RECOMMENDATIONS

These recommendations have been formed by a consensus exercise involving all those listed in the acknowledgements. The recommendations have been independently edited by medical editors experienced in developing recommendations for healthcare audiences to act on.

The recommendations in this report support those made previously by other organisations, and for added value should be read alongside:

- NICE Guideline [CG83]: Rehabilitation after critical illness in adults, 2009
- NICE Quality Standard [QS158]: Rehabilitation after critical illness, 2017
- Intensive Care Society: Framework for assessing early rehabilitation needs following treatment in intensive care, Version 1. 2020
- GIRFT programme: National Specialty Report on Adult Critical Care, 2021
- Intensive Care Society and the Faculty of Intensive Care Medicine: Guidelines for the Provision of Intensive Care Services, 2022
- NHS England: Service specification for Adult Critical Care
- NHS England: Improving Rehabilitation
- Commissioning Guidance for Rehabilitation

The recommendations highlight areas that are suitable for regular local clinical audit and quality improvement initiatives. The results should be presented at quality or governance meetings, and action plans to improve care should be shared with executives in trust/health boards.

1	Improve the co-ordination and delivery of rehabilitation following critical illness at both an organisational level and at a patient level. ▪ At an organisational level by assigning a trust/health board rehabilitation lead with oversight and responsibility for the provision of holistic rehabilitation. ▪ At a patient level by having a named rehabilitation care co-ordinator(s) role to oversee patients' rehabilitation needs within the ICU, on the ward and in the community.
FOR ACTION BY	Commissioners, integrated care boards, hospital trusts/health boards

ADDITIONAL STAKEHOLDERS	Intensive Care Society, Faculty of Intensive Care Medicine, British Dietetic Association, Royal College of Speech and Language Therapists, Royal College of Occupational Therapists, Chartered Society of Physiotherapists, British Geriatric Society.
RATIONALE FOR THE RECOMMENDATION	The data showed an absence of good multidisciplinary team working and communication across the recovery pathway as the patient moved between healthcare settings.
ASSOCIATED GUIDANCE	NICE Guideline [CG83] Rehabilitation after critical illness in adults, 2009 NICE Quality Standard [QS158] Rehabilitation after critical illness, 2017 Intensive Care Society: GPICS

IMPLEMENTATION SUGGESTIONS	AT A TRUST/HEALTH BOARD LEVEL ▪ Include a senior executive responsible for developing and overseeing implementation of a rehabilitation policy ▪ Include a senior manager responsible for the implementation of the rehabilitation policy ▪ Commission rehabilitation services and multidisciplinary team provision based on patient need rather than diagnosis, across multiple pathways of care ▪ Enable critical care survivors and their relatives/carers to be involved in the design of services ▪ Develop and introduce relevant training to non-specialists to increase knowledge of the impact of critical illness and rehabilitation requirements ▪ Regular audits would provide high level overview of rehabilitation services and evaluation of services/outcomes. AT A PATIENT LEVEL ▪ Provide access to a rehabilitation care co-ordinator in hospital and in the community following hospital discharge ▪ The rehabilitation care co-ordinator role could be like that of a major trauma co-ordinator, any healthcare professional with the appropriate skills and competency and a designated role with its own job description and ring-fenced time. There may be more than one in larger units. The rehabilitation care co-ordinator role could: ▪ Triage patients at risk while having a general oversight ▪ Co-ordinate the assessments and make sure they are being done ▪ Ensure that handovers are taking place and being received ▪ Ensure that patients are getting access to the multidisciplinary team members that they need at all stages of the pathway ▪ Support communication/information to patients, their carers and families, such as rehabilitation plans and goals ▪ Ensure that all referrals are in place as patients step-down to the community ▪ Be a named point of contact for patients following hospital discharge ▪ Liaise with primary care. Many patients only see their GP in the first year after an ICU admission. As an example, major trauma centres provide telephone follow-up by co-ordinators at two- and six-weeks following discharge. These calls can identify patients who are struggling and then generate early face-to-face review or referral to an appropriate service.

2	Develop and validate a national standardised rehabilitation screening tool to be used on admission to an intensive care unit. *This would identify patients at risk of long-term physical, psychological, cognitive or social effects and trigger an earlier comprehensive assessment of their rehabilitation needs sooner than 'day four' currently defined by NICE Quality Standard 158.*
FOR ACTION BY	Intensive Care Society, Faculty of Intensive Care Medicine, National Institute of Health Research (area of potential research), NHS England, Welsh Government, Health Department of Northern Ireland, Jersey.

ADDITIONAL STAKEHOLDERS	Commissioners, integrated care boards (England), Royal College of Speech and Language Therapists, Royal College of Occupational Therapists, Chartered Society of Physiotherapists British Dietetic Association, British Geriatric Society, Royal College of Psychiatrists, Association of Clinical Psychologists-UK, British Association of Critical Care Nurses, UK Critical Care Nursing Alliance.
RATIONALE FOR THE RECOMMENDATION	Baseline assessments were infrequently undertaken, and comorbidity and functional status were the most performed evaluations. However, baseline assessments should include both physical and non-physical factors.
ASSOCIATED GUIDANCE	NICE Guideline [CG83] Rehabilitation after critical illness in adults, 2009 NICE Quality Standard [QS158] Rehabilitation after critical illness, 2017 The post-ICU presentation screen (PICUPS) and rehabilitation prescription (RP) for intensive care survivors Commissioning Guidance for Rehabilitation

IMPLEMENTATION SUGGESTIONS	The tool could be developed by incorporating some of those already available (e.g. clinical frailty scales) and might include:
	▪ Severity of illness
	▪ Underlying comorbidities and frailty
	▪ Pre-existing sensory deficits
	▪ Baseline status
	  • Physical factors: respiratory function, muscle weakness, activities of daily living
	  • Nutrition
	  • Cognition: memory, attention and performance
	  • Psychological factors: post-traumatic stress disorder and affective disorders
	▪ The tool should include the patient's voice, be validated and should be useable by any healthcare professional working in critical care services.

3	Undertake and document a comprehensive, holistic assessment of the rehabilitation needs of patients admitted to an intensive care unit at risk of physical and/or non-physical morbidity. ▪ Assessments should be repeated and documented at key stages along the patient's pathway from admission to community services and GP follow-up. *NB: The assessment should be undertaken by day four following admission (in line with NICE Quality Standard 158) or sooner if the patient is identified as needing a more comprehensive assessment at the screening stage (see recommendation 2), noting that elements of the assessment not possible by day four (e.g. swallow if the patient is orally intubated) should be completed as soon as clinically possible.*
FOR ACTION BY	Healthcare professionals involved with patients on the intensive care unit.

ADDITIONAL STAKEHOLDERS	Executives in trust/health boards, Royal College of Speech and Language Therapists, Royal College of Occupational Therapists, Chartered Society of Physiotherapists British Dietetic Association, British Geriatric Society, Royal College of Psychiatrists, Association of Clinical Psychologists-UK, British Association of Critical Care Nurses, UK Critical Care Nursing Alliance.
RATIONALE FOR THE RECOMMENDATION	Elements were often missing from comprehensive assessments. Non-physical aspects of rehabilitation, nutrition and a lack of multidisciplinary team (MDT) involvement were the most frequently cited missing elements. However, the completion of comprehensive assessments was associated with better quality of care throughout the rehabilitation care pathway.
ASSOCIATED GUIDANCE	NICE Guideline [CG83] Rehabilitation after critical illness in adults, 2009 NICE Quality Standard [QS158] Rehabilitation after critical illness, 2017 Intensive Care Society: GPICS

IMPLEMENTATION SUGGESTIONS	▪ A standardised assessment proforma/tool of rehabilitation needs would aid this process to ensure that all required specialties are included ▪ This could be held electronically as part of the patient's care record and repeated as required, but to include ICU discharge and hospital discharge as key milestones for reassessment ▪ The latest version of the assessment proforma could also be part of the discharge summary to general practitioners ▪ Where available, outcome measures could be used to capture progress as part of the proforma.

4	Ensure that multidisciplinary teams are in place to deliver the required level of rehabilitation in intensive care units and across the recovery pathway. Include: ▪ All relevant healthcare professionals needed to provide co-ordinated, consistent care in the ICU, ward and community ▪ Regular communication between specialties and discussion of patients' needs at a dedicated multidisciplinary team meeting or rehabilitation rounds when appropriate ▪ Staff to deliver the required rehabilitation.
FOR ACTION BY	Commissioners, integrated care boards.

ADDITIONAL STAKEHOLDERS	Hospital trusts/health boards, Royal College of Speech and Language Therapists, Royal College of Occupational Therapists, Chartered Society of Physiotherapists British Dietetic Association, British Geriatric Society, Royal College of Psychiatrists, Association of Clinical Psychologists-UK, British Association of Critical Care Nurses, UK Critical Care Nursing Alliance.
RATIONALE FOR THE RECOMMENDATION	Multidisciplinary staffing levels often did not meet national guidance, resulting in a lack of dedicated time for patients within the intensive care unit.
ASSOCIATED GUIDANCE	NICE Guideline [CG83] Rehabilitation after critical illness in adults, 2009 NICE Quality Standard [QS158] Rehabilitation after critical illness, 2017 Intensive Care Society: GPICS GIRFT: Adult Critical Care The post-ICU presentation screen (PICUPS) and rehabilitation prescription (RP) for intensive care survivors

IMPLEMENTATION SUGGESTIONS	▪ Rehabilitation provision should be commissioned based on patient need rather than diagnosis and cover the ICU, ward and community rehabilitation, using local clinical networks to share resources where possible. ▪ Along with the medical and nursing teams, these specialties could be part of the multidisciplinary team (MDT): physiotherapists, dietitians, speech and language therapists, occupational therapists, psychiatrists and mental health professionals, psychologists, and pharmacists. ▪ Include assessment by geriatricians for physical and cognitive rehabilitation ▪ Ring-fence MDT planning time ▪ Provide MDT care seven days per week both on the ICU and wards ▪ Formal MDT meetings or ward rounds within intensive care units (ICUs) could be held at least weekly and attended by all required members of the MDT. A structured tool, such as the standardised assessment proforma/passport (see recommendation 3) could be used ▪ Formal post-ICU ward rounds may not be practical due to the geographical spread of patients following step-down to the ward. Processes could be put in place to ensure that the MDT jointly discuss and document rehabilitation needs/discharge planning for all patients and track progress.

5	Standardise the handover of rehabilitation needs and goals for patients as they transition from the intensive care unit to the ward and ward to community services.
FOR ACTION BY	Healthcare professionals involved with patients on the intensive care unit and hospital trusts/health boards.

ADDITIONAL STAKEHOLDERS	Intensive Care Society, Faculty of Intensive Care Medicine, Royal College of Speech and Language Therapists, Royal College of Occupational Therapists, Chartered Society of Physiotherapists British Dietetic Association, British Geriatric Society, Royal College of Psychiatrists, Association of Clinical Psychologists-UK, British Association of Critical Care Nurses, UK Critical Care Nursing Alliance.
RATIONALE FOR THE RECOMMENDATION	A good handover was associated with good continuity of care, including continued assessment and delivery of rehabilitation.
ASSOCIATED GUIDANCE	NICE Guideline [CG83] Rehabilitation after critical illness in adults, 2009 NICE Quality Standard [QS158] Rehabilitation after critical illness, 2017

IMPLEMENTATION SUGGESTIONS	▪ The standardised assessment proforma/care passport could be used to aid the handover process and include the current assessment of rehabilitation needs, individualised rehabilitation plan and current goals for treatment ▪ Members of the critical care multidisciplinary team (MDT) may support the handover processes from the intensive care unit (ICU) to the ward through joint rehabilitation sessions ▪ Critical care discharge summaries could be copied to GPs and include predicted rehabilitation needs ▪ Knowledge of an admission to an ICU could be used to trigger a telephone call from the GP to the patient ▪ Alerts/flags on primary care records could be used to identify patients who have had an admission to an ICU, making it easier for primary care to search for patients who might need support – there is a SNOMED CT code for this.

6	Provide patients and their family/carers with clear information about their admission to an intensive care unit, impact of critical illness and likely trajectory of recovery. ▪ Include the contact details of a named healthcare professional or rehabilitation care co-ordinator ▪ Involve patients/family/carers in multidisciplinary team discussions and rehabilitation planning.
FOR ACTION BY	Healthcare professionals involved with patients on the intensive care unit and hospital trusts/health boards, integrated care boards, and patient organisations.

ADDITIONAL STAKEHOLDERS	Intensive Care Society, Faculty of Intensive Care Medicine, ICUsteps.
RATIONALE FOR THE RECOMMENDATION	The patient survey highlighted that this was the most important issue for patients but was not often carried out. Patients were often not updated by the hospital or GP, and there was a lack of follow-up.
ASSOCIATED GUIDANCE	NHS England: Involving patients in their care The Faculty of Intensive Care Medicine: Life After Intensive Care

IMPLEMENTATION SUGGESTIONS	▪ The standardised assessment proforma could take the form of a rehabilitation passport that travels with individual patients along their care pathway ▪ Regular family updates could be provided regarding rehabilitation progress, including the involvement of the patient and their family in rehabilitation rounds as appropriate ▪ The *'All About Me'* booklets help to provide insight and understanding of the person who is being looked after ▪ The use of rehabilitation boards in the patient's bedspace can help to share information about current goals and treatment plans ▪ Patient diaries can be an effective method of capturing the critical care experience ▪ A discharge summary (with technical terms explained) and/or providing relevant patient information booklets. Explaining the events of their critical illness, what to expect in recovery and their individualised rehabilitation plan are all vital parts of this communication to patients and their families. This could be provided digitally or part of the NHS app (or on paper if the patient is not digitally active) ▪ Provide contact details of a named healthcare professional (rehabilitation care co-ordinator) who has job-planned time to ensure they can respond to patients/families who get back in touch.