at this point - potentially still critically unwell
- Suggestion to separate the timeframe:
    - therapy needs to be assessed within 48 hours
    - needs for assessment and referral to specialised rehabilitation services considered and documented prior to discharge from critical care
- The timescale of 4 days is very dependent on rehab needs, patient type and service availability. This timescale may still include patients who do not require rehabilitation. More flexibility is needed - “4 to 7 days”, or “within 7 days”.
- 4 days seen as an excessive delay - at 24 hours all patients should be assessed for their suitability to commence active rehabilitation (in ICU).

5.2 Draft statement 2

Adults transferring from critical care to a general ward have a formal handover of their individualised structured rehabilitation programme.

Consultation comments

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

- Suggestion to change word “programme” to “plan” - more than one form/format of rehabilitation programme is possible.
- Further definition of formal handover needed:
    - input from all involved healthcare professionals needed, not just doctors and nurses – allied healthcare professionals ensure all dimensions of the individualised structured rehab programme are met
    - commitment from the ward staff to meet the rehabilitation goals needed -services need to be commissioned to meet these goals
    - from the psychological point of view, the handover should include the results of the pre-CCU discharge psychological assessment including any problems with stress, mood, sleep, communication, hallucinations, delusions, other cognitive dysfunction, and recommendations for ongoing psychological support or therapy to manage these problems
    - verbal handover may be more feasible in a smaller critical care unit which may not be possible in larger units - formalised written handover may be preferable
- Handover in itself is not sufficient. Physical rehabilitation and psychological support also need to be delivered during the time the patient is on the ward.
- Concern that there is no mention of nutritional issues in the section on the required information about the needs of the adult being discharged to the ward.

- Statement should address adults transferring from critical care to a general ward or between critical care units.

- Concerns about measurability of this statement – handovers rely on verbal communication between therapists; medical teams have written discharge/handover summary but usually a standardised form detailing medical history and events rather than a written patient's individualised rehab programme.

- Data sources for evidence of handover should include a document such as a rehabilitation prescription or enhanced ICU discharge summary.

5.3 Draft statement 3

Adults who have been in critical care and are discharged from hospital are given information about what to expect after discharge.

Consultation comments

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

- Suggestion that a lot of hospitals already give this type of information - information on its own is usually not sufficient to make a difference – someone, such as a rehabilitation coordinator, should go through it with the patients and families.
- Concern that the quality statement is very broad and does not specify who should provide the information after discharge and what it should contain - the ambiguity would be reflected in confusion and lack of ownership amongst healthcare professionals – suggested a template to provide some standardisation in what information is given.
- Concerns about timing of this information being given:
    - some of the information required before hospital discharge, especially for families
    - information should be given depending on the patient's pathway, understanding, mental status etc. - may include a degree of information giving at or around critical care discharge and a further amount during their ward recovery
- Suggestions about the type of information given:
    - summary of physical, psychological and social issues that are still outstanding at hospital discharge, treatment plan for these issues, and phone numbers/websites to use, if they require further help
    - fit note at discharge or GPs should be sent suggested timeframe for return to work to avoid inadvertent loss of employment opportunities.

- Suggestion that other services should have a role at this point:
    - primary care – GPs should receive the same information and be involved in monitoring rehabilitation
    - social care, voluntary sector and other community services – potential to support people's rehabilitation and recovery
- Concerns about measurability of this statement - patients given information in the form of a booklet on discharge from ICU (given out by nursing staff) - not recorded who/when gets the information.

5.4 Draft statement 4

Adults with rehabilitation needs identified from a functional assessment have a review 2 to 3 months after their discharge from critical care.

Consultation comments

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

- Current population in the statement is too broad and likely to include about 90% of patients; following up everyone is not manageable; only those having rehab needs at the point of discharge should be brought back to clinic.
- Suggestion to change “review” to “further physical/non-physical functional assessment” to emphasise the importance of a full multi-disciplinary assessment for the most high-risk patients at the 2-3 month time point.
- Review period of 2-3 months should be regarded as a minimum - consequences of critical illness extend for longer than this period for many patients and the follow up may need to be extended.
- Concern that the word ‘rehabilitation needs’ doesn’t capture that patients may be experiencing psychological problems – suggestion to change to “adults experiencing physical, psychological or social problems following critical care”
- Suggestion that data collection should include documentation of any residual physical and psychological difficulties but also referrals to any further rehabilitation that may be needed, situation re return to work, benefits received if needed, and advice on return to driving.
- Suggestion that expected nutritional problems post hospital stay should be included in either physical or non-physical morbidity; patients may experience taste changes, loss of appetite, body changes, muscle loss/weight loss etc.
- Suggestion that other services should have a role at this point:

    - primary care – GPs should receive the same information and be involved in monitoring rehabilitation
    - occupational therapists - work across acute and community settings and have a key role to play in rehabilitation
    - social care, voluntary sector and other community services – potential to support people's rehabilitation and recovery

- Definition of 'functional assessment' needed - what should be included or what tool is recommended.
- Greater clarity required on the format of follow-up review - a 'review' conducted via telephone is likely to have a different impact (financial, resource, patient experience) compared to a multi-disciplinary outpatient clinic 'review'.

6 Suggestions for additional statements

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

- Nutritional screening on discharge from ICU to the ward
- Assessing psychological needs after critical illness
- Psychological support after critical illness

Appendix 1: Quality standard consultation comments table – registered stakeholders

ID	Stakeholder	Statement number	Comments
1	Association of Chartered Physiotherapists in Respiratory Care (ACPRC)	General	Does this quality standard include patients admitted to Critical Care following Major Trauma, for whom other (non-NICE) guidance exists surrounding rehabilitation provision and commissioning resources? This patient group should be clearly stated as either an inclusion or exclusion.
2	Association of Chartered Physiotherapists in Respiratory Care (ACPRC)	General	It is stated within the introduction that the quality standard does not cover conditions for which published quality standards already include specialist rehabilitation after a critical care stay (such as head injury, myocardial infarction and stroke). This reflects what is previously stated from NICE CG83. It was previously stated in NICE CG83 that the guidance did not cover those admitted to Critical Care for routine elective post-operative care (however, this may have changed). In which case, should this quality standard not also state, similar to NICE CG83, that the quality standard does not cover those admitted to Critical Care for routine elective post-operative care?
3	British Psychological Society	General	The Society has concerns over the use of the term “non-physical” which is consistently used here and throughout the document to refer to “psychological”. This term should not be used as it is not in common parlance with psychological or other professionals. It is also misleading as it may suggest it is the opposite of “physical”. The term “psychological” should be used, this refers to both emotional and cognitive concerns.
4	British Society of Rehabilitation Medicine	General	A rehabilitation prescription has been suggested as a tool for documenting the nature of illness or injury and a.current functional status, b.individual therapy needs and c. rehab complexity (numbers of different therapies needed and intensity of therapy needed) as well as d,longer term rehabilitation goals. Various versions of a “rehabilitation prescription” are already used for people recovering from trauma in almost all major trauma centres. A version has been suggested for use after any critical illness and was submitted for consideration by the ICU CRG. Versions of rehab prescriptions and the embedded measures used to record rehab need and complexity (eg rehabilitation complexity score, patient categorisation tool) can been seen on the BSRM website. Rehabilitation prescriptions are used by TARN for national audit. They can be used in electronic form so could be readily incorporated into ICU for audit; reporting to commissioners as well as for delivery to patients and use in handovers to ward s, GPs and community therapists.

5	Faculty of Intensive Care Medicine & Intensive Care Society	General	As the quality statements stand, they are not sufficient to remind or alert health professionals to focus on the psychological as well as physical aspects of recovery. We do not believe the statements are strong and hence may not lead to significant changes in behaviour or practice.
6	Faculty of Intensive Care Medicine & Intensive Care Society	General	Does this quality standard include patients admitted to Critical Care following Major Trauma, for whom other (non-NICE) guidance exists surrounding rehabilitation provision and commissioning resources? This patient group should be clearly stated as either an inclusion or exclusion.
7	Faculty of Intensive Care Medicine & Intensive Care Society	General	It is stated within the introduction that the quality standard does not cover conditions for which published quality standards already include specialist rehabilitation after a Critical Care stay (such as head injury, myocardial infarction and stroke). This reflects what is previously stated from NICE CG83. It was previously stated in NICE CG83 that the guidance did not cover those admitted to Critical Care for routine elective post-operative care (however, this may have changed). In which case, should this quality standard not also state, similar to NICE CG83, that the quality standard does not cover those admitted to Critical Care for routine elective post-operative care?
8	Faculty of Pain Medicine of the Royal College of Anaesthetists	General	Pain following critical illness is common and impacts adversely on rehabilitation. We welcome its inclusion in this document to enable appropriate care both during initial recovery and in the long-term.
9	Guy's and St.Thomas' NHS Foundation Trust	General	We would like to propose the term "post intensive care syndrome" as a useful concept for the document.
10	Royal College of Nursing	General	This draft quality standard is a good document with some aspirational statements that are yet to be implemented fully across the critical care community. It is accepted that there is more work to be done to ensure it is effectively implemented across board.
11	Sheffield Teaching Hospitals NHS Foundation Trust	General	Does this quality standard include patients admitted to Critical Care following Major Trauma, for whom other (non-NICE) guidance exists surrounding rehabilitation provision and commissioning resources? This patient group should be clearly stated as either an inclusion or exclusion.
12	Sheffield Teaching Hospitals NHS Foundation Trust	General	It is stated within the introduction that the quality standard does not cover conditions for which published quality standards already include specialist rehabilitation after a critical care stay (such as head injury, myocardial infarction and stroke). This reflects what is previously stated from NICE CG83. It was previously stated in NICE CG83 that the guidance did not cover those admitted to Critical Care for routine elective post-operative care (however, this may have changed). In which case, should this quality standard not also state, similar to NICE CG83, that the quality standard does not cover those admitted to Critical Care for routine elective post-operative care?

13	Sherwood Forest Hospitals NSH Trust	General	At Sherwood Forest hospitals NHS Trust we currently devise physiotherapy goals related to rehabilitation needs within 24 hours of admission & verbally hand over our rehabilitation plans on discharge to the ward. We also provide written booklets for pt's about the recovery process post discharge. We also run a follow up clinic for for pt's who have physical or psychological needs. I won't submit examples of paperwork, as I am sure Michele Platt our nurse consultant who is on the panel has already provided copies.
14	University Hospital Southampton (UHS)	General	Locally at SGH critical care rehab pathway created in order to have documentation of rehab goals/programme making it easier to then audit against NICE CG83 guidelines
15	University Hospital Southampton (UHS)	General	UHS therapists have developed a critical care rehabilitation pathway incorporating NICE guidelines where patient goals, progress, dates and outcome measures are recorded and documentation of this can be audited. It is completed for all patients identified as 'at risk'.
16	Faculty of Sports and Exercise Medicine	Question 1	The Draft does reflect accurately key areas. Additionally, in terms of physical rehabilitation, this should take into account not only lean mass/ muscle loss, but also individualised programme structure to address adverse metabolic and physiological consequences which may relate to disease type, treatment and complications of immobility (Bergouignan 2011; Larsson, 2000). Physiotherapy and OT could be supported, for example by rehabilitation medicine and exercise medicine, in practice and in further developing the evidence base to optimise rehabilitation in the critically ill patient. Bergouignan, A., et al., Physical inactivity as the culprit of metabolic inflexibility: evidence from bed-rest studies, Journal of Applied Physiology. 2011;111 (4):1201-1210. Larsson L, et al., Acute quadriplegia and loss of muscle myosin in patients treated with non depolarizing neuromuscular blocking agents and corticosteroids: mechanisms at the cellular and molecular levels. Crit Care Med. 2000; 28: 34-45.
17	Royal College of Occupational Therapists	Question 1	These statements reflect well the importance of rehabilitation through every stage of a person's journey after critical illness, and are good areas for quality improvement.
18	Sherwood Forest Hospitals NSH Trust	Question 1	I believe the quality standard does accurately reflect the key areas for quality improvement. I feel with some minor amendments we have local structures in place to collect this data. I think all the components are achievable.
19	Faculty of Sports and Exercise Medicine	Question 2	Data should be collected to support and develop the current evidence in this area. This has shown that physical rehabilitation strategies can reduce length of both critical care stay and total hospital stay and improve patient outcomes (as shown in a small prospective study: Needham, 2009). Current economical modelling also supports rehabilitation strategies with increased investment (e.g. through ward-based physiotherapy and OT as well as MDT planning) (Lord, 2013). Further such modelling will be needed. Lord, R.K., et al, ICU Early Physical Rehabilitation Programs: Financial Modelling of Cost Savings Critical Care Medicine. 2013; 41(3)717-724. Needham, D., Early physical medicine and rehabilitation for patients with acute respiratory failure: a quality improvement project, Arch Phys Med Rehabil. 2010;91(4):536-42.

20	North East & Cumbria Critical Care Network (Now known as North of England Critical Care Network)	Question 2	Achieving all the quality statements and delivering potential cost savings would initially require investment to establish and maintain a fully resourced Rehabilitation service. Once established cost savings can be seen in reduction of length of stays and potentially reducing incidents of readmissions.
21	British Psychological Society	Question 5	Throughout the quality statement a period of 4 days is referred to as a time to set rehabilitation goals. We do not believe that this is not reasonable or achievable in all cases. In some cases it is not possible to infer what a patients rehabilitation needs will be until there is a more accurate prognosis. We believe that generic goals may be set but will need to be reviewed as the patient progresses. The nature of goals is such that it is better to set these in collaboration with the patient, rather than impose them. It may be a confusion of terminology here, and what the patient requires is a *care plan* guiding the multidisciplinary team which will include physical and psychological needs. When a patient is more able they will be able to negotiate their own goals with expert guidance.
22	Faculty of Intensive Care Medicine & Intensive Care Society	Question 5	Response to Question 5: The timescale of 4 days is very dependent on rehab needs, patient type and service availability. This timescale may still include patients who do not require rehabilitation. An appropriate timescale may be one which affords a degree of flexibility such “4 to 7 days”, or “within 7 days”. The timescale(s) in which quality standard 1 must be met may influence compliance with this standard and not be met through lack of resources/time, especially in units which have a high patient turnover rate. A longer timescale for quality standard 1 (eg. 7 days) may facilitate a focus of rehabilitation provision for patients who have longer admissions to Critical Care, and who therefore are more likely to have greater rehabilitation needs and also benefit from rehabilitation. Psychological assessment and support may not be possible within 4 days – if the patient is too sedated or too ill. This can only begin once a patient is sufficiently awake/alert to participate. Many critical care units do not directly employ SLTs, so identifying swallowing and communication problems may be problematic. For those that do have sessions on critical care this may not be achieved within 4 days.
23	Guy’s and St.Thomas’ NHS Foundation Trust	Question 5	Please clarify the rationale for 4 days rather than a different timescale. From clinical experience we deem this to be an excessive delay. Our multidisciplinary team approach is that at 24 hours we should be assessing all patients for their suitability to commence active rehabilitation (in ICU).
24	Lancashire Teaching Hospitals NHS Trust	Question 5	I do not feel defining medium term goals within 4 days of admission to critical care is a helpful target. I feel it will difficult to predict what, as such an early stage for many of our patients, will be their goals once they return home. A more appropriate target may be to have medium term goals defined prior to discharge from critical care
25	North East & Cumbria Critical Care Network	Question 5	Extending the timescale to within 72hrs (rather than 4 days) for assessment will be more useful allowing a more accurate prediction of risk to be made and definitely more feasible than original statement and will also highlight rehabilitation issues earlier.

	(Now known as North of England Critical Care Network)		
26	Sherwood Forest Hospitals NSH Trust	Question 5	I think the timescale of 4 days for assessing rehab needs is more than adequate.
27	Southport and Ormskirk Hospital	Question 5	If patients are still very unstable and undergoing aggressive treatment, fully sedated and ventilated will not necessarily have ST & MT goals set by day 4. Instead goals will be set as soon as a full assessment can be conducted. Whilst patients are that unwell and may have multiple comorbidities it is difficult to establish what a MT goal would be as you have no baseline to base this upon. Instead ST & MT goals are set at the first appropriate opportunity for their condition. ST goals can be considered- positioning, edge of bed sit, weaning plans which are usually able to be completed by day 4 but MT goals around how they might transfer, what *they* want to achieve etc may be more difficult to establish by day 4. Why 4 days?
28	University Hospital Southampton (UHS)	Question 5	4 days is an appropriate and feasible timescale in which to set short and medium term goals. All specialities will have had time to review and assess, will have medical plans and know a direction so will be able to set individualised short and medium term goals. Predominantly set and reviewed by therapists on the unit.
29	Association of Chartered Physiotherapists in Respiratory Care (ACPRC)	1	Response to Question 4: Yes (partially). This quality standard would be achievable by local services, however, the actual quality of rehabilitation goals or plans is likely to be highly variable and inherently linked with the existing resources within each local service. For example, a local service may lack the appropriately funded resources for speech and language therapy or occupational therapy within Critical Care, therefore the patient's rehabilitation goals or plan may not address their holistic needs.
30	Association of Chartered Physiotherapists in Respiratory Care (ACPRC)	1	Response to Question 5: The timescale of 4 days is both appropriate and feasible. However, this timescale may still include patients who do not require rehabilitation. Therefore it may be sensible to clarify that all patients should have their rehabilitation needs **assessed** within 4 days, and a rehabilitation plan agreed **for those patients with rehabilitation needs**. This may facilitate a focus of rehabilitation provision for patients who have greater rehabilitation needs and will benefit from rehabilitation.
31	Association of Chartered Physiotherapists in Respiratory Care (ACPRC)	1	The current definition of **short-term** rehabilitation goals stated is "goals for the patient to achieve before they are discharged from hospital". This does not adequately reflect the emphasis of rehabilitation **during** Critical Care. The definition of "**short-term**" should be changed to "goals for the patient to achieve before they are discharged from Critical Care". As such the definition for **medium-term** rehabilitation goals requires modification to "goals for the patient to achieve before they are discharged from hospital". And subsequently, the definition "goals to help the patient return to their normal activities of daily living after they are discharged from hospital" should be changed to **long-term**.

			Additionally, this revised definition of long-term rehabilitation goals should include the following addendum “goals to help the patient return to their normal activities of daily living after they are discharged from hospital, [including vocational rehabilitation needs/return to work, if applicable]”
32	Association of Chartered Physiotherapists in Respiratory Care (ACPRC)	1	The Quality Statement states “Adults in critical care who are at risk of physical and non-physical morbidity have short- and medium-term rehabilitation **goals** agreed within 4 days of being admitted to and before discharge from critical care.” We believe this should instead be substituted for “**individualised, structured rehabilitation plan** [or programme]”. It is more important at the stated time points (4 days and discharge from Critical Care) that a co-ordinated plan is in plan than just rehabilitation goals. As stated within the associated guidance, “the individualised, structured rehabilitation programme should include rehabilitation needs and goals based on the comprehensive clinical assessment.” A co-ordinated rehabilitation plan encompasses both needs and goals and is likely to facilitate better patient care than rehabilitation goals alone. The suggested quality standard would read “Adults in critical care who are at risk of physical and non-physical morbidity have an **individualised, structured [multi-disciplinary] rehabilitation plan** agreed within 4 days of being admitted to and before discharge from critical care. [This should include rehabilitation needs, short- and medium-term rehabilitation goals, and, where applicable, appropriate referrals.]”
33	British Dietetic Association (BDA)	1	If the resources were in place, this quality standard should be feasible to measure, however it will likely require the consideration of 7 day services for all staff required to contribute to the setting of goals (eg. Physiotherapists, dietitians, speech therapists, occupational therapists, psychologists). The Guideline for the provision of intensive care services (GPICS) recommend 0.05-0.1 WTE dietitian per bed on critical care, this is to provide a clinical service in addition to audit/research/teaching. Currently across the UK most Trusts fall short of this guideline. In addition this guideline is only for critical care and does not include dietetic service to patients upon discharge from ICU onto wards.
34	British Dietetic Association (BDA)	1	There is no mention of malnutrition or weight loss under the definition of risks of physical and non-physical morbidity. If patients are admitted to the ICU with existing malnutrition and weight loss this needs to be indentified via screening on admission as this will likely impact on short and medium term rehabilitation goals being set within the first 4 days.
35	British Psychological Society	1	Psychological assessment of a patient is more accurate when a patient is able to respond to questions, this may not be within 4 days due to mechanical ventilation.
36	British Psychological Society	1	Psychological support of a patient is only possible when a patient is able to respond to conversation, this may not be within 4 days due to mechanical ventilation, delirium, and associated cognitive impairment in critical care.
37	British Psychological Society	1	Rehabilitation is a commonly used term for physical goal setting. Psychological needs are more accurately captured under the heading of care needs or care plan. If the guidance wishes to continue to utilise the terminology of rehabilitation goals they may want to offer guidance to critical care teams of psychological goals: E.g. Short term (within hospital). • To have a reasonable method for communication • To have access to personal items

			• To enable a good sleep/wake cycle to minimise delirium risk • For family to be involved with care E.g. medium term (towards and post discharge) • To have access to information • To be offered a post critical care review To have access to psychological support from a trained professional
38	British Psychological Society	1	The Society believes that reference to commissioning outside of NHS England, need to be included, such as Wales and Scotland.
39	British Psychological Society	1	The Society believes that the guideline needs to include the examples of cognitive concerns and delirium as these are widely recognised in critical care. Delirium has a prevalence of up to 80%. (Pandharipande, 2006, 2013). References Pandharipande, P., Shintani, A., Peterson, J., et al. (2006) Lorazepam is an independent risk factor for transitioning to delirium in intensive care unit patients. Anesthesiology; **104**, 21-6. Pandharipande, P.P., Girard, T.D., Jackson, J.C., Morandi, A., Thompson, J.L., Pun, B.T., Brummel, N.E. Hughes, C.G., Vasilevskis, E.E., Shintani, A.K., Moons, K.G., Geevarghese, S.K., Canonico, A., Hopkins, R.O., Bernard, G.R., Dittus, R.S. and Ely, E.W. (2013) Long-Term Cognitive Impairment after Critical Illness. N. Engl. J. Med, **369(14)**, 1306–1316.
40	British Psychological Society	1	We believe that the assessment of the patient should be mentioned. Initial assessment of the patient's physical and psychological risk can be assessed within the timeframe of 4 days. However many patients are unable to actively participate in assessment until later in their hospital stay due to the impact of the critical illness and treatment such as a ventilator impacting upon communication. Mean length of stay in critical care is 4.8 days and 51% of patients require at least basic respiratory support according to ICNARC data sourced from: https://www.icnarc.org/Our-Audit/Audits/Cmp/Reports/Summary-Statistics
41	British Society of Rehabilitation Medicine	1	Assessment by all members of an MDT should be available for patients in ICU after any disabling or critical illness; including not only Physio and Psychology but also Occupational therapy, Speech and language therapy and Rehab physicians. Ideally all ICUs would be liaising with and supported by rehabilitation medicine departments however it is understood that there is limited access to rehabilitation medicine in many hospitals. It may therefore be helpful for the quality standard to refer to use of a rehab needs assessment tool to help teams decide when to refer to Rehabilitation Medicine. This is being used by therapy teams in Major trauma centres where there is limited access to initial assessment by Rehabilitation medicine. Use of structures information in a document similar to a rehab prescription could then be used directly for audit and feedback to commissioners as well as for family and patient information.

42	British Society of Rehabilitation Medicine	1	The focus on early therapy involvement and assessment of rehabilitation needs is welcomed and very much supported. However this statement may cause confusion. An assessment of immediate needs for therapy such as chest physio, posture and pain management, communication, swallowing etc should start earlier than 4 days while the need for referral to inpatient rehabilitation services following discharge from ICU may not be apparent after only 4 days of admission. It may be better to separate the 2 out. Ie recommend that therapy needs are assessed within 48 hours and needs for assessment and referral to specialised rehabilitation services considered and documented prior to discharge from ICU …
43	British Society of Rehabilitation Medicine	1	This quality standard may be hard to achieve as there is currently only limited rehabilitation professional time allocated to ICU in many hospitals. It is however very important to recommend that all therapies as listed above and including rehab medicine and psychiatry are available to review patients when needed and it is hoped that this quality standard will facilitate prioritisation of funding to improve access to early rehabilitation by the whole MDT after acute disabling illness.
44	Critical Care National Network Nurse Leads – CC3N	1	1. I think it would be difficult to set goals for hospital discharge at this point. At this time it should be an assessment and plan for the next achievable goals, and this may be simply involving the other Allied Health Professionals (AHP) at this point, making them aware and referrals if required. 2. The document defines short term goals as 'goals for the patient to achieve before they are discharged from hospital' and medium term goals as 'goals to help the patient return to their normal activities after discharge' – and then states that these should be set within 4 days of admission to ITU – I'm not sure that goal setting is realistic for many patients at this stage – especially the sicker patients who are still sedated and ventilated at 4 days – I think the standard should be around them having had a comprehensive rehab assessment by this stage or maybe define the short term goals differently – perhaps goals for the end of their ITU stay, which may be more accurate. Also, as these goals are supposed to be multidisciplinary, it would be very difficult to have set them for each patient within 4 days as MDT meetings are often weekly. 3. This draft quality standard accurately reflects the key areas for quality improvement. If the systems and structures were available, It is possible to collect the data for the proposed quality measures. This timescale is appropriate and feasible 4. Reflects area for improvement. 4 days - agreement of short / medium goals. Do not think this is actually appropriate - Would argue on day 4 in CCS only able to consider short term goals (CCS specific goals) - not necessarily able to set short term goals at this point for hospital stay. Medium term goals to be achieved post discharge – not really relevant to be set on day 4 in CCS. CCS patients vary in length of stay and when patients are fully sedated / ventilated – the setting of goals is more difficult at day 4 when outcome at the is time is not always known / able to predict. Agreeing goals with patients at this time – generally is not possible ? appropriateness of family involvement in goal setting for unconscious patients. Knowledge / understanding of whole CCS impact will be lacking. Short Clinical assessment carried out on admission – Goal setting at present is carried out on an individualised basis with patient involvement. Using CPAX tool for goal setting / monitoring progress and data base created to record impact. Comprehensive Clinical assessment currently carried out on discharge from CCS – current rehab status documented & ongoing physio input on ward.

			There are currently no structures in place for data collection for these measures. Although some evidenced in patients notes. ICNARC does not collect rehab data at present. 5. Statement one (measure) - I think this is reasonable
45	Faculty of Intensive Care Medicine & Intensive Care Society	1	Response to Question 1: If the comments made above are taken into account then this quality standard **does** accurately reflect t key areas for quality improvement. If the comments made above are not taken into account then this quality standard currently o partially reflects the key areas for quality improvement.
46	Faculty of Intensive Care Medicine & Intensive Care Society	1	Response to Question 2: Yes. Data collection would be possible for this quality standard. This would be feasible without the need for local financial investment to facilitate data collection.
47	Faculty of Intensive Care Medicine & Intensive Care Society	1	Response to Question 4: Yes (partially). This quality standard would be achievable by local services, however, the actual quality of rehabilitation goals or plans is likely to be highly variable and inherently linked with the existing resources within each local service. For example, a local service may lack the appropriately funded resources for speech and language therapy, occupational therapy and clinical psychology within Critical Care, therefore the patient's rehabilitation and psychological goals or plan may not address their holistic needs. Many critical care units do not directly employ SLTs, so identifying swallowing and communication problems may be problematic. For those that do have sessions on critical care this may not be achieved within 4 days. Ideally, instrumental assessments are needed to help diagnose swallowing problems and develop a focussed intervention. This equipment is often not available on critical care, leading to delays in assessment and sometimes inappropriate management. Development of joint goals may be limited if SLT may not be embedded in critical care team – no evidence of this currently
48	Faculty of Intensive Care Medicine & Intensive Care Society	1	The current definition of **short-term** rehabilitation goals stated is "goals for the patient to achieve before they are discharged from hospital". This does not adequately reflect the emphasis of rehabilitation **during** Critical Care. The definition of "**short-term**" should be changed to "goals for the patient to achieve before they are discharged from Critical Care". As such the definition for **medium-term** rehabilitation goals requires modification to "goals for the patient to achieve before they are discharged from hospital". And subsequently, the definition "goals to help the patient return to their normal activities of daily living after they are discharged from hospital" should be changed to **long-term**. Additionally, this revised definition of long-term rehabilitation goals should include the following addendum "goals to help the patient return to their normal activities of daily living after they are discharged from hospital, [including vocational rehabilitation needs/return to work, if applicable]"

49	Faculty of Intensive Care Medicine & Intensive Care Society	1	The term "**goals**" should instead be substituted for another term within the quality standards/associated guidance: "**individualised, structured rehabilitation plan** [or programme]". It is more important at the stated time points (4 days and discharge from Critical Care) that a co-ordinated plan is in place rather than just rehabilitation goals. As stated within the associated guidance, "the individualised, structured rehabilitation programme should include rehabilitation needs and goals based on the comprehensive clinical assessment." A co-ordinated rehabilitation plan encompasses both needs and goals and is likely to facilitate better patient care than rehabilitation goals alone. The suggested quality standard would read "Adults in critical care who are at risk of physical and non-physical morbidity have an **individualised, structured [multi-disciplinary] rehabilitation plan** agreed within 4 days of being admitted to and before discharge from critical care. [This should include rehabilitation needs, short- and medium-term rehabilitation goals, and appropriate referrals, if applicable.]"
50	Faculty of Intensive Care Medicine & Intensive Care Society	1	The term non-physical morbidity is not common usage and may easily be misunderstood, or just misread and ignored. **We should use the term "psychological" instead**, as this is what is actually being referred to in QS1. The term "psychological" covers cognitive impairment as well as emotional distress. This statement misses out the important stage of carrying out a psychological and physical assessment in critical care. Goals cannot be set without an assessment first. Most health care staff would take the term "rehabilitation goals" to mean physical goals, attained mainly through physiotherapy. If we are equally to address psychological impact and recovery (which CG83 makes very clear that we should), we need to provide psychological support as well as physical rehab. The type of support needed to make psychological progress is not necessarily goal-orientated in the same way as physical. CG50 also says that an important patient outcome is a "positive experience of care"
51	Faculty of Sports and Exercise Medicine	1	Agreeing short and medium term goals within 4 days may be attainable with full engagement of the MDT and with suitable levels of staffing support (e.g. physiotherapy and OT support). However it should be recognised within the plan that short term goals may need to be revised during admission. Medium-term goals could be linked to longer-term care pathways to ensure continuity of patient support during and after transition of care.
52	Gateshead NHS Foundation Trust	1	It would be useful to have some real examples of these short and medium term goals. Does this mean that the short clinical assessment should still be completed within 24 hours or at the 4 day mark? Who is going to set these goals? I think that a co-ordinator role is required to make any pathway or intervention meaningful and effective. It is important that these goals are holistic taking into account both the physical and psychological effects of critical illness.
53	Guy's and St.Thomas' NHS Foundation Trust	1	We question the current classification of short/medium rehabilitation goals. The current classification does not permit short term goals relevant to the patient's stay in ICU to be captured or defined. We would recommend that "short term" goals apply to rehabilitation within ICU (e.g. sit to stand with assistance of two and a rollator frame in 3 days) as opposed to "medium term" goals which we would consider to be those relevant just prior to hospital discharge, as opposed to "long term" goals which we view as those pertaining to full recovery/baseline function/employment.

54	North East & Cumbria Critical Care Network (Now known as North of England Critical Care Network)	1	Extra resource would need to be made available to accurately measure the standard, e.g. Incorporating reportable fields in ICNARC and local patient management systems e.g. Wardwatcher
55	Patients and Relatives Committee Intensive Care Society	1	We support this standard believing that it is essential if progress is to be made in improving the longer term outcome of patients who have been critically ill. Our concern is, however, that early estimated rehabilitation goals need to be flexible enough to accommodate changing patient acuity. We are also concerned that however timely the setting of rehabilitation goals may be, there will also need to be sufficient time, resources and information provided to ensure that these goals can be realistically achieved. Setting goals without monitoring whether they are actually being attempted or accomplished is pointless. Simply writing goals into a rehabilitation prescription without ensuring follow-up would be to miss the point of this Standard.
56	Royal College of Speech and Language Therapists (RCSLT)	1	Many critical care units do not directly employ speech and language therapists, therefore, the RCSLT believe that identifying swallowing and communication problems may be problematic. For those that do have sessions on critical care this may not be achieved within 4 days. Ideally, instrumental assessments are needed to help diagnose swallowing problems and develop a focussed intervention. This equipment is often not available on critical care, leading to delays in assessment and sometimes inappropriate management. Development of joint goals may be limited if speech and language therapy may not be embedded in critical care team (of which, there currently appears to be a lack of evidence for)
57	Sheffield Teaching Hospitals NHS Foundation Trust	1	Response to Question 1: If the comments made above are taken into account then this quality standard **does** accurately reflect the key areas for quality improvement. If the comments made above are not taken into account then this quality standard currently only partially reflects the key areas for quality improvement.
58	Sheffield Teaching Hospitals NHS Foundation Trust	1	Response to Question 2: Yes. Data collection would be possible for this quality standard. This would be feasible without the need for local financial investment to facilitate data collection.
59	Sheffield Teaching Hospitals NHS Foundation Trust	1	Response to Question 4: Yes (partially). This quality standard would be achievable by local services, however, the actual quality of rehabilitation goals or plans is likely to be highly variable and inherently linked with the existing resources within each local service. For example, a local service may lack the appropriately funded resources for speech and language therapy or occupational therapy within Critical Care, therefore the patient's rehabilitation goals or plan may not address their holistic needs.
60	Sheffield Teaching Hospitals NHS Foundation Trust	1	Response to Question 5: The timescale of 4 days is both appropriate and feasible. However, this timescale may still include patients who do not require rehabilitation. An appropriate timescale may be one which affords a degree of flexibility such "4 to

			7 days", or "within 7 days". The timescale(s) in which quality standard 1 must be met may influence compliance with this standard and not be met through lack of resources/time, especially in units which have a high patient turnover rate. A longer timescale for quality standard 1 (eg. 7 days) may facilitate a focus of rehabilitation provision for patients who have longer admissions to Critical Care, and who therefore are more likely to have greater rehabilitation needs and also benefit from rehabilitation.
61	Sheffield Teaching Hospitals NHS Foundation Trust	1	The current definition of **short-term** rehabilitation goals stated is "goals for the patient to achieve before they are discharged from hospital". This does not adequately reflect the emphasis of rehabilitation **during** Critical Care. The definition of "**short-term**" should be changed to "goals for the patient to achieve before they are discharged from Critical Care". As such the definition for **medium-term** rehabilitation goals requires modification to "goals for the patient to achieve before they are discharged from hospital". And subsequently, the definition "goals to help the patient return to their normal activities of daily living after they are discharged from hospital" should be changed to **long-term**. Additionally, this revised definition of long-term rehabilitation goals should include the following addendum "goals to help the patient return to their normal activities of daily living after they are discharged from hospital, [including vocational rehabilitation needs/return to work, if applicable]"
62	Sheffield Teaching Hospitals NHS Foundation Trust	1	The Quality Statement states "Adults in critical care who are at risk of physical and non-physical morbidity have short- and medium-term rehabilitation **goals** agreed within 4 days of being admitted to and before discharge from critical care." I believe the term "**goals**" should instead be substituted for another term within the quality standards/associated guidance: "**individualised, structured rehabilitation plan** [or programme]". It is more important at the stated time points (4 days and discharge from Critical Care) that a co-ordinated plan is in plan than just rehabilitation goals. As stated within the associated guidance, "the individualised, structured rehabilitation programme should include rehabilitation needs and goals based on the comprehensive clinical assessment." A co-ordinated rehabilitation plan encompasses both needs and goals and is likely to facilitate better patient care than rehabilitation goals alone. The suggested quality standard would read "Adults in critical care who are at risk of physical and non-physical morbidity have an **individualised, structured [multi-disciplinary] rehabilitation plan** agreed within 4 days of being admitted to and before discharge from critical care. [This should include rehabilitation needs, short- and medium-term rehabilitation goals, and appropriate referrals, if applicable.]"
63	Sherwood Forest Hospitals NSH Trust	1	With discussion with my fellow physiotherapy colleagues we would suggest an amendment to the definition of short & medium term goals. To us short term goals are small goals to be achieved within a few days-a week. Medium term goals would be what they need to achieve for discharge (with long term goals being goals to help them return to their normal functional ability on discharge).
64	University Hospital Southampton (UHS)	1	Possible to collect data through documentation audits (can be done retrospectively) – but does rely on goals being clearly documented

65	University Hospital Southampton (UHS)	1	Potential for cost savings as identifying early individualised rehab goals and starting this rehab early on thus potentially reducing length of ICU and hospital stay
66	Association of Chartered Physiotherapists in Respiratory Care (ACPRC)	2	Response to Question 1: Yes. This quality standard does accurately reflect the key areas for quality improvement..
67	Association of Chartered Physiotherapists in Respiratory Care (ACPRC)	2	Response to Question 2: Yes. Data collection would be possible for this quality standard. This would be feasible without the need for local financial investment to facilitate data collection.
68	Association of Chartered Physiotherapists in Respiratory Care (ACPRC)	2	Response to Question 4: Yes. This quality standard would be achievable by local services potentially without the need for local financial investment dependent upon each local services method(s)/informatics system for recording and sharing of patient records.
69	Association of Chartered Physiotherapists in Respiratory Care (ACPRC)	2	The definition for “individualised, structured rehabilitation programme”: see comment number 3. ‘Programme’ should be substituted for the word ‘plan’. A ‘plan’ may include more than one form/format of rehabilitation programme.
70	British Dietetic Association (BDA)	2	The section regarding what the statement means for different audiences does not include any of the healthcare professionals who are likely to be setting the goals (eg. Physiotherapists, dietitians, speech therapists, occupational therapists, psychologists). It states doctors and nurses only. AHP's are key to this handover process to ensure all dimensions of the individualised structured rehab programme are met and this section should reflect that.
71	British Dietetic Association (BDA)	2	There is no mention of nutritional issues in the section on the required information about the needs of the adult being discharged to the ward. From a nutritional perspective research has shown that patients struggle to meet their nutritional requirements during their ward stay and good nutritional care is an important part of their rehabilitation.
72	British Psychological Society	2	A verbal handover may be more feasible in a smaller critical care unit where there are fewer patients to handover each day. However, in larger units this may not be possible, and a formalised written handover may be preferable. We believe that this should be changed to reflect this.
73	British Psychological Society	2	We believe that this needs to be made clearer as a formal handover does not imply the rehabilitation goals will be met. The handover needs to include commitment from the ward staff to meet the rehabilitation goals, and services need to be commissioned to meet these goals.
74	British Society of Rehabilitation Medicine	2	Handover at transfer is essential and should be expected for all patients leaving ICU. This is particularly important when patients are transferred from one hospital to another. Data sources for evidence of handover should include more than patient survey; a document such as a rehabilitation prescription or enhanced ICU discharge summary could be used for this. It should

			list any ongoing therapy needs and plans for any expected specialist rehabilitation service referrals. This should include information given to patient and family to date and any information already collected about the patient's premorbid situation.
75	Critical Care National Network Nurse Leads – CC3N	2	1. This will be difficult to achieve, but not impossible, and it is measurable but to produce one document for all specialties is difficult especially with electronic systems. It is more important that the correct referrals are made and the individual AHPs manage their own goals for the patient. There is a danger of this becoming a paperwork exercise and unless education is received throughout all ward teams (who frequently rotate), the paperwork will not be updated for the one or two patients that might be on a particular ward. 2.. A bit disappointing that there is no mention of Therapists AT ALL in the section about handover of the rehabilitation programme from Critical Care to the ward – Just Doctors and Nurses. 3. Service providers descriptor, statement 2 page 9. These handovers should be via the therapy teams as they are the primary rehabilitation specialists. Therapists assess, prescribe and implement the rehabilitation. Hand over should be given to the receiving ward therapists, who continue the patients prescribed rehabilitation. Hand over to include the critical care/ ward doctors and nurses. This draft quality standard accurately reflects the key areas for quality improvement. But does not reflect the key people involved. If the systems and structures were available, It is possible to collect the data for the proposed quality measures. 4. Reflects area for improvement Formal handover of care currently made to both medical / nursing teams. Physio – handover goals & these are then set and updated daily once in ward area. SALT / Dietician – ongoing management & rehab goals set by individual teams in patients management plan. CCS Follow Up Team – do preparatory work with patients to inform/educate about stepdown and changes in care. Provided with written information about what to expect both physically / psychologically during their recovery. Again no formal data collection at present. 5. Statement 2 (terminology) - I see that they have dropped the word rehab prescription from this, which I like as it was a very confusing term and one which the professionals could never agree on. Does that mean that it will no longer be within the guidelines at all?Statement 2 (specific detail) - A formal handover to whom? My concern with this is that there is an assumption that someone is going to continue the patient's rehab on the ward, which I fear given resources, is very often not the case. Physical needs are frequently addressed by the Physio's and OT, psychological issues are rarely, if ever, addressed. There is a distinct lack of dedicated critical care follow up on the ward; perhaps even less that when the patient is discharged.
76	Faculty of Intensive Care Medicine & Intensive Care Society	2	Response to Question 1: Partially.. The definition for "individualised, structured rehabilitation programme": 'Programme' should be substituted for the word 'plan'. A 'plan' may include more than one form/format of rehabilitation programme. The formal handover should include input from all involved healthcare professionals not just Dr and Nurses.

			This statement may not trigger ward staff to do anything different. The statement needs to be more specific. From the psychological point of view, the handover should include the results of the pre-CCU discharge psychological assessment including any problems with stress, mood, sleep, communication, hallucinations, delusions, other cognitive dysfunction, and recommendations for ongoing psychological support or therapy to manage these problems. From experience, staff forget to hand over psychological issues at critical care discharge, so that patients do not receive the necessary support or treatment they need, often leading to long-term psychological problems that can also hinder physical recovery. Handover in itself is not sufficient. Physical rehabilitation and psychological support also need to be **delivered** during the time the patient is on the ward. While structured handovers are commonly done, patients often do not receive the support they need on the wards – many just languish there receiving less and less input.
77	Faculty of Intensive Care Medicine & Intensive Care Society	2	Response to Question 2: Yes. Data collection would be possible for this quality standard. This would be feasible without the need for local financial investment to facilitate data collection.
78	Faculty of Intensive Care Medicine & Intensive Care Society	2	Response to Question 4: Yes. This quality standard would be achievable by local services potentially without the need for local financial investment dependent upon each local services method(s)/informatics system for recording and sharing of patient records.
79	Faculty of Sports and Exercise Medicine	2	In terms of physical rehabilitation, this should take into account lean mass/muscle loss (as documented in the draft and in the stakeholder responses (Appendix 2.7 2.9*) and also individualised programme structure to address adverse metabolic and physiological consequences of critical care admission, which may relate to disease type, treatment and complications of immobility. Physiotherapy and OT could be supported by rehabilitation medicine and exercise medicine specialties to address these needs holistically (i.e. include signposting toward these sources of support within the pathway at handover). (*citing evidence: Ferrando et al. 1995; Haines 1974; Nava 1998)
80	Gateshead NHS Foundation Trust	2	This is a very difficult transition for patients and relatives and clear handover of information and specific onward plans are essential. A medical discharge summary from critical care to the ward home team is standard at our hospital, as part of this patients are categorised into one of three rehabilitation pathways – high, medium and low intensity. This information and onward plans should also be shared with family/carers and support given at this transition.
81	Guy's and St.Thomas' NHS Foundation Trust	2	Please consider adding "Adults transferring from critical care to a general ward OR BETWEEN CRITICAL CARE UNITS…" as we frequently encounter patients who are transferred/repatriated between institutions at the critical care level and we wish to ensure the quality standard captures this scenario.
82	North East & Cumbria Critical Care Network	2	Extra resource would need to be made available to accurately measure the standard e.g. Incorporating reportable fields in ICNARC and local patient management systems e.g. Wardwatcher

	(Now known as North of England Critical Care Network)		
83	Patients and Relatives Committee Intensive Care Society	2	Again this is a welcome ambition but all parties need to understand what is involved. All staff based on general wards need to understand the potential implications for patients and their families of critical illness. Many ward staff do not always appreciate that patients recovering from critical illness may have complex psychological as well as physiological complications that may take time to resolve and that these will impact on family members / carers. The handover process will be to ensure that this is comprehensively covered.
84	Royal College of Speech and Language Therapists (RCSLT)	2	If speech and language therapists are involved with patients on critical care, they will usually follow-up on the ward until problems have resolved. The RCSLT believe there does not appear to be evidence of a formal process of handover that includes speech and language therapist's input.
85	Sheffield Teaching Hospitals NHS Foundation Trust	2	Response to Question 1: Yes. This quality standard does accurately reflect the key areas for quality improvement.
86	Sheffield Teaching Hospitals NHS Foundation Trust	2	Response to Question 2: Yes. Data collection would be possible for this quality standard. This would be feasible without the need for local financial investment to facilitate data collection.
87	Sheffield Teaching Hospitals NHS Foundation Trust	2	Response to Question 4: Yes. This quality standard would be achievable by local services potentially without the need for local financial investment dependent upon each local services method(s)/informatics system for recording and sharing of patient records.
88	Sheffield Teaching Hospitals NHS Foundation Trust	2	Terminology/Phrasing: Within the wording of the quality standard it should specifically state 'multi-disciplinary' when referring to handover.
89	Sheffield Teaching Hospitals NHS Foundation Trust	2	The definition for "individualised, structured rehabilitation programme": see comment number 3. [ID 114] 'Programme' should be substituted for the word 'plan'. A 'plan' may include more than one form/format of rehabilitation programme.
90	Southport and Ormskirk Hospital	2	Any patients with ongoing rehabilitation needs and identified goals will have a formal, structured individualised handover when going to a general ward.
91	University Hospital Southampton (UHS)	2	Currently lacking psychology input and outcome measures for our rehab programmes and supporting transfer from critical care to ward environment.
92	University Hospital Southampton (UHS)	2	Would be difficult to objectively measure as currently rely on verbal handover between therapists. Medical teams have written discharge/handover summary but usually a standardised form detailing medical history and events rather than a written patient's individualised rehab programme.

93	University Hospital Southampton (UHS)	2	Would be feasible to improve handover using current resources such as rehab pathway, joint MDT discharge paperwork, joint sessions between ward, critical care and outreach teams.
94	University Hospital Southampton (UHS)	2	Would need clarification of term 'formal handover' eg would a telephone conversation suffice?
95	Action on Smoking and Health	3	This statement discusses the support individuals who have been in critical care should receive prior to discharge. Specifically it states that where applicable individuals being discharged should be given information on diet and any other continuing treatments. In line with NICE Guidance PH48 patients can be expected to have been smokefree during their stay in hospital and should have received support including nicotine replacement therapy (NRT) to help them achieve this. On discharge from hospital it is appropriate that individuals and their carers receive information on remaining smokefree. Following surgery, for example, it is essential that smokers are supported to remain smokefree. Research has found that smokers who quit smoking after coronary surgery had significantly better outcomes, including lower risk of repeat coronary procedures than those who return to smoking.[1] The statement outlines the expectation that health and social care practitioners will provide adults leaving care with guidance on where to seek further advice and support. Adults who have been smokefree during their time in hospital should be signposted to stop smoking services for additional support on quitting smoking and remaining smokefree, this should include guidance on NRT. Providing information and advice to support people in remaining smokefree after discharge is essential to achieving the outcomes set out in the draft quality standard including ensuring that: adults who have been in critical care and are discharged from hospital feel they have received the right information to help them recover at home, and that: adults feel supported to manage their rehabilitation after discharge from critical care.
96	Association of Chartered Physiotherapists in Respiratory Care (ACPRC)	3	Response to Question 1: Yes. This quality standard does accurately reflect the key areas for quality improvement.
97	Association of Chartered Physiotherapists in Respiratory Care (ACPRC)	3	Response to Question 2: Yes. Data collection would be possible for this quality standard. This would be feasible without the need for local financial investment to facilitate data collection.

[1] van Domburg RT, Meeter K, van Berkel DFM. et al. Smoking cessation reduces mortality after coronary artery bypass surgery: a 20 year follow-up study. Journal American College of Cardiology 2000; 36 (3): 878-883.

98	Association of Chartered Physiotherapists in Respiratory Care (ACPRC)	3	Response to Question 4: Yes. This quality standard would be achievable by local services without the need for significant local financial investment.
99	Association of Chartered Physiotherapists in Respiratory Care (ACPRC)	3	The suggested information which should be given before discharge is very positive.
100	British Dietetic Association (BDA)	3	The quality statement is currently very broad and does not specify who should provide the information after discharge and what it should contain. The ambiguity of this statement would be reflected in confusion amongst healthcare professionals with the potential of lack of ownership of this quality standard.
101	British Psychological Society	3	The Society believes that the guidance needs to state a standard or recommendation for the information to be shared with patients- there are multiple sources in existence, including charitable sector information and local variations for e.g. ICU-Steps.
102	British Psychological Society	3	The timing for being given information is key; patients may be still too unwell upon leaving the critical care unit, and general wards may not have access to the best information.
103	British Society of Rehabilitation Medicine	3	At discharge from hospital patients should be given a fit note or GPs sent suggestion for time frame for return to work. In complex situations, this needs careful thought and advice from OTs and rehabilitation professionals to avoid inadvertent loss of employment opportunities. (currently some people give up or lose employment due to undue professional pessimism about recovery and ability and in other situations people return to work too early after insufficient rehabilitation and then fail to keep their jobs). Documentation and advice about driving is essential and should be itemised in the quality standard. Data collection should include more than a patient survey and should include evidence of documentation of the advice
104	Critical Care National Network Nurse Leads – CC3N	3	1. Some of the information is required before hospital discharge, especially for families. Without a dedicated rehabilitation co-ordinator it will be difficult to achieve and measure at hospital discharge. 2. Sounds good but so few trusts are achieving this, I would question how that will change and whether it is realistic. 3. This draft quality standard accurately reflects the key areas for quality improvement. If the systems and structures were available. It is possible to collect the data for the proposed quality measures. 4. Reflects area for improvement. Evidenced need for provision of information for patients on discharge. We know there is limited / variable support once home from community teams – physio / OT/ Dietician – long waiting lists for on-going input. Psychology support – poor / difficult to access. Realistic expectations / time frames for rehab and recovery need to be discussed & documented. Patients should have written information about recovery / physical / psychological difficulties post CCS discharge & home.

			Currently our CCS Follow Up team do prep work with patients whilst on the ward- identify long term difficulties & expectations. On-going support contact numbers given. We know there is limited / variable support once home from community teams – physio / OT/ Dietician – long waiting lists for on-going input. Psychology support – poor / difficult to access. No formal data collection currently in place 5. Statement 3 (clarification on measure) - This is an honourable statement but without the ward based follow up by dedicated critical care staff I do not believe that there is anyone qualified to determine fully what the patient should/could expect following discharge and to give them this information. Information is frequently generic, eg ICU Steps booklet. Statement 3 (measure) - There was mention made of the patient being given a copy of their critical care discharge summary. Again, an honourable ambition but without someone to give them the time to go through it I believe this may be of minimal benefit and, possibly, counterproductive.
105	Faculty of Intensive Care Medicine & Intensive Care Society	3	Response to Question 1: Partially. This quality standard does accurately reflect the key areas for quality improvement. However, it is a fairly weak recommendation. Many hospitals already give patients this type of information booklet at discharge from the critical care unit. Information on its own is usually not sufficient to make a difference. One idea is that patients could also be given a summary (in patient-friendly language) of physical, psychological and social issues that are still outstanding at hospital discharge, a treatment plan for these issues, and phone numbers/websites to use, if they require further help with these issues. (Research on patient-friendly discharge summaries has been carried out by ICU Steps)
106	Faculty of Intensive Care Medicine & Intensive Care Society	3	Response to Question 2: Yes. Data collection would be possible for this quality standard. This would be feasible without the need for local financial investment to facilitate data collection.
107	Faculty of Intensive Care Medicine & Intensive Care Society	3	Response to Question 4: Yes. This quality standard would be achievable by local services without the need for significant local financial investment.
108	Faculty of Sports and Exercise Medicine	3	This information should be comprehensive to the lay patient e.g. ensure a rehabilitation plan providing ‘information about physical recovery,’ and which is ‘based on the goals set during ward-based care,’ as set out in the guidance, is provided in addition to the discharge letter. Rehabilitation goals set by the MDT in the critical care setting could be supported within a pathway and with formal referral e.g. to physiotherapy in the outpatient setting and by appropriate referral where indicated (e.g. to OT, rehabilitation, exercise).
109	Gateshead NHS Foundation Trust	3	Re equality and diversity – ICU Steps provide their information in some other languages. Again I would stress the importance of giving support and information to family/carers.
110	Guy’s and St.Thomas’ NHS Foundation Trust	3	We question whether “discharge from hospital” is the correct time point for delivering information to patients. We suggest the approach to information giving should be individualised and graded depending on the patient’s pathway, understanding, mental status etc. This may include a degree of information giving at or around critical care discharge and a further amount during their ward recovery.

111	North East & Cumbria Critical Care Network (Now known as North of England Critical Care Network)	3	Consideration to be given to develop a National template to provide some standardisation in what information is given
112	North East & Cumbria Critical Care Network (Now known as North of England Critical Care Network)	3	Extra resource would need to be made available to accurately measure the standard
113	Patients and Relatives Committee Intensive Care Society	3	This is a critical issue but is not always achieved adequately. We have examples of patients who were discharged from critical care without even being fully aware of what exactly their critical illness was let alone the potential consequences of that illness, or of the treatments administered to resolve that illness, upon their future live style. For instance, it should be but is not always fully appreciated by treating clinicians that patients recovering from critical illness may be disorientated, confused or have poor memory retention. Patient diaries may assist with this but the same information may need to be provided on more than one occasion to ensure that it is fully understood. Involving family members (where appropriate and agreed) is important but cannot be relied upon as they may be equally confused or traumatised by the critical illness experienced by their loved one. Good communication during the period in critical care and particularly at discharge / transfer cannot, in our view, be replaced by any amount of written literature.
114	RCGP	3	As has happened with other NICE documents, I am struck by the way that primary care appears by implication to have no role to play in rehabilitation. The opportunity exists to use this quality standard to encourage better integration between secondary and primary care, and seems to have been ignored by the authors of this document. Specifically, under statement 3 it is obviously a good idea to encourage information to be given to patients, but no attempt has been made to ensure that the same information (together with the responsibility for assuming responsibility to monitor continuation of the rehabilitation programme) passes to general practitioners. By the same token, it would be possible to draw up a slightly different statement 4, where GPs have the primary responsibility to decide whether the rehabilitation goals have been achieved and whether in consequence there is any need for further specialist follow up.
115	Royal College of Speech and Language Therapists (RCSLT)	3	Speech and language therapists are usually involved in discharge planning, and providing patient and families details of on-going care requirements, including follow-up. This is often done as a team, especially for those requiring rehabilitation. We believe there is currently no uniform practice so there may be local variations to how this is done.
116	Sheffield Teaching Hospitals NHS Foundation Trust	3	Response to Question 1: Yes. This quality standard does accurately reflect the key areas for quality improvement.

117	Sheffield Teaching Hospitals NHS Foundation Trust	3	Response to Question 2: Yes. Data collection would be possible for this quality standard. This would be feasible without the need for local financial investment to facilitate data collection.
118	Sheffield Teaching Hospitals NHS Foundation Trust	3	Response to Question 4: Yes. This quality standard would be achievable by local services without the need for significant local financial investment.
119	Sheffield Teaching Hospitals NHS Foundation Trust	3	The suggested information which should be given before discharge is very positive.
120	Southport and Ormskirk Hospital	3	This is difficult to promise as Critical Care staffs are reliant on ward staff knowing when a patient is leaving the hospital and feeding this back- priorities on wards differ. What to expect is vague- what to expect in terms of follow-up, therapy, fatigue, nightmares, PTSD This statement could encompass several different things.
121	University Hospital Southampton (UHS)	3	Currently difficult to measure as pt's given information in the form of a booklet on discharge from ICU (given out by nursing staff), Not recorded who/when get the information booklet
122	University Hospital Southampton (UHS)	3	If done appropriately and formally with evaluation could be an opportunity for cost saving with the potential to reduce readmissions / GP referrals.
123	University Hospital Southampton (UHS)	3	On discharge from hospital patients given verbal information and paper leaflets regarding follow-ups and ongoing therapy care therefore becomes difficult to measure. Discharge summary covers medical aspects but doesn't often include rehab programme. Each speciality is responsible for their own discharge information and therefore difficult to record/measure against all specialties.
124	Royal College of Occupational Therapists	3 & 4	We would be concerned about the feasibility of health and social care professional within the critical care settings completing review 2-3 months after discharge. Given the move towards more integrated teams in 2020, should there be more collaborative work suggested with community services and adult social care in this section and indeed in QS.3? Under Commissioners it mentions CCGs but this could also include local authorities' responsibilities as part of integrated working. In addition, the list of health and social care practitioners doesn't include occupational therapists who work across acute and community settings. Occupational therapists have a key role to play in rehabilitation and should be acknowledge as such within this quality standard. In the section entitled **Adults who need support to help them recover**, the inclusion of the voluntary section would be of benefit. There is an important role that the voluntary sector and other community service can have in supporting people's

			rehabilitation and recovery. This area could also acknowledge the role of self-management in supporting people's long term maintenance of health.
125	Royal College of Occupational Therapists	3 & 4	We would be concerned about the feasibility of health and social care professional within the critical care settings completing review 2-3 months after discharge. Given the move towards more integrated teams in 2020, should there be more collaborative work suggested with community services and adult social care in this section and indeed in QS.3? Under Commissioners it mentions CCGs but this could also include local authorities' responsibilities as part of integrated working. In addition, the list of health and social care practitioners doesn't include occupational therapists who work across acute and community settings. Occupational therapists have a key role to play in rehabilitation and should be acknowledge as such within this quality standard. In the section entitled **Adults who need support to help them recover**, the inclusion of the voluntary section would be of benefit. There is an important role that the voluntary sector and other community service can have in supporting people's rehabilitation and recovery. This area could also acknowledge the role of self-management in supporting people's long term maintenance of health.
126	Association of Chartered Physiotherapists in Respiratory Care (ACPRC)	4	Response to Question 1: Yes. This quality standard does accurately reflect the key areas for quality improvement. However, greater clarity and/or precision is required regarding the format of follow-up review. The wording of current draft quality standard ("adults with rehabilitation needs identified from a functional assessment have a **review** 2 to 3 months after their discharge from critical care") remains too vague as to what a '**review**' may constitute. For example, a 'review' conducted via telephone follow-up is likely to have a different impact (financial, resource, patient experience) compared to a multi-disciplinary outpatient clinic 'review'.
127	Association of Chartered Physiotherapists in Respiratory Care (ACPRC)	4	Response to Question 2: Yes. Data collection would be possible for this quality standard. This would be feasible without the need for local financial investment to facilitate data collection.
128	Association of Chartered Physiotherapists in Respiratory Care (ACPRC)	4	Response to Question 4: This quality standard would **only** be achievable by local services through central or local financial investment. As the authors are likely to be aware, surveys/research conducted since the publication of CG83 have highlighted that the provision of follow-up is low nationally. The costing tool developed at the time of CG83 did not include costing or commissioning guidance to support follow-up services. There is a need for clear guidance on commissioning and tariffs for critical care follow-up services/clinics.
129	British Dietetic Association (BDA)	4	'Health and Social Care Practitioners' involved in follow-up clinics needs to specify the full range of HCP involved to prevent ambiguity in interpreting the quality standard.
130	British Dietetic Association (BDA)	4	Definition of a 'functional assessment' would be helpful, in particular what aspects should be included or what tool is recommended to assess this.

131	British Dietetic Association (BDA)	4	Expected nutritional problems post hospital stay should be included in either physical and non-physical morbidity, appropriate, such as taste changes, appetite loss, body changes, muscle loss/weight loss etc.
132	British Dietetic Association (BDA)	4	Physical dimensions in the table defining rehabilitation needs does not include appetite, taste changes, early satiety etc. This could be helpful to guide the user in terms of information package development and educating patients and their carers.
133	British Psychological Society	4	From clinical experience, often the benefit of a follow up is not about rehabilitation needs but about patient experience, and being able to make sense of their critical care stay. Although "making sense of critical care stay" is broader than a rehabilitation need.
134	British Psychological Society	4	The guidance might benefit from a re-wording from "adults with rehabilitation needs" to "*adults with ongoing medical, psychological, or physical concerns*".
135	British Psychological Society	4	The guidance would benefit from the functional assessment of psychological needs to be identified as: *"a psychological screening and assessment by a suitably trained professional"*
136	British Psychological Society	4	There is insufficient evidence and multiple models for how to run a follow up clinic. A nurse-led ICU follow-up programme is not cost effective in improving patients' Quality of Life in the year after ICU discharge (Cuthbertson, et al. 2009) Although the majority of patients believes a post-ICU clinic is beneficial. *(Farley et al. 2016)* References Cuthbertson, B. H., Rattray, J., Campbell, M.K., Gager, M., Roughton, S., Smith, A. (2009) The PRaCTICaL study of nurse led, intensive care follow-up programmes for improving long term outcomes from critical illness: a pragmatic randomised controlled trial; BMJ 2009; 339 :b3723 Farley, J.F. et al. (2016) Continuity of Medication Management in Medicaid Patients With Chronic Comorbid Conditions: An Examination by Mental Health Status Schizophrenia; Gen Hospital Psychiatry, **45**, 25-31.
137	British Psychological Society	4	We believe that the guidance needs to offer clarity on what functional assessment exists to identify adults with rehabilitation needs after discharge.
138	British Society of Rehabilitation Medicine	4	The aim of this standard to ensure follow up is excellent and very much supported. However to make the most of this activity, data collection should include documentation of not only any residual physical and psychological difficulties but also referrals to any further rehabilitation that may be needed, situation re return to work, benefits received if needed, and advice on return to driving.(while it is understood that a quality standards document such as this would not usually specify a particular measure it would be helpful to recommend that at least one measure of overall function is used for future comparisons and audit. We are aware that there are several outcome measures of symptoms, activity and participation that ICU teams already use, but the BSRM would be happy to discuss further if the quality standards team preferred. Suggesting that at least one check list or outcome measure is used could ensure more complete data collection and thus facilitate service evaluation and audit.

139	Critical Care National Network Nurse Leads – CC3N	4	1. This still needs to specify a Follow-up clinic with clear definitions and funding. More specific detail will encourage the commissioning it requires. 2. Sounds good but so few trusts are achieving this, I would question how that will change and whether it is realistic. 3. This draft quality standard accurately reflects the key areas for quality improvement. If the systems and structures were available, It is possible to collect the data for the proposed quality measures. Regarding who conducts the "review" at 2-3 months This is not specified, possibly deliberately, but does make comparison measurement more tricky as could be done by anyone. Substantial resources would be required to implement a follow up programme to include 1 senior grade nurse and 1 senior grade Physiotherapist. Employment of a clinical psychologist or alternative to provide non-physical care. 4. Reflects area for improvement. Currently our CCS Follow Up team review patients 6 weeks post discharge in an out patient clinic. Physical and Psychological assessment carried out and ongoing referrals made if required. Hold 3 monthly patient support groups to provide ongoing support. 5. Statement 4 (measure) - I am saddened by the limitations of this statement. Having an assessment at 2-3 months is simply not enough for a number of patients. I am a strong believer in continued rehabilitation post discharge that is co-ordinated by critical care yet appreciate that this is frequently lacking due to lack of resource. We hear time and again that GP's have limited understanding of the needs of may critical care patients and yet we have a default system where they are the first port of call for far too many. One big problem with this is being able to demonstrate the benefit of continued rehab and this is not helped by the variation in service models currently making evaluation of outcome difficult. We also do not focus enough on outcomes that are hard to measure or have no direct impact on NJHS spending. A classic example is return to work or the return to work of a carer/relative. A great boost to the patient and a cost saving to the economy as a whole.
140	Faculty of Intensive Care Medicine & Intensive Care Society	4	Please add to physical problems - > Difficulties with eating or appetite (this is different from swallowing difficulties. The patient may be too weak or drowsy to eat or be experiencing taste changes or loss of appetite as a consequence of the critical illness) Weight loss – must be included and is much easier to measure than muscle loss.
141	Faculty of Intensive Care Medicine & Intensive Care Society	4	Response to Question 1: Partially. This quality standard does accurately reflect the key areas for quality improvement. However, greater clarity and/or precision is required regarding the format of follow-up review. The wording of current draft quality standard ("adults with rehabilitation needs identified from a functional assessment have a **review** 2 to 3 months after their discharge from critical care") remains too vague as to what a '**review**' may constitute. For example, a 'review' conducted via telephone follow-up is likely to have a different impact (financial, resource, patient experience) compared to a multi-disciplinary outpatient clinic 'review'. The statement uses the word 'rehabilitation needs' and this doesn't capture that patients may be experiencing psychological problems

			Suggest changing it to “adults experiencing physical, psychological or social problems following critical care”
142	Faculty of Intensive Care Medicine & Intensive Care Society	4	Response to Question 2: Yes. Data collection would be possible for this quality standard. This would be feasible without the need for local financial investment to facilitate data collection.
143	Faculty of Intensive Care Medicine & Intensive Care Society	4	Response to Question 4: This quality standard would **only** be achievable by local services through central or local financial investment. As the authors are likely to be aware, surveys/research conducted since the publication of CG83 have highlighted that the provision of follow-up is low nationally. The costing tool developed at the time of CG83 did not include costing or commissioning guidance to support follow-up services. There is a need for clear guidance on commissioning and tariffs for critical care follow-up services/clinics. Currently if clinics are run, they do not involve key professions such as SLT and clinical psychology. This would involve financial investment. 6
144	Faculty of Sports and Exercise Medicine	4	This assessment should link into a longer-term pathway to ensure continuity of care recognising the long-term nature of complex conditions and ensuring holistic care during ongoing rehabilitation.
145	Gateshead NHS Foundation Trust	4	Will there be a standardised functional assessment tool?
146	Guy’s and St.Thomas’ NHS Foundation Trust	4	Rather than the term “review”, we would recommend changing this to “further physical/non-physical functional assessment” to emphasise the importance of a full multi-disciplinary assessment for the most high-risk patients at the 2-3 month time point.
147	North East & Cumbria Critical Care Network (Now known as North of England Critical Care Network)	4	Delivery of this statement would be difficult without adequate resource to ensure engagement and involvement of the full MDT.
148	Patients and Relatives Committee Intensive Care Society	4	This is another Standard that we fully support but we believe that the suggested review period of 2-3 months should be regarded as a minimum. The consequences of critical illness do, for many patients, extend for longer than this period and we would like to see follow-up extended for longer as well. A corollary to this is that by this time most patients who have been critically ill will be home and also receiving care from clinicians working in the community. Most of these clinicians will have very limited experience of treating patients with a history of critical illness so we would recommend that – where this does not already happen – the critical care follow-up must include arrangements to explore the support the patient is getting from the community and investigate areas where this may be lacking.
149	Royal College of Speech and Language Therapists (RCSLT)	4	Not all critical care services run a follow-up clinic and very few, if any involve speech and language therapists. Patients tend to be reviewed directly by speech and language therapists. For those patients with a high level of care need, who require on-going rehabilitation at a tertiary service, they are unable and unlikely to access a review after 2-3 months. There are also

			groups of patients who experience admission to more than critical care unit and they seem to get lost in the system with no reviews.
150	Sheffield Teaching Hospitals NHS Foundation Trust	4	Response to Question 1: Yes. This quality standard does accurately reflect the key areas for quality improvement. However, greater clarity and/or precision is required regarding the format of follow-up review.
151	Sheffield Teaching Hospitals NHS Foundation Trust	4	Response to Question 2: Yes. Data collection would be possible for this quality standard. This would be feasible without the need for local financial investment to facilitate data collection.
152	Sheffield Teaching Hospitals NHS Foundation Trust	4	Response to Question 4: This quality standard would **only** be achievable by local services through central or local financial investment. As the authors are likely to be aware, surveys/research conducted since the publication of CG83 have highlighted that the provision of follow-up is low nationally. The costing tool developed at the time of CG83 did not include costing or commissioning guidance to support follow-up services. There is a need for clear guidance on commissioning and tariffs for critical care follow-up services/clinics.
153	Sheffield Teaching Hospitals NHS Foundation Trust	4	Terminology/Phrasing: The wording of current draft quality standard ("adults with rehabilitation needs identified from a functional assessment have a **review** 2 to 3 months after their discharge from critical care") remains too vague as to what a '**review**' may constitute. For example, a 'review' conducted via telephone follow-up is likely to have a different impact (financial, resource, patient experience) compared to a multi-disciplinary outpatient clinic 'review'. Also, regarding the wording of this standard 'adults **with rehabilitation needs identified from a functional assessment** have a review 2 to 3 months after their discharge from critical care' the timepoint of this assessment may require clarification. Is this 'functional assessment' the one completed at Critical Care discharge or hospital discharge or any other time point in between? Also, the term 'functional assessment' may not necessarily emphasise a comprehensive assessment taking into account a patient's holistic needs (eg. physical, cognitive, psychological, emotional, social, occupational).
154	Sheffield Teaching Hospitals NHS Foundation Trust	4	The work adults with rehabilitation needs identified from a functional assessment have a **review** 2 to 3 months after their discharge from critical care
155	Sherwood Forest Hospitals NSH Trust	4	The only concern I have is statement 4 states a having a functional assessment pre discharge from ICCU (which is fine) but then those with rehabilitation needs from this assessment having a follow up review 2-3 months later. At the point of discharge from ICCU I would say approximately 90% of our patients have rehab needs on discharge from ICCU. This would be a massive & unmanageable increase in our ICCU follow up clinic capacity. Also many of the rehab needs would be resolved prior to discharge from hospital, therefore bringing people back unnecessarily. I would suggest that only those

			having rehab needs at the point of discharge should be brought back to clinic. I may have misinterpreted this, but if I have then I suspect many less experienced people would also.
156	Southport and Ormskirk Hospital	4	A follow up appointment is completed at 2-3 months but what is included during this follow-up and who it is completed by is greatly variable between Trusts. What the functional assessments include and the ability for staff in follow up clinic to make referrals for ongoing rehab needs varies depending on community services and funding. The structure and set-up of follow-up clinics is also vastly different between Trusts. Involvement from- psychology, outreach, consultant, nutrition and therapy differs as well.
157	University Hospital Southampton (UHS)	4	Currently have ICU follow up clinic 2-3 months post hospital discharge for all patients ventilated for more than 3 days (deemed 'at risk'). Seen by nurse/consultant +/- psychologist. Standardised form therefore able to audit/collect data from.
158	University Hospital Southampton (UHS)	4	Follow up clinic currently not physical specific (no physiotherapist funded) but will be asked about physical problems. Patients are referred back to GP if they have ongoing physical/ non physical needs.
159	British Dietetic Association (BDA)	Additional areas	Nutrition is not consistently reflected along the pathway, apart from in the discharge to home section. There is no mention of the need for nutrition assessment within the ICU, despite evidence suggesting improved nutritional intakes with dietetic input. Nutrition screening is mandatory for all in patients, this should be reflected as a quality standard upon discharge from ICU to the ward to ensure appropriate follow up. There is also no mention of nutritional issues that would require follow up once the patient has been discharged from hospital to the community.
160	British Psychological Society	Additional areas	The Society welcomes the quality standard, however, the overall document needs to more recognition of psychological needs as well as physical recovery. Psychological needs within post critical care and including a psychologist early in critical care reducing long term psychological impacts is now widely evidenced. (Peris et al, 2011). We believe that the Standard would greatly benefit from an additional quality statement to assess the psychological needs after critical illness and offer psychological support, and, where necessary, intervention post critical illness. There is evidence to suggest including a psychologist early in critical care reduces long term psychological impacts. Reference Peiris, C.L., Taylor, N.F., Shields, N. (2011) Extra Physical Therapy Reduces Patient Length of Stay and Improves Functional Outcomes and Quality of Life in People With Acute or Subacute Conditions: A Systematic Review; DOI: http://dx.doi.org/10.1016/j.apmr.2011.04.005

Registered stakeholders who submitted comments at consultation

- Action on smoking and health
- British Dietetic Association
- British Psychological Society
- British Society of Rehabilitation Medicine
- Critical Care National Network Nurse Leads
- Faculty of Intensive Care
- Faculty of Sports and Exercise Medicine
- Gateshead NHS
- Guys and St Thomas NHS
- Intensive Care Society
- Lancashire Teaching Hospitals
- North East & Cumbria Critical Care Network
- Royal College of Anaesthetists
- Royal College of General Practitioners
- Royal College of Nursing
- Royal College of Occupational Therapists
- Royal College of Speech and Language Therapists
- Sheffield Teaching Hospitals

- Sherwood Forest Hospitals NSH Trust
- Southport and Ormskirk Hospital
- The Association of Chartered Physiotherapists
- University Hospital Southampton