Recovery, rehabilitation, and follow-up services following critical illness: an updated UK national cross-sectional survey and progress report

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ONLINE DATA SUPPLEMENT

E1. Discharge process from critical care to hospital ward

The discharge process for patients transferring from critical care to the hospital ward is a written handover in 90.9% (n=160/176) of institutions, commonly accompanied by telephone (n=120/176, 68.2%) or face-to-face (n=118/176, 67.0%) handover. Domains contained within the handover document include nursing (n=174/176, 98.9%), medical (n=167/176, 94.9%), physical rehabilitation (n=145/176, 82.4%), nutritional management (n=141/176, 80.1%), medicines' reconciliation (n=121/176, 68.8%), and speech and language therapy plan (n=102/176, 58.0). In the majority of cases (n=157/176, 89.2%) respondents reported using more than one delivery process for patients, with either paper (n=79/176, 44.9%), digital (n=35/176, 19.9%), or both (n=62/176, 35.2%) forms of delivery used. Less frequently reported components of handover included psychology/cognitive rehabilitation (n=49/176, n=27.8%) and occupational therapy (n=44/176, 25.0%). Other reported content (n=11/176, 6.3%) included outreach liaison, social work, and any specific individual aspects of care. A critical care discharge summary is sent to patients' primary care physician in 74 (/176, 42.0%) of institutions.

E2. Inpatient recovery and follow-up services

Of 127 targeted inpatient recovery and follow-up services, most were led by nursing staff (n=65/127, 51.2%, n=4 missing responses), with just over one quarter led by the multi-professional team (n=36/127, 28.3%), and a small proportion by ICU physicians (n=16/127, 12.6%). Physiotherapists (n=3) and rehabilitation co-ordinators (n=1) were reported in a minority of cases (both /127, ≤ 3.0%).

The most frequently reported professions missing from inpatient services were psychology (n=55/127, 43.3%), occupational therapy (n=29/127, 22.8%), and physical therapy (n=18/127, 14.2%). Other missing professions were reported as follows: Medical (n=11/127, 8.7%), speech and language therapy (n=11/127, 8.7%), dietetics (n=10/127, 7.9%), and in a minority of cases, nursing, psychiatry, rehabilitation assistants, social workers, pharmacists, cognitive behavioural therapy, occupation health, advanced critical care practitioners, and administrators (all ≤ n=5/127, ≤ 4.0%). Eleven and 2 respondents respectively reported the whole multi-professional team, and 'All allied health professionals' as missing from services. Twenty-three respondents (/127, 18.1%) reported that there were no professions missing from their services.

E3. Outpatient recovery and follow-up services

One hundred and thirty respondents (/176, 73.9%) reported providing outpatient (following hospital discharge) recovery and follow-up services for adult post critical illness patients. Additional reasons for excluding patients from services (all n=≤3 respondents) included: cardiothoracic/cardiology diagnoses, neurological diagnoses, dementia/cognitive impairment, diagnosis of an overdose, requiring home mechanical ventilation, residing out of geographical hospital area, discharged to a residential or nursing home, other specialist rehabilitation pathway in place, prisoners, elective surgery, aged >75 years, previous non-attendance. Whilst ICU physician and nursing staff were the most frequently reported staff leading services, a small number of other professions/teams were detailed by respondents: joint ICU physician and nurse (n=7), multi-professional team (n=4), joint ICU physician and psychologist (n=2), and physiotherapist, joint advanced critical care practitioner and physiotherapist, surgeon, joint ICU physician and physiotherapist, and joint nurse and physiotherapist (all n=1).

The majority (n=108/130, 83.1%) of services involved 2 or more healthcare professions, with further breakdown according to number of healthcare professions involved; 1, (n=22), 2 (n=41), 3, (n=36), 4 (n=14), 5 (n=7), 6 (n=4), 7 (n=4), 8 (n=2). Combinations of healthcare professions providing services are reported in Table E1. The most frequently reported professions missing from outpatient services were psychology (n=61/130, 46.9%), physiotherapy (n=45/130, 34.6%), occupational therapy (n=41/130, 31.5%), and dietetics and speech and language therapy (both n=22/130, 16.9%). Less frequently reported missing professions included intensive care medicine and pharmacy (both n=11/130, 8.5%), social work (n=7/130, 5.4%). A minority of respondents reported psychiatry, administrative support, nursing, the multi-professional team, rehabilitation team, primary care physician, pain team, occupational health, counsellor, wellbeing services, and service improvement team, as professions missing from outpatient services (all n=≤4/130, ≤3.1%). Clinic rooms available for services typically ranged 1-4. Subsequent appointments, after the initial one, typically ranged between 1 and 3, but some respondents reported no limits on the number of repeat visits patients could have.

Seventy-six respondents (/130, 58.5%) reported using some form of screening tool for post intensive care issues; specifically named tools were not always provided but where they were these included the Chelsea Critical Care Physical Assessment Tool, Intensive Care Psychological Assessment Tool, Hospital Anxiety and Depression Scale, Post-Traumatic Stress Symptoms-14 scale, Short-Form 36. Where specific tools were not listed respondents reported use of their own locally developed

proformas and concerns checklists, and rating scales (e.g. distress thermometer), and/or indicated the broad domains they assessed e.g. activities of daily living, psychological status. Eight-five respondents gave examples of outcome measures or tools to assess aspects of critical illness recovery, which are summarised in Table E2.

Twelve (/130, 9.2%) respondents indicated they strongly agreed their current outpatient service met the needs of their local case-mix, 56 (/130, 43.1%) were in agreement, 21 (/130, 16.2%) neither agreed or disagreed, 34 (/130, 26.2%) were in disagreement, and 7 (/130, 5.4%) in strong disagreement. When asked whether existing service models (including funding, venue, staffing, resources) were sustainable for the next 5 years, 9 (/130, 6.9%) reported they strongly agreed, 46 (/130, 35.4%) agreed, 32 (/130, 24.6%) neither agreed or disagreed, 36 (/130, 27.7%) disagreed, and 7 (/130, 5.4%) strongly disagreed. Increased personnel (n=103/130, 79.2%), commissioned funding (n=89/130, 68.5%), administrative support (n=74/130, 56.9%), and physical space for the service (n=56/130, 43.1%) were factors required to support services.

Additional factors reported to help sustain services over the next 5 years included better referral pathways, clear standards to guide services, greater medical engagement, enhanced links with primary care services, and improved profile of the service (all individually reported by one respondent).

137 **Table E1.** Features of outpatient recovery and follow-up services

Feature	Options	Frequency of occurrence (n/130, %)
Timeframe for first follow-up	2-3 months after hospital discharge 6 months after hospital discharge 1 month after hospital discharge Other[a]	102 (78.5) 8 (6.2) 6 (4.6) 13 (10.0)
Number and combination of professions of clinicians involved[b]	1 clinician - Nurse - ICU physician - Physiotherapist	22 (16.9) - 18 - 3 - 1
	2 clinicians - Nurse, ICU physician - Nurse, Physiotherapist - ICU physician, Physiotherapist - ICU physician, OT	41 (31.5) - 29 - 9 - 2 - 1
	3 clinicians - Nurse, ICU physician, Physiotherapist - Nurse, ICU physician, Psychologist - Nurse, ICU physician, OT - ICU physician, Physiotherapist, Psychologist - Nurse, ICU physician, Psychiatrist - Nurse, Physiotherapist, SLT - Nurse, ICU physician, GRA	36 (27.7) - 19 - 10 - 2 - 2 - 1 - 1 - 1
	4 clinicians - Nurse, ICU physician, Physiotherapist, Psychologist - Nurse, ICU physician, Physiotherapist, OT - Nurse, ICU physician, Physiotherapist, Dietitian - Nurse, Physiotherapist, Psychologist, Dietitian - Nurse, ICU physician, Physiotherapist, Psychiatrist	14 (10.8) - 7 - 3 - 2 - 1 - 1
	5 clinicians - Nurse, ICU physician, Physiotherapist, Psychologist, Pharmacist - Nurse, ICU physician Physiotherapist, OT, SLT - Nurse, ICU physician, Physiotherapist, SLT, Dietitian - Nurse, ICU physician, Physiotherapist, OT, Psychologist	7 (5.4) - 4 - 1 - 1 - 1
	6 clinicians - Nurse, ICU physician, Physiotherapist, OT, Psychologist, SLT - Nurse, ICU physician, Physiotherapist, Psychologist, Dietitian, Pharmacist	4 (3.1) - 2 - 2
	7 clinicians	4 (3.1)

	- Nurse, ICU physician Physiotherapist, OT, Psychologist, SLT, Dietitian, - Nurse, ICU physician Physiotherapist, Psychologist, SLT, Dietitian, Pharmacist - Nurse, ICU physician Physiotherapist, Psychologist, SLT, Dietitian, GP - Nurse, ICU physician, Physiotherapist, OT, Psychologist, SLT, Pharmacist	- 1 - 1 - 1 - 1
	8 clinicians - Nurse, ICU physician Physiotherapist, OT, Psychologist, Psychiatrist, Dietitian, Pharmacist	2 (1.5) - 2
Location of service delivery	Dedicated hospital outpatient area Adapted space within critical care Other area within the hospital Community site Other[c]	83 (63.8) 26 (20.0) 11 (8.5) 6 (4.6) 3 (2.3)
Format of assessment by multiple clinicians[d]	Together (i.e. all clinicians in the same room) Separately (i.e. clinicians in different rooms	77 (59.2) 42 (32.3)

Abbreviations: OT = Occupational Therapist; SLT = Speech and Language Therapist; GRA = Generic Rehabilitation Assistant; GP = General Practitioner

Legend: [a]Other includes: 2 weeks, n=3, 2-4 weeks, n=1, 6 weeks, n=2, 3 months, n=1, 3-6 months, n=4, 4-5 months, n=1, 6-12, n=1. [b]Administrative support counted separately; 29 (22.3%) sites reported administrative support for outpatient service. [c]Other includes: Multiple areas for service deliver, n=2, Other clinical outpatient area, n=1 (n=1 blank response). [d]n=11 missing responses.

161 **Table E2.** Examples of outcome measures or tools to assess aspects of post critical illness recovery in
162 outpatient services

Impairment	Examples of outcome measures/tools
Anxiety	Hospital Anxiety and Depression Scale; Intensive Care Psychological Assessment Tool; Generalised Anxiety Disorder Assessment; Post-Traumatic Stress Symptoms-14 Instrument; EuroQol-5Dimension; Short Form-36
Depression	Hospital Anxiety and Depression Scale; Intensive Care Psychological Assessment Tool; Post-Traumatic Stress Symptoms-14 Instrument; EuroQol-5Dimension; Patient Health Questionnaire-9; Major ICD-10 Depression Inventory; Perceived Stress Questionnaire;
Post-traumatic stress disorder	Intensive Care Psychological Assessment Tool; Post-Traumatic Stress Symptoms-14 Instrument; Trauma Screening Questionnaire; EuroQol-5Dimension; Impact of Events Scale-Revised; Primary Care Post Traumatic Stress Disorder Screen;
Sleep quality	Insomnia Severity Index; Pain and Sleep Questionnaire
Sleep apnoea	STOP-Bang Questionnaire
Cognition	Montreal Cognitive Assessment; Mini-Mental State Examination; 4AT test; Confusion Assessment Method for the ICU; Addenbrooke's Cognitive Examination-Revised;
Health-related quality of life	Short Form-36; EuroQol-5Dimension; Schwartz Outcomes Scale-10
Personal activities of daily living	Barthel Index; Self-efficacy Tool; Short Form-36
Pain	Verbal/numeric 0-10 rating scale; Brief Pain Inventory; Critical Care Pain Observation Tool;
Breathlessness	Borg scale; Modified Medical Research Council scale; RAND breathlessness scale; pulmonary function tests; chest x-ray
Palliative care needs	RAND Mental Health Inventory
Sexual function	Sexual Health Questionnaire
Nutritional status	Weight
Physical function	Functional Independence Measure + Functional Assessment Measure; Rivermead Mobility Index; ICU Mobility Scale; Barthel Index; Chelsea Critical Care Physical Assessment Tool; Physical Function in ICU Test; Handgrip dynamometry; Six Minute Walk Test; Berg Balance Scale; Sit-to-Stand test; Short-Form 36; EuroQol-5Dimension
Exercise capacity	Six Minute Walk Test; Borg scale; EuroQol-5Dimension; Chelsea Critical Care Physical Assessment Tool; Tinetti test; Metabolic equivalents
Disability	Chelsea Critical Care Physical Assessment Tool; EuroQol-5Dimension

Frailty	Rockwood Clinical Frailty Scale; Clinical Frailty Scale; EuroQol-5Dimension
Dependency	EuroQol-5Dimension; Post-Traumatic Stress Symptoms-14 scale
Socioeconomic status	EuroQol-5Dimension
Pharmacological risk	-
Alcohol intake	Unit-based calculation
Smoking status	Pack year history
Driving status	Referral to a local driving centre; reference to DVLA (Driver and Vehicle Licensing Agency) guidelines
Flying status	Reference to British Thoracic Society (UK) guidelines
Additional comments	*A number of respondents reported no use of specific tools, but thorough clinical assessment +/- use of a 'concerns checklist', or 'distress thermometer', to identify and rate problems.*

E4. Links between recovery and follow-up services and other services

Forty-three respondents (/176, 24.4%) reported no links between their recovery and follow-up services and any neighbouring institutions, networks, or other referral pathways.

Remaining respondents (133/176, 75.6%) reported examples of links between their own services, and other similar services in neighbouring institutions, summarised into 8 categories: i) informal links into critical care networks including knowledge and best practice sharing (n=67/176, 38.1%), ii) linking to community service pathways e.g. pulmonary rehabilitation, psychology (n=27/176, 15.3%), iii) informal referrals made to neighbouring centres (n=20/176, 11.4%), iv) coordination with other specialty clinics e.g. respiratory, trauma, neurosciences (n=19/176, 10.8%), v) formal referrals made to neighbouring centres (n=10/176, 6.0%), vi) peer support referral (n=9/176, 5.1%), vii) formal referrals accepted from neighbouring centres (n=8/176, 4.5%), and viii) informal referrals accepted from neighbouring centres (n=6/176, 3.4%).

Examples given by respondents where links were present (87/176, 49.4%) between their recovery/follow-up services and primary care and/or community interfaces, were summarised into 8 categories: i) referral to community therapy services (n=27/176, 15.3%), ii) patient letter sent routinely to primary care physician (n=26/176, 14.8%), iii) ad hoc contact with primary care physician (n=16/176, 9.1%), iv) post critical illness information provided to primary care physician (n=15/176, 8.5%), v) signposting to community citizens advice and employment services support (n=11/176, 6.3%), vi) referral to community independent exercise programmes (n=9/176, 5.1%), vii) referral to community independent psychology services (n=8/176, 4.5%), viii) support for residential ventilation care (n=2/176, 1.1%). Eighty-nine respondents (/176, 50.6%) indicated that there were no links available with primary/community care sectors.

Around three-quarters of respondents indicated no links between their (adult) recovery/follow-up services and services managing paediatric, adolescent, or transition-to-adult (n=135, 76.7%), or with services for care of older adults (n=131/176, 74.4%). For the former, a small number of respondents (n=24/176, 13.6%) reported ad hoc links with paediatric services, and a minority (n=7/176, 4.0%) reported available links with transition-to-adult services. For the latter, a small number of respondents (n=23/176, 13.1%) indicated some ad hoc links with services during the inpatient stage of recovery, and a minority indicated links with community services (n=10/176, 5.7%) and older person psychiatric service (n=3/176, 1.7%).

E5. Peer support after critical illness

Additional forms of peer support offered included: composite involving multiple options of delivery, visits from former patients, and a peer-mentor led group (all reported by one respondent each). Furthermore, one respondent indicated their service was currently under active development, and detail was not reported by one respondent.

Three services were peer-facilitated only, and one other service involved former patients and families. Other staffing was reported very infrequently (ranging 1-3 occasions); chaplaincy, critical care outreach staff, counselling staff, advanced critical care practitioners, social work, pharmacy, administrative staff, and ICU volunteers.

E6. Post hospital discharge physical rehabilitation programmes

Critical illness-specific post hospital discharge physical rehabilitation programmes were offered by 31 (/176, 17.6%) hospitals. Physiotherapists led all but one programme, either alone (n=26/31, 83.9%), or in combination with a nurse, exercise/sports therapist, rehabilitation medicine specialist, or rehabilitation assistant (all n=1/31, 3.2%, each). One programme was led by an exercise/sports therapist. Clinicians leading programmes were either ICU-specialist (n=19/31, 61.3%) or rehabilitation-specialist (n=12/31, 38.7%). Physical rehabilitation programmes were primarily hospital-based (n=22/31, 71.0%), with some community-based (n=5/31, 16.1%), home-based (n=2/31, 6.5%), and combination (home and community, n=2/31, 6.5%) delivery. Telehealth (or other interactive forms of intervention delivery) was used by only one respondent. Three-quarters of programmes were stand-alone (n=23/31, 74.2%), but a small number of respondents reported programmes were integrated with other disease-specific rehabilitation services n=5/31, 16.1%). Eighteen programmes (/31, 58.1%) were rolling programmes i.e. patients could enter the programme at any point, as opposed to part of a discrete cohort. Programmes were generally well serviced with no waiting list (n=23/31, 74.2%) and capacity to meet need (n=23/31, 74.2%). Further features of physical rehabilitation programmes are summarised in Table E3.

All but one programme included an exercise component (n=30/31, 96.8%), albeit no further responses were provided by one respondent to detail their programme further. For the remaining respondents (n=29), features of the exercise component of their physical rehabilitation programme are reported in Table E4.

Barriers to the delivery of post hospital discharge physical rehabilitation programmes are summarised in Table E5. These were reported by both respondents who did, and did not, offer a service. Lack of funding was both the most frequently reported barrier (n=128,176 72.7%) as well as the main barrier reported (n=86/176, 48.9%). Lack of sufficient staff was the second most frequent (n=116/176, 65.9%), and main (n=28/176, 15.9%), barrier.

289 **Table E3.** Features of physical rehabilitation programmes

Feature	Options	Occurrence (/31, (n, %))
Timepoint post hospital discharge that programme commences*	Immediately post hospital discharge	8 (25.8)
	2-3 months post hospital discharge	7 (22.6)
	Other – individualised per patient	5 (16.1)
	1 month post hospital discharge	3 (9.7)
	4-6 weeks post hospital discharge	2 (6.5)
	2 weeks post hospital discharge	2 (6.5)
Assessment criteria for patient inclusion~	Duration of ICU admission	22 (71.0)
	Duration of mechanical ventilation during ICU	17 (54.8)
	Physical function at ICU discharge	9 (29.0)
	Muscle strength at ICU discharge	9 (29.0)
	Exercise capacity at ICU discharge	9 (29.0)
	Physical function at hospital discharge	7 (22.6)
	Duration of hospital admission	5 (16.1)
	Muscle strength at hospital discharge	5 (16.1)
	Health-related quality of life at ICU discharge	4 (12.9)
	Exercise capacity at hospital discharge	4 (12.9)
	Health-related quality of life at hospital discharge	3 (9.7)
	All patients eligible	3 (9.7)
Session details[a]	Weekly	20 (64.5)
	Twice-weekly	3 (9.7)
	Individualised per patient	3 (9.7)
	Fortnightly	2 (6.5)
	Number of sessions (median (IQR))	6 (5.5-9.0)
Duration of sessions[a]	1 hour	15 (48.4)
	30 minutes	6 (19.4)
	Individualised	5 (16.1)
	45 minutes	2 (6.5)
Number of patients attending a session (*open- ended question*)	Responses variable, ranging from individual patients (if a home-based programme or 1:1 format), to up to 20 in a group. Examples reported include 4-8, 6-8, average 6, up to 12, 8-10, 8-15	-
Staff: patient ratio (*open-ended question*)	Responses variable; examples include 1:1, 1:3, 1:4, 1:5-6, 2:8, 2:6, 2:12; staff could be qualified or a combination of qualified and assistant	-
Education topics, and members of the MDT involved[b]	Yes	22 (71.0)
	No	6 (19.4)
	Exercise	18 (58.1)
	- PT, Nurse, Doctor*, PTA	
	Recovery expectations	17 (54.8)

	- PT, Nurse, MDT, Doctor*	
	Energy conservation	16 (51.6)
	- PT, Nurse, Psychology, PTA, OT, Independent	
	Nutrition	13 (41.9)
	- PT, DT, Nurse, Doctor*, MDT	
	Return to work	12 (38.7)
	- PT, Doctor*, Nurse, OT, Vocational Specialist	
	Medications	11 (35.5)
	- Doctor*, Nurse, PT, Pharmacist	
	Motivational training	11 (35.5)
	- PT, Nurse, Psychology, PTA	
	Stress management	9 (29.0)
	- PT, Nurse, Psychology, OT, Doctor*	
	Other e.g. falls management, breathing control, mindfulness, individualised needs, goal-setting	5 (16.1)
Use of outcomes and examples of outcome measures[c]	Strength assessment	14 (45.2)
	- Quadriceps strength, handgrip strength, repetition count, CPAx	
	Exercise capacity	17 (54.8)
	- Walking tests (6MWT, ISWT), Timed Up and Go, CPEX	
	Health-related quality of life	
	- HADS, EQ-5D, SF-36	18 (58.1)
	Cognitive/Mental health	
	- Readiness for return to work	2 (6.5)
	Function	
	- NEADL, SPPB, Sit-to-stand	7 (22.6)
Onwards referral to other rehabilitation programmes[d]	Yes	20 (64.5)
	No	7 (22.6)
	Pulmonary rehabilitation	16 (51.6)
	Cardiac rehabilitation	15 (48.4)
	Community gym session	14 (45.2)
	Exercise on prescription (or similar community exercise/walking programme)	6 (19.4)

Abbreviations: ICU = intensive care unit; PT = physiotherapist; PTA = physiotherapy assistant; OT = occupational therapist; DT = dietitian; MDT = multidisciplinary team; CPAx = Chelsea Critical Care Physical Assessment Tool; 6MWT = Six Minute Walk Test' ISWT = Incremental Shuttle Walk Test; CPEX = cardiopulmonary exercise test; HADS = Hospital Anxiety and Depression Scale; EQ-5D = Euroqol-5 Dimension; SF-36 = Short-Form 36; NEADL = Nottingham Extended Activities of Daily Living; SPPB = Short Physical Performance Battery.

Legend: Respondents could choose more than one option from multiple response-option questions. *Two respondents reported uncertainty on time-frame for programme commencement, one respondent reported it commenced after attendance at local follow-up programme, and one respondent did not report. ~Four respondents reported aspects of individual patient assessment by clinicians for appropriateness, and may be dependent on underlying diagnosis and/or ongoing rehabilitation requirements. One respondent reported inclusion was based on assessment after attendance at local follow-up programme. One respondent expanded on the use of the Chelsea Physical Assessment Tool and the Intensive Care Psychological Assessment Tool as assessment measures for applicable criteria. [a]Three non-responses. [b]Eleven non-responses. [c]Seven non-responses. [d]Four non-responses. *Doctor = specialty not specified.

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Table E4. Features of exercise components of physical rehabilitation programmes

Feature	Options	Occurrence (/29, (n, %))
Approach to patient exercise	Under supervision	15 (51.7)
	Independently	2 (6.9)
	Combination of aforementioned	11 (37.9)
	Dependent on individual patient	1 (3.4)
Design of exercise component	Patient-specific plan	17 (58.6)
	Pre-determined circuit	10 (34.5)
	Combination of aforementioned	2 (6.9)
Type of exercise included*	Strength	28 (96.6)
	Functional	26 (89.7)
	Cardiovascular	25 (86.2)
	Balance	23 (79.3)
Approach to exercise prescription~	Clinician judgement	23 (79.3)
	Results of physical function assessment	17 (58.6)
	Target level of exertion	13 (44.8)
	Results of walking tests	11 (37.9)
	Results of balance assessment	7 (24.1)
	Repetition maximum principle	4 (13.8)
	Target heart rate	3 (10.3)
Approach to exercise monitoring and progression[#]	Clinical observation of patient	20 (69.0)
	Patient verbal feedback	20 (69.0)
	Level of exertion	17 (58.6)
	Oxygen saturation level	10 (34.5)
	Reassessment of baseline measures	10 (34.5)
	Heart rate targets	9 (31.0)
	Visual analogue scale	2 (6.9)
	No formal monitoring	1 (3.4)
Accompanying rehabilitation or exercise manual	Yes	15 (51.7)
	No	14 (48.3)

Abbreviations: ICU = intensive care unit

Legend: *Strength exercise e.g. lower limb, upper limb, free weights; Functional exercise e.g. sit-to-stand, walking; Cardiovascular exercise e.g. step-up, treadmill, cycling; Balance exercise e.g. static, dynamic; 2 respondents reported also including work-based movement pattern exercise. ~In addition to the response options, one respondent also indicated use of a local graded exercise system incorporating 3 levels at each exercise station depending on individual patient ability. [#]3 respondents reported uncertainty as to detail of approach.

Table E5. Barriers to the delivery of post hospital discharge physical rehabilitation programmes

Barrier	Occurrence overall (n/176, %)	Occurrence as main barrier (n/176, %)
Lack of funding	128 (72.7)	86 (48.9)
Lack of sufficient staff	116 (65.9)	28 (15.9)
Resources prioritised to other patient groups/clinical areas	82 (46.6)	8 (4.5)
Not considered required service at managerial level	70 (39.8)	12 (6.8)
Lack of available space	70 (39.8)	4 (2.3)
Time constraints	49 (27.8)	5 (2.8)
Lack of trained staff	34 (19.3)	1 (0.6)
Not sure what content to include in a programme	30 (17.0)	0
No evidence to demonstrate rationale/requirement for service	25 (14.2)	3 (1.7)
Extracontractual (out of area) patient caseload	18 (10.2)	1 (0.6)
Insufficient patient numbers to justify	13 (7.4)	2 (1.1)
Other*	13 (7.4)	11 (6.3)

Missing responses, n=23 (overall), n=43 (main).

Legend: *Other (overall) = Lack of patient motivation, n=3; no staff willing/motivated to run service, n=3; never considered as a service previously, n=2; significantly large rural catchment area of hospital, n=1; lack of patient facilities e.g. transport, parking, n=1; local referral pathways to physiotherapy services already in place, n=1; rehabilitation the responsibility of the admitting clinical specialty, n=1; onset of the COVID-19 pandemic, n=1. Other (main) = no staff willing/motivated to run service, n=3; non-commissioned service, n=1; no time to develop service, n=1; lack of patient motivation, n=1; onset of the COVID-19 pandemic, n=1; patient moved from acute setting, n=1; patient heterogeneity limiting standardised service, n=1; other rehabilitation service available to refer into, n=1; no single main barrier (all options apply), n=1.

E7. Impact of COVID-19 on recovery and follow-up services following critical illness

Summative content analysis{ ADDIN EN.CITE <EndNote><Cite><Author>Hsieh</Author><Year>2005</Year><RecNum>47634</RecNum><DisplayText><style face="superscript">1</style></DisplayText><record><rec-number>47634</rec-number><foreign-keys><key app="EN" db-id="awf2prsswtspfqedx5ax0v55adwsvfz2r05x" timestamp="1509203785">47634</key></foreign-keys><ref-type name="Journal Article">17</ref-type><contributors><authors><author>Hsieh, Hsiu-Fang </author><author>Shannon, Sarah E. </author></authors></contributors><titles><title>Three Approaches to Qualitative Content Analysis</title><secondary-title>Qualitative Health Research</secondary-title></titles><periodical><full-title>Qualitative Health Research</full-title><abbr-1>Qual. Health Res.</abbr-1><abbr-2>Qual Health Res</abbr-2></periodical><pages>1277-1288</pages><volume>15</volume><number>9</number><keywords><keyword>content analysis,qualitative research,research methodology,end-of-life care</keyword></keywords><dates><year>2005</year></dates><accession-num>16204405</accession-num><urls><related-urls><url>http://journals.sagepub.com/doi/abs/10.1177/1049732305276687</url></related-urls></urls><electronic-resource-num>10.1177/1049732305276687</electronic-resource-num></record></Cite></EndNote>} was used to review and identify themes from respondents' free text responses detailing the impact of the COVID-19 pandemic on their services e.g. any changes to existing services, if applicable, or the development of any new services. Table E6 presents the themes generated, and the frequency with which they featured across all responses. Table E7 reports the narrative free text responses with accompanying thematic coding.

Table E6. Themes describing changes to services as an impact of COVID-19 pandemic

Theme	Letter denoting theme	Frequency of occurrence (/162) (n, %)
No change to service	a	17 (10.5)
Applying for funds/new service as an impetus/response	b	44 (27.2)
Research about follow-up initiated	c	1 (0.6)
New service implemented: telephone based	d	14 (8.6)
New service implemented: face to face	e	16 (9.9)
New service implemented: virtual	f	12 (7.4)
New service implemented: exercise	g	15 (9.3)
Increased capacity/activity of existing service	h	40 (24.7)

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Decreased capacity/activity of existing service	i	48 (29.6)
Increased frequency of existing service	j	20 (12.3)
Existing service conversion to telephone	k	30 (18.5)
Existing service conversion to virtual	l	44 (27.2)
Shortened review interval compared to previous	m	11 (6.8)
Addition of psychologist to service	n	6 (3.7)
Follow-up combined with respiratory medicine services	o	20 (12.3)

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Table E7. Narrative free text responses with accompanying thematic coding (with reference to Table E6)

Free text response*	Themes
We have performed telephone triage of all patients within a week of discharge and have then provided an MDT zoom clinic, each patient assessed for 30 mins with further follow up phone calls/ongoing referrals made (all patients have ongoing needs and will receive further follow up, our patient support group is virtual, we have started an exercise class and now have links to an exercise class run by the respiratory team for pulmonary fibrosis). We still have no psychologist though have funding for this service#	d, g, l, n, o
Business case being rewritten	b
Our Follow Up team had been pulled to work clinically on ITU during Covid 19. Currently one member now back to doing follow up. Limited in hospital follow up has occurred due to infection risk in different ward locations. Outpatient clinic follow up being done virtually using video technology#	i, l
More frequent follow up clinics, more exercises based reviews for discharge. We would love some psychology input	g, h, j, n
Currently the rehab role is 18.5hrs for the clinical nurse specialist, this is being increased 37.5 for 8 weeks due to increased patient numbers. No other services hours have been increased	h
Currently have an intensivist running clinic and doing more patient assessments and tests. Running 5 physio rehab classes a week on line with support group. Post ICU ward visits taking much longer. Telephone consultations have increased	g, h, j
Follow-up service is now online	l
Awaiting response to business case for dedicated follow up funding	b
Services have been delayed as needed to work clinically. We are looking at trying to get funding to provide rehab sessions post discharge.	b, i
No outpatients since start of covid, now setting up video conference for non covid patients and outpatient appointments for covid patients with further physical examination and other clinician input.	i, l
Plans for physical rehabilitation programme whilst inpatient and following discharge, trying to obtain psychology input, formal payment from commissioners for follow up clinic	b, g, n
With COVID there is a much greater demand for all of these services. We are including all COVID level 2 and 3 patients on our post ICU pathway (including those having CPAP in non ICU areas), and ICU follow up clinic, we are only in the early stages of working out how we are going to deal with the increased work load. The patients are all receiving an earlier psychol review and cognitive assessment as an inpatient, and once at home an initial in depth 1:1 virtual rehab assessment with them and then will be invited to a virtual exercise class (increased to twice weekly from the usual once weekly) , with a link to access exercise videos in their own time. We have separated off the psychological and physical aspects of clinic - the former is done first, then the latter. There will need to be more sessions for ICU clinic. We are also linking in with the respiratory consultants, so as not to be duplicating workload as a result of their COVID BTS guidelines. This will all require increased resources, we are unsure where this will come from currently	b, g, h, l, m, o
Our therapists have visited each of our Covid admissions at home as part of a research study that we have devised and gained approval for. We also held a follow up Covid clinic with a respiratory physician, a physio and an OT.	c, e, o
Telephone contact not face to face	d
Use of online platforms for follow up, communication with relatives and discharged patients	l
Telephone follow up to discharged patients	k
Just setting up a multidisciplinary follow up clinic for covid patients and trying to expand that to all patients but not commissioned yet... Using modified pickups tool for screening	b
Covid-19 essentially stalled all non-pandemic business and delayed implementation. The loss of SPA time negatively impacted planning.	b, i

During COVID 19 the clinic was point on hold. Due to lockdown and the senior sister required to work clinically. Since the lockdown the clinic has now been undertaken via telephone consultation. We have increased the service to two nurses to help "catch up"	i, l
This will have to be a "telephonic" clinic and I am not sure how effective it will be. The numbers will be overwhelming and I am not sure as we have not yet commenced clinics at our hospital.	b, i, k
Face to face follow up clinic now telephone based Delay in getting x2 Rehabilitation therapy assistant practitioners interviewed in March 2020 into post, Delay in being able to set up post ICU Support groups	i, l
Have submitted business case for proper follow up service	b
Increased clinic as we have a white worker calling patients from home	h, k
Step down rehabilitation ward created and patients received a lot of input from allied health professionals to reduce length of stay. Increased hours for Follow Up clinic	h, j, m
Physio involvement. Difficulty delivering Follow-up clinics	h, i
Not received OT funding. Availability of working at home. Clinic & rehab class now online. Increased info available online. Timing delayed as Follow up role during pandemic paused as helping on unit.	b, g, i, l
Usually 3 critical care follow-up nurses and 0.3 physiotherapist in follow-up (physiotherapy only reviewed ward based patients needing assistance of 2 or more to transfer) - nil involvement in outpatient follow-up. During COVID physiotherapy now 1.0 equivalent - partaking in telecommunications with patients and MDT follow-up clinic. MDT follow up clinic due to be trialled this week (Consultant, nurse, physiotherapy, OT, SLT, dietician)	e, h
New joint clinic with respiratory team for COVID ICU pts	e, h, o
Permanent loss of gym. Restrictions on group exercise. Limited staffing. Limited suitable patients	i
No	a
Impetus to develop follow-up services for critical care	b
We have established a 6 week MDT to discuss patients after phone contact. Full MDT attendance (physio, nurses, OT, psychology, dietitian, SLT, medic). All good will with no funding	d, h
Implemented Nurse led follow up for all COVID-19 patients and general critical care patients who have been on critical care for 4 days or longer	d, f, h
Phone triage for follow up clinic	k
Outpatient clinics have been done via telephone rather than face to face. We haven't yet been able to secure support to run the clinic via a virtual medium - although we are hoping to run clinics this way soon	b, k
We have set up a COVID follow up service alongside the respiratory physicians. This involves a phone clinic to all patients admitted to hospital with COVID and those with ongoing resp needs only are then seen face to face by resp alone, those with multimorbidity and post ITU issues are seen in an MDT. The MDT comprises of Critical care physician, respiratory physician, critical care physio, critical care OT, SLT, Specialist nurses for critical care and psychology. The clinic runs fortnightly and we see 6 patients face to face. The patients have lung function done on arrival. They are in clinic for 2.5-3 hours. The aim is a one stop assessment and they are referred onto other services such as musculoskeletal physio, dysfunctional breathing clinic, outpatient cognitive rehab etc. This is funded in part by emergency funds at the moment and a significant amount of goodwill. It will stop once the COVID patients are seen but we are hoping to use the information gained from this to set up a fully fledged critical care follow up service[#]	b, d, e, h, m, o
All clinic activity halted other than phone calls	d, i
Our class is now running virtually with weekly phone calls, booklets and exercises sent to patient, videos emailed of exercise. Follow up is now just telephone but looking to being able to meet patients face to face again	g, k, l
No	a
Due to COVID for first few weeks the service was suspended. But then started via phone call. Currently Follow up clinic is up and running virtually.	i, k, l
Inpatient round initially paused, restarted a few months ago. Follow up clinics now virtual, either via video or telephone. Timescale to follow up potentially longer due to back log.	i, k, l
Telephone follow up. Email	k

Current loss of outpatient service and exercise programme. Unable to allow patients to visit critical care post-discharge. Using teleconference for ICU Steps meetings. Using more telephone consultations.	i, l
Separate fully funded MDT follow up clinic for Covid including those through ICU. Continue with inpatient ward round reviews, now also supported by a Physio. Clinic review now in virtual format, phone or attend anywhere	b, l
The staff load was much higher, so the Rehabilitation After Critical Illness pathway was sometimes not followed up. We had to move to phone calls only review.	i, k
Rehabilitation After Critical Illness consultant and Coordinator had meeting with Mental Health consultant but decided to continue link already established as numbers very small	a
No follow-up clinics	a
Business case approved so now working on developing service for the Trust	b
No new services	a
Covid have stopped all our services, but i have restarted ward based follow up visits	i
We are running the same service but at the moment the follow up clinic is being run via video link	l
Support group currently suspended - telephone calls made ad hoc to patients needing support. Priority given to acute patients on outreach service - however post discharge to ward patients still reviewed[#]	d, i
Outpatient clinic cancelled for three months - now via telephone, video Increased managerial interest in post covid problems	i, k, l
This has made the management think this may be important. This has led to some management cooperation with setting up a future service and a post covid service now. However we have to fund from within our dept. This may change. Clinical director now working with the ICU medical director to develop local covid rehab. It is still being shaped as a service by people with no expertise in the topic. A box will be ticked but it won't be great.	b
None so far	a
Service under development anyway. Has highlighted need for service to senior management	b
Some consultant and nursing staff went to local acute trust to help out for 3 months	i
Plan on having virtual clinics Aim to see bereaved relatives who did not get the chance to visit	i, l
Will be referred to pulmonary rehab service. Increase in staff in that service. Will not be COVID specific	i
No more resources or funding but many more patients and relatives	i
Virtual follow-up clinic now running Increased frequency to weekly rather than bi-weekly (for 3 month period) to meet patient demand Virtual or telephone physiotherapy rehabilitation Developing electronic notes for all MDT[#]	h, j, m
As staff were redeployed then an 2-3x weekly inpatient review was provided on the wards for all ICU survivors, but physio, physio assistant (and ICU nurse at one site). A post-COVID rehabilitation group has been set up at (second site) for ICU Survivors once home, with aim to roll out across the trust imminently, Increased clinic capacity provided for time limited period to be able to offer ICU Follow Up clinic to all ICU COVID Survivors[#]	g, h, j, m
Adapted to remote delivery - now weekly 1 hour group - 30 mins physio + Q+A + 'guest speakers' + mindfulness[#]	l
Dedicated therapy team to ICU during pandemic with a view to make this permanent. Combined COVID clinics with respiratory team/consultant. Further highlighting need for OT. Respiratory consultant has attended Group support meetings are now via zoom	b, f, h, o
Trialing of telephone follow up - very time consuming; unable to follow through patients with current staffing levels[#]	i, k
Reduced in hospital follow up due to staffing pressures.	i
All services paused during the peak of the pandemic. Since then the service has doubled each month to see the increased number of discharges that require rehab follow up	h, j
We have secured funding for a post Covid 19 follow up clinic. This resource can only deliver services to a small number of patients. Patients initially receive a phone-call screening. If required they can be seen in a follow up clinic (either remotely or face-to-face). This clinic is run by Medics, Nursing, Physio, OT and Psychology (one of each).	b, e, f

Trialling a clinic model for covid patients	b, h
Virtual pathway set up on discharge - 12/52 pulmonary rehab pathway run by gym techs	f, g, h
No face to face reviews difficulty progressing with launch of rehab service instead of existing follow up clinic	b, h
Have developed a follow-up service specifically for COVID patients	e
We delayed the follow up clinic during the pandemic period and we are not having to reinstate it. - ITU consultants are also seeing all the covid patients as we expect to see a lot of PTSD.	i
Difficult question to answer as our hospital was shut due to COVID outbreak. All admissions were diverted to surrounding hospitals. At time of writing we are only just starting to reopen	A
Fewer available healthcare professionals due to sickness or shielding	i
Now telephone clinic	k
Limited peer support	i
All assessments and follow up appointments have been done via either telephone or video call. No face to face appointments within the physio clinic as yet. Consultant follow up at 3/12 is now face to face as an option. Rehab group not currently running with lots of barriers to work round before it can run again. Patients are sent home exercise programme to complete with support and guidance remotely. Hoping to try a virtual class if ongoing delay to physical class being restarted. A positive has been greater joint working with Dieticians and due to the increased numbers, as the Physio now undertake the initial nutrition screen if they aren't routinely following up. will then refer to them if needed. Definitely greater MDT working with them.	g, k, l
We had MDT staff all working together	h
Sadly follow up was temporary halted due to clinical need, now back up and running. Sudden interest in COVID patients and their rehab needs but it is all ICU patients that need it.	i
Video and teleconferencing to patients	f
2 weeks post-discharge telephone follow up in addition to the usual 2-3 months post discharge follow up clinic, virtual clinics (so far telephone only)	d, j
Improved follow-up from ICU Therapists from ICU to ward. Improved connections with specialist rehab services. Unable to offer gym 1:1 follow-up rehab.	b, h
Face to face clinics now on a virtual platform; peer support meeting to go on Zoom virtual platform. Forced reduction of follow up service for non-covid patients. In-patient rehab support and information for covid patients but now discontinued due to staff returning to clinical areas. Support from the Rehabilitation clinical team for non-ventilated ICU covid patients i.e. had NIV only	i, l
Not critical care linked but follow up outpatient appointments for COVID patients within the respiratory department, linked with a clinical psychologist. Cards sent to critical care patients post COVID offering them to get in touch/ meet with members of staff to discuss their ICU stay	e, n, o
Daily physio input to covid patients as part of outreach team as 6 week pilot Referral pathway to clinical psychologist via outreach Letter to patient's home explaining ICU journey Extended outreach on the ward including family support Telephone screening of problems prior to follow up clinic Transition from face-to-face to telephone clinic[#]	d, h, k
Our service has been put on hold temporarily due to staffing constraints	i
Critical care rehab team changed referral criteria to pick up all patients from ICU with Covid-19. Covid-19 rehab guide produced for inpatient and to continue once discharged. Covid-19 MDT in community is being developed. Follow Up clinic has stopped due to lockdown and acute caseload. Not yet restarted but patients highlighted are being called by Intensivist.	i, k
Increased number of clinics and expansion of personnel	h, j
MDT approach and referrals pathway	h
Increased ITU beds, Increased number of clinics More professionals involved. Video consultation intensive care follow up clinics[#]	h, j, l
A new Covid19 follow up clinic has been set up combined with respiratory team.	b, e, o
Psychology support for patients and relatives	b, h
Routine video clinic for most patients (with option of face-to-face review if required). Sooner first review (4 weeks rather than 8-12 weeks)	l, m
Initially clinic paused therefore generated waiting list. Criteria remains > 3 days on critical care. Have introduced telephoning screening system, inclusive of locally designed symptom screening questions, PHQ2, GAD2, and trauma screening questionnaire to identify patients who need MDT	i, k, l

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review in follow-up clinic. If patients score > 3 on screen, > 3 on PHQ2 or GAD2, or >6 on TSQ they are invited to clinic. This screening is completed by a nurse, occupational therapist or physiotherapist. Patients who have ongoing symptoms are invited to clinic, they can attend via teleconference, face-to-face or virtually via attend anywhere. Our clinic team now includes an occupational therapist, based on temporarily agreed funding.	
Remote clinic	l
Expansion by 46 beds Recruitment of 15 consultants, 30 trainees, and ~200 nurses[#]	a
COVID follow up. Video conferencing clinic appointments, patients can no longer be taken back to the ITU - setting up virtual reality tours. No diaries kept during COVID - looking into virtual diaries. More interest in MDT follow up.	h, l
Considering doing outpatient follow up clinic virtually - allocated team reaching into ICU and following patients up on ward -physio led virtual clinics for all critical care patients - all post covid patients discharged from hospital, will be seen in a virtual physio led clinic	b, f
Additional clinics and more physiotherapy services	h, j
Review of services - COVID evidence/guidance as instigated review of critical care unit follow up services	b
There are plans for a follow up service	b
Increased from x2/month to x2/week. Face to face to video/telephone consultation with Respiratory physicians doing face to face clinic with investigations of heart and lungs in hospital. We focused on holistic, cognitive and psychosocial aspects. Funded via Covid block payment[#]	h, j, l, o
All initial assessments done over telephone, but greater input earlier in discharge process. MDT input from respiratory team	j, k, o
Increased use of phone and video call follow up	k, l
Follow up service currently on hold, although many patients have been written to and sent an ICU Steps booklet. These patients will be followed up virtually In due course. New build planned with expanded number of beds, and then re-purposing of existing beds for respiratory beds and level 1.5 beds	i, l
Nil	a
Delayed as still significant covid demand. All clinics have been cancelled & telephone clinics have been set up but hindered by lack of resources & information	j, k
Face to face clinics suspended. Support groups suspended. Home visits carried out as per government guidelines maintaining social distance at all times	i
Not aware	a
The patient support group has not been running due to social distancing and members of the public not being able to attend the hospital. The Critical care Outreach team implementation has been delayed. (it is a new service)	b, i
We have had funding for 2 rehab techs to follow pts from ITU to the ward and then home to give physical support. This funding was secured prior to Covid but has the staff have started this month so in line with Covid.	b, e
We have seen our COVID patients at 2-3 weeks post discharge instead of 2-3 months and have instigated a rehab course for them in conjunction with pulmonary rehab team[#]	j, l, m, o
We started the first follow up clinic last week virtually. We plan on continuing with the virtual clinics[#]	l
We have gone to virtual clinics. The numbers are high. It pushed the follow up agenda. During the COVID-19 response the unit now has 2 clinics that it contributes to, developed from a need to provide critical care input alongside respiratory for follow-up of all ventilated COVID-19 patients as part of the British Thoracic Society's follow-up recommendations. One clinic is led by one consultant (dual Intensive Care Medicine/Respiratory) that follows up all patients at 12 weeks (or thereabouts) in terms of physical/cognitive/psychological symptoms, and co-ordinating any on-going need for investigation/management. This clinic runs on one or two afternoons a week dependent on clinical availability of that consultant, and only started in July. It is a face to face clinic, and several screening questionnaires are used as part of the appointment. The other clinic that has been created out of the COVID-19 response is a virtual multi-disciplinary clinic (hosted on Attend Anywhere) involving consultant intensivist, psychologist and physiotherapist. They each have a half hour slot with the patient for their assessment. It runs once a week, and three consultants contribute to it. It includes all heath	a, b, e, f, h, l, o

board patients that have been ventilated on the unit for 72 hours or longer. It was initially established in July as well, as a way of attempting to deliver the 6 week virtual COVID follow-up as per the BTS recommendations, but also follows up non-COVID patients[#]	
Psychology now directly involved (previously ICU consultant would screen and refer as needed which incurred some delay) and attend each clinic visit along with the ICU consultant Clinics suspended for 3 months due to Covid activity and escalated rotas. Unable/unwise to bring patients to hospital during lockdown so virtual clinic format set up. Due to service reconfiguration, the area formerly used for ICU clinic is unavailable, so virtual clinic will continue for the foreseeable future. Virtual format works reasonably well but it limits our ability to bring patients into the physical space of the ICU environment which many patients found very useful. We have replaced this with sharing pictures and videos over Zoom which is good but not ideal. We have found in the virtual format we have less contact with family members. In a face-to-face clinic a family member would usually attend with them and we were able to give them some support and debrief too. Patients seem less likely to involve family members on video call for some reason	b, i, l, n
New pilot service established for COVID patients - combination of virtual and face to face. Intensivist/physio/psychology team and hope to get an exercise program delivered virtually[#]	b, e, f, g
n/a	a
Face to face abandoned during Covid surge. Now reinstated but backlog of cases so some telephone triage occurring. Patients currently attending later after discharge than previously	i, k
We will need to do virtual clinics and lose the peer support but we will aim to bring back face to face clinics asap	i, l
Along with another hospital in the health board, we have applied for funding for a post covid follow up clinic	b
n/a	a
Nil	a
Timing, use of virtual clinic, videoconferencing. Work starting for respiratory follow up for all COVID patients admitted to level 2 or level 3 May have a one stop clinic involving many specialties specifically for COVID patients which is (organisation) wide. Still all in pipeline. Otherwise clinics will be virtual rather than meeting with limited peer support	b, l, o
No changes at present	a
Unable to offer class format so at planning level re moving forward. Phone call check-ins are commencing. Virtual appointments have been discussed but concerns re; funding and staff availability. Time consuming processes so trying to factor that in.	i, k
Cancellation of face to face reviews/ exercise classes. Move to telephone assessments in first phase. Then videoconferencing if deemed useful. Likely to result in significant reduction in what can be offered.	i, k
Testing delivery virtually via telephone and Near Me	k, l
Programme now virtual/online	l
Formal follow-up not been continued- currently on hold. Support given to bereaved families with psychology support. Letters/phone call follow up	i
No new staffing but more formalised ICU follow-up service and screening being planned with relevance to what we already do and what we could do more in a joined up fashion. All covid positive pneumonia patients have been triages and follow-up as deemed necessary within existing pulmonary rehab services.	b, h, o
During COVID the Critical Care Outreach Team were redeployed to other posts and the service was disbanded temporarily.	i
New Post ICU follow up service now partially funded	b, e, f
We have just received funding to set service up	b
1. New bi-weekly MDT initially for COVID patients but thus far has extended, at least for now, to include non-COVID patients. 2. "Tailored Talks" as discussed earlier. Novel personalised information provision support service. 3. Chest, Heart and Stroke nursing support through telephone follow up post hospital discharge, as previously mentioned	d, h, j, o
Nil	a

Unable to deliver current group model. We have started to try and deliver a virtual programme to individuals using near me consultations and assessments. We are also considering delivering presentations remotely via videoconferencing links.	i, l
Massive impact on ability to deliver ward based follow up. Patients no longer attending hospital for follow up clinic. Now exploring the use of technology for virtual follow up clinic. Using a lot more telephone consultations. However, this has given us an opportunity to rethink how we do things and as a consequence we are developing a more joined up service using the MDT.	b, k, l
There has been no changes to our service. In fact this service was cut for the first 4 weeks of the pandemic to allow staff to be pulled to deliver direct patient care.	i
We had disruption of our service due to Covid	i
Hospital wide Post-COVID discharge follow up service. We are also developing a post Critical Care follow up service for post-COVID patients.	b, h

*Responses reported verbatim with the exception of edits made to ensure no identifiable detail. #Indicates a response that applied to more than one individual hospital within an overarching healthcare organisation.
Abbreviations: MDT = multidisciplinary team; ICU/ITU = intensive care/therapy unit; OT = occupational therapy; SLT = speech and language therapy.

References

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