D02/S/a

NHS STANDARD CONTRACT
FOR SPECIALISED REHABILITATION FOR PATIENTS WITH HIGHLY COMPLEX NEEDS (ALL AGES)

SCHEDULE 2 – THE SERVICES A. SERVICE SPECIFICATIONS

Service Specification No.	D02/S/a
Service	Specialised Rehabilitation for patients with highly complex needs (All Ages)
Commissioner Lead	
Provider Lead	
Period	12 months
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

National Context

This specification covers Specialised Rehabilitation for patients with highly complex needs. It concerns the tertiary and specialised rehabilitation for patients as opposed to secondary or local community rehabilitation.

Rehabilitation is a process of assessment, treatment and management by which the individual (and their family / carers) are supported to achieve their maximum potential for physical, cognitive, social and psychological function, participation in society and quality of living(1). Patient goals for rehabilitation vary according to the recovery trajectory and stage of their condition.

Specialist rehabilitation is delivered by a multi-professional team who have undergone recognised specialist training in rehabilitation, led /supported by a consultant trained and accredited in rehabilitation medicine (RM) or neuropsychiatry in the case of cognitive / behavioural rehabilitation(2). Services are identified on the basis of complexity of their caseload.

Following illness or injury, the majority of patients requiring rehabilitation will progress satisfactorily with the support of the local non-specialist rehabilitation services. Those

with more complex needs may require referral to their local specialist (Level 2) rehabilitation services. A small number of patients with highly complex needs require the staff expertise and facilities of **tertiary specialised (Level1) rehabilitation** services which are the subject of this specification. (Please see Annex 1 for more details on the different categories of patient needs and levels of rehabilitation service)

Table 1 below gives examples of the types of condition that commonly give rise to complex disability and may require tertiary specialised rehabilitation services.

Table 1: Some of the conditions that commonly give rise to complex disability as classified by the Long Term Conditions National Service Framework

Sudden onset conditions	• Acquired brain injury, due to any cause including trauma, severe stroke, subarachnoid haemorrhage, meningitis, encephalitis, vasculitis, post-surgical, tumour, anoxia • **Spinal cord conditions** e.g. trauma with incomplete spinal cord injury, myelitis, myelopathy, vascular, tumour, combined brain/spinal cord injury • **Peripheral nervous system conditions** e.g. Guillain-Barre syndrome, neuropathy-post-critical-illness • **Multiple trauma**
Progressive and intermittent conditions	• **Neurological and neuromuscular conditions** (e.g. multiple sclerosis, motor neurone disease, Huntington's disease, muscular dystrophies, neoplasm, inherited metabolic disorders) • **Severe musculoskeletal or multi-organ disease** (e.g. rheumatoid arthritis with neurological complications) • **Physical illness / injury** complicated by psychiatric or behavioural manifestations
Stable conditions (with / without degenerative change)	• **Congenital conditions** e.g. cerebral palsy or spina bifida in children or adults • **Post polio or other previous neurological injury.** Many of these conditions may remain stable for years but subsequently progress with accrual of problems due to age-related change or other secondary complications.

It should be noted that diagnosis is known to be a poor determinant of rehabilitation needs. Instead patients may be more usefully described by their levels of impairment or disability or the complexity of their needs for rehabilitation (see below). A range of tools has been developed within the UK Rehabilitation Outcomes Collaborative (UKROC) programme to describe complexity of rehabilitation needs, the inputs provided to meet those needs, and the resulting outcomes.

'Tertiary specialised' rehabilitation services (Level 1) are high cost / low volume services, which provide for patients with highly complex rehabilitation needs following illness or injury, that are beyond the scope of their local general and specialist services.

- These are normally provided in co-ordinated service networks planned over a regional population of 1-3 million through collaborative (specialised) commissioning arrangements.
- Level 1 services may be further divided into:
    - High Dependency - a complex caseload with mainly high physical dependency
    - High Risk - a complex caseload of mainly 'walking wounded' patients with cognitive / behavioural problems who may be a danger to themselves or others, and/or at risk of wandering / absconding.

A small number of services cater specifically for:

- Extremely dependent cases, such as those in the immediate post-acute step down from neuro-intensive care with unstable medical needs, e.g. following acute trauma, stroke etc. or those requiring assisted ventilation etc.
- Extremely high risk cases, such as those with very severe physically aggressive behaviours or requiring treatment under section of the Mental Health Act.

1.2 The Evidence base

There is now strong research based evidence to show that:

- Rehabilitation in specialist settings for people with traumatic brain or spinal cord injury and stroke is effective and provides value for money in terms of reducing length of stay in hospital and reducing the costs of long-term care (3-5)
- Early transfer to specialist centres and more intense rehabilitation programmes are cost effective (6), the latter particularly in the small group of people who have high care costs due to very severe brain injury(7,8)
- Clinical and cost-benefits are similar for people with severe behavioural problems following brain injury (9)
- Continued co-ordinated multidisciplinary rehabilitation in the community improves long-term outcomes and can help to reduce hospital re-admissions (3).

Key Publications and References

1. National Definition Set for Specialised Services No 7: "Complex specialised rehabilitation for brain injury and complex disability (Adult)". Third Edition. London: Department of Health 2009.
2. Specialist neuro-rehabilitation services: providing for patients with complex rehabilitation needs. London: British Society of Rehabilitation Medicine 2010.
3. Turner-Stokes L, Nair A, Disler P, et al. Cochrane Review: Multi-disciplinary rehabilitation for acquired brain injury in adults of working age. The Cochrane Database of Systematic Reviews Oxford: Update software 2005; Issue 3.
4. Turner-Stokes L. Evidence for the effectiveness of multi-disciplinary rehabilitation following acquired brain injury: a synthesis of two systematic approaches. J Rehabil Med. 2008;40(9):691-701.
5. The National Service Framework for Long-term Conditions, Department of Health March 2005
6. Turner-Stokes L. The evidence for the cost-effectiveness of rehabilitation
7. Turner-Stokes L, Paul, S, Williams H. Efficiency of specialist rehabilitation in reducing dependency and costs of continuing care for adults with complex acquired brain injuries. JNNP 2006; 77: 634-639
8. Turner-Stokes L. Cost-efficiency of longer-stay rehabilitation programmes: Can they provide value for money? Brain Injury 2007 21(10):1015-21.

9. Oddy M and Ramos S. The clinical and cost-benefits of longer stay neurobehavioural rehabilitation. Brain Injury. in press 2013

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	
Domain 2	**Enhancing quality of life for people with long-term conditions**	✓
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	✓
Domain 4	**Ensuring people have a positive experience of care**	✓
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	✓

2.2 Key Service Outcomes

Tertiary specialised services play an important role in relieving pressure on acute services and facilitating discharge to the community or on-going placement. Therefore all units report process data including

- Response times – waiting times for assessment, admission etc.
- Length of stay
- Discharge destination

Key service outcome:

Patients (and their family / carers) are supported to achieve their maximum potential for physical, cognitive, social and psychological function, participation in society and quality of living.

Key measurable outcomes:
The relevant outcome measures may vary from individual to individual, but services are required to record one or more of the following key standardised measures which are collated and reported through the UKROC database:

- Functional gain measured by change in the UK Functional Assessment measure

(FIM+FAM) – a global assessment of functional independence reflecting both physical and psychosocial function.
Reduced requirement for on-going care and care costs in the community , measured by the Northwick Park Dependency Scale and Care Needs Assessment)

- Attainment of individual goals for rehabilitation measured by Goal Attainment Scaling (GAS)

Services are also required to collect a measure of patient satisfaction. A range of adapted tools has been developed to facilitate feedback from patients with cognitive / communicative impairments.

Other optional measures include measures of cognitive/behavioural function, quality of life tools, community integration and/or workability, as appropriate to the type of programme and intervention.

3. Scope

3.1 Aims and objectives of service

Tertiary specialised rehabilitation services support patients with complex disabilities whose rehabilitation needs are beyond the scope of their local rehabilitation services.

Key aims of the service are to provide rehabilitation for patients with complex needs in order to assist them to achieve their maximum potential for physical, cognitive, social and psychological function, participation in society and quality of living.

The services also play an important role in relieving pressure on acute services and facilitating discharge to the community or on-going placement.

3.2 Service description/care pathway

Service Delivery

Tertiary specialised rehabilitation services include a combination of individual and group-based interventions to support appropriate social interaction, communication, life and work skills.

They are primarily offered as time-limited in-patient / residential programmes, to provide a rehabilitative milieu and peer group for patients engaging in the programme.
However, they may also include associated activity such as:

- In-reach – assessment / advice and treatment for patients in acute care services awaiting transfer to specialised rehabilitation.
- Follow-up day-patient / out-reach / community programmes (again in time-limited) to extend support for patients with particularly complex needs to ensure carryover of gains in their community context.
- Intermittent review /surveillance for specific groups of patients with highly complex needs eg patients in continuing vegetative or minimally conscious states (VS/MCS) until either they emerge or a diagnosis of permanent VS/MCS is made.

Tertiary specialised rehabilitation is provided by a multi-professional team which has undergone recognised specialist training in rehabilitation, led by a consultant trained and accredited in Rehabilitation Medicine. The team works in a co-ordinated inter-disciplinary fashion towards an agreed set of goals

- The tertiary specialised service takes patients with more complex rehabilitation needs than local or non-specialist services and has specialist equipment, facilities and staffing levels to meet those needs, according to the definitions aid down by the BSRM document “Specialist neuro-rehabilitation services: providing for patients with complex rehabilitation needs” London 2010.
- The service supports local rehabilitation teams in hospital and community and has a recognised role in education, training in the field of rehabilitation
- The service meets the national BSRM standards for specialist rehabilitation

services and routinely collects

- The service reports at full national dataset for specialist rehabilitation (UK Rehabilitation Outcomes Collaborative (UKROC) dataset) for all case episodes.

Figure 1 shows an exemplar of the care pathway for patients with sudden onset injury. Tertiary Specialised activity under this definition is that shown in the yellow box.

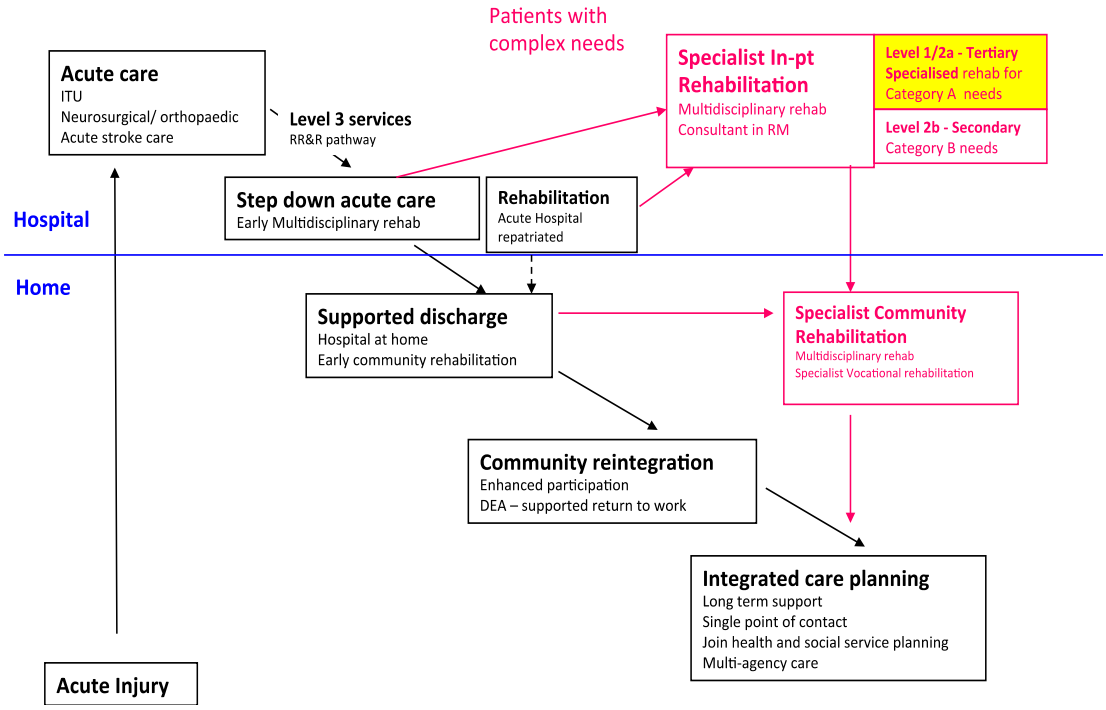

Figure 1 legend: The red part of the pathway represented specialist rehabilitation.
The tertiary specialised services covered by this specification are highlighted in yellow
The black part of the pathway is usually provided by non-specialist (level 3) rehabilitation services, for example through the Recovery, Rehabilitation and Re-enablement pathway.

Resources

Tertiary specialised rehabilitation services are provided in **dedicated rehabilitation units or wards**, under the care of a **consultant trained and accredited in rehabilitation medicine (RM)** or **neuropsychiatry**, depending on the nature of the programme.

They have highly specialised staff and facilities to meet the needs of their complex caseload. The BSRM has defined criteria for Level 1 and 2 services, including minimum staffing levels – see annex 2 and 3. Level 2a services will have staffing levels somewhere between those of a Level 1 and 2 service.

Care Pathway

Referral and assessment

Appropriate referral is usually made by a consultant or a community rehabilitation team Within the major trauma pathway, referral is often made via the Rehabilitation Prescription – a model which may equally apply in the context of other acute pathways including stroke and neurosciences

Assessment should be completed within 10 working days of the initial referral [domain 2]. It is best undertaken by a consultant in RM (or their deputy in the form of a senior member of the interdisciplinary team) who is able to determine the category of rehabilitation need and has a good knowledge of the range of alternative rehabilitation and care service options available within the region. Wherever assessment should also involve the individual's family / carers.

The outcome of assessment should be reported back to the referrer within 2 working days of the assessment. Assessment reports should include:

- An evaluation of clinical need, including assessment using the patient categorisation tool
- A recommendation of service(s) most likely to meet the assessed need
- An indication of the ability to benefit from rehabilitation and possible outcomes
- Aims of admission
- An indication of the likely duration of specialist rehabilitation
- The likely discharge destination and care and support needs on discharge.

Patients should be admitted to the facility assessed as best to meet their needs within 6 weeks of being fit for transfer to rehabilitation [domain 2].

Local Clinical Commissioning Groups (CCGs) retain overall responsibility for patients admitted to the service **in collaboration with** the Local Area Team commissioners for tertiary neuro-rehabilitation. Level 1/2a service providers should keep CCGs advised with respect to all assessments, admissions and discharges.
(See Notification Procedures for Specialised Rehabilitation for reporting forms Appendix 3)

Tertiary Inpatient Rehabilitation Programmes

Rehabilitation is a process of assessment, treatment and management by which the individual (and their family / carers) are supported to achieve their maximum potential for physical, cognitive, social and psychological function, participation in society and quality of living.

Patient goals for rehabilitation vary according to the recovery trajectory and stage of their condition. Specialist rehabilitation services may be provided along three main (frequently overlapping) pathways:

- **Restoration of function** (e.g. for those recovering from a 'sudden onset' or 'intermittent' condition) where the patient goals are focussed not only on improving independence in daily living activities, but also on participatory roles such as work, parenting, etc.
- **Disability management** (e.g. for those with stable or progressive conditions) where the patient / family goals are focussed on maintaining existing levels of functioning and participation; compensating for lost function (e.g. through provision of equipment / adaptations); or supporting adjustment to change in the context of deteriorating physical, cognitive, and psychosocial function
- **Neuro-palliative rehabilitation** where the goals are focussed on symptom management and interventions to improve quality of life during the later stages of a progressive condition or very severe disability, at the interface between rehabilitation and palliative care.

Tertiary specialised rehabilitation is a time-limited programme (normally limited to a maximum of 6 months) focused on specific goals. Because individuals change at different rates, the length of intervention may vary.

- Many people with complex needs require rehabilitation programmes that last 3-6 months.
- Longer-term intervention is occasionally required, e.g. for severe neurological injury, and is shown to be highly cost-effective for some patients, particularly for young patients with catastrophic brain injuries(10, 11).
- Some patients will require repeated episodes of rehabilitation planned over a period of time, with intermittent periods of consolidation.
- The process for requesting time extension of a rehabilitation programme is described in 3.3 below.

Tertiary specialised rehabilitation service programmes fall broadly into four categories:

- Programmes for people with profound and complex physical disability
- Cognitive/behavioural rehabilitation programmes for people who are independently mobile but have severe cognitive / behavioural / neuropsychiatric needs
- Specialist community integration / vocational rehabilitation programmes
- Programmes for children, adolescents (including 16-18 year olds) or young adults who require tertiary specialised rehabilitation in the context of schooling or on-going education, some of whom may have may have particular needs with regard to safeguarding and consent issues.

Tertiary specialised rehabilitation services vary in their emphasis, but encompass some or all of the following elements:

- Hyper-acute rehabilitation taking patients directly from acute or intensive care settings eg neurocritical care, major trauma centres etc who still have acute or unstable medical/surgical or trauma care needs
- Medical care in the context of the individual's rehabilitation (including specialist procedures / investigations, and acute out-of-hours medical cover – depending on the caseload)
- Tracheostomy and / or ventilator care

- Assessment / management of vegetative and low awareness states, including medico-legal issues and support for families in extreme distress
- Cognitive and / or behavioural management, including challenging, aggressive or violent behaviours
- Neuropsychiatric care, including risk management, treatment under sections of the Mental Health Act 1983 as amended by the 2007 Mental Health Act
- Special facilities: assistive technology such as specialist seating systems, orthotics, environmental control systems / computers or communication aids
- Specialist interventions e.g. spasticity management with botulinum toxin
- Surgical implants/interventions (e.g. intrathecal baclofen or follow-up procedures e.g. tenotomy, dorsal rhizotomy, deep brain stimulation) may be arranged in conjunction with the rehabilitation service subject to appropriate specific funding arrangements
- Specialist vocational rehabilitation services / support to return to work / education.

Within a given geographical area there should be access to a range of tertiary specialised rehabilitation services including:

- Programmes for people with complex physical disability,
- Cognitive/behavioural rehabilitation programmes for people who are independently mobile
- Programmes for patients with profound disability requiring very high level nursing /medical and/or therapy needs (eg those with tracheostomies or requiring assisted ventilation)
- Assessment /management of vegetative and minimally conscious states (dedicated units)
- Specialist community integration / vocational rehabilitation programmes
- Programmes for children or adolescents (including 16-18 year olds)

Initial assessment period

Providers will arrange a goal setting meeting within 10 working days of admission involving the individual and their family (if appropriate).

A full assessment will be completed in [an agreed number] of weeks [to be agreed between provider and commissioner depending on anticipated length of stay].

The assessment will include an outline of the goals agreed for the individual and an indication of the likely date, destination and needs on discharge. This should be communicated to the commissioner if it varies considerably from the initial assessment report.

Active rehabilitation

- A goal planning process should be in place.
- Progress against goals should be reviewed at least every two weeks.
- Family and carers should be involved in the goal setting and rehabilitation

programme where appropriate.

In-reach / Outreach

In general community-based rehabilitation is provided by local community rehabilitation teams commissioned by CCGs. However, an important role of tertiary specialised rehabilitation services is to provide outreach support for acute services or local specialist and community rehabilitation teams. This may take the form of assessments, support and shared care for management of complex disability, or on-going review and surveillance for patients who needs are beyond the scope of their local specialist rehabilitation services. Tariffs are currently under development for community outreach services provided under this programme

Education and Training

Clear policies should be in place to ensure that staff maintain and develop their specialist skills and knowledge which should include:

- Access to specialist rehabilitation journals and textbooks
- Time allocated for regular training
- Support to attend conferences and courses within the field of special expertise.

Many of the tertiary specialised units play an important role in research and development of the much needed evidence base for effective rehabilitation interventions. In some cases this will be through formal academic links, in others as part of NHS R&D activity. Involvement in clinical research will be recognised as an integral part of the service

Discharge Planning, Continuing Care and care closer to home (Appendix 2)

Communication

Service User and Care Information

This should include:

- up-to-date information about the service provided to patients and family/carers by the rehabilitation unit (in written and spoken form, and via its website);
- information and advice about disability benefits
- information about further rehabilitation services, relevant community services and specialist and other support groups;
- information about useful publications produced by the voluntary sector (including some copies kept in the unit)
- signposting to relevant helplines; and
    - to benefits and support/advice/advocacy organisations; and
    - to information and signposting services themselves.

Information should be provided in a variety of formats to enable it to be available to all who need it, including those with communication and cognitive difficulties.

Patient and public engagement (PPE)

It is important that patients and family/carers are engaged in all relevant aspects of the rehabilitation process, in order that the rehabilitation itself is most effective on an individual basis; and the effectiveness of the service as a whole is optimised

Rehabilitation should be a collaborative process between the rehabilitation team and the patient and family/carers

The family/carers should (subject to consent) be involved, as appropriate, in the assessment, goal setting, rehabilitation and discharge-planning processes. They should, in effect, be regarded as part of the team.

Education

There is a need for education of patients and family/carers about the neurological (or other) condition and its effects, and possible approaches to dealing with them.

Specific support for family/carers

This should include:

- individual support (including psychological support / counselling / psychotherapy)
- group support, including psychological support and peer support through facilitating contact with other family/carers, including those of ex-patients
- support/training with managing particular difficulties (physical /cognitive/ behavioural)
- support in considering their own role vis-à-vis other (paid) care and support services
- support with developing coping strategies

Consultation with, and representation of, patients and family/carers

A designated staff lead for the service should enable engagement of patients and family/carers.
Mechanisms should be established to consult patients and family/carers on:

- day-to-day, on-going matters - through an independent route - possibly involving volunteers, who can facilitate communication between patients & family/carers and the clinical team; and
- all aspects of running the service; and more-strategic matters, such as service development, and the planning and delivery of changes - this should be through a 'service user group' and involve ex-patients and their family/carers and, possibly, representatives from local voluntary organisations

There should be structured feedback of views from patients and family/carers about all aspects of the service and PPE activities and initiatives:

- through questionnaires, focus groups, and other means
- both during the patient's stay and on discharge

Governance, Audit and Research

Providers of specialist neurorehabilitation should have an active audit programme and be able to demonstrate that they are working towards the implementation of the Quality Requirements in the NSF for Long Term Conditions.

Effective interdisciplinary working should be in place including:

- Multi-disciplinary notes
- Combined goal setting, combined objectives and combined evaluation process
- Regular opportunities for multi-disciplinary training.

In addition to reporting data on process, complexity and outcomes to the UKROC dataset, providers should record and audit

- Lengths of stay and discharge destination
- Evaluation of client-centred goals achieved or goal attainment scaling
- Numbers of staff and ratio of senior staff
- Multi-disciplinary training undertaken
- How users and carers are involved
- Information provided to patients and carers
- Adverse and near miss incidents and complaints
- At least one validated standardised outcome measure appropriate to the client group managed.

Following each discharge an interdisciplinary team case review should be conducted to look at positive and negative lessons learned from aspects of the person's care and achievement of goals.

All staff should be subject to annual performance appraisal and a policy should be in place to govern this.

The unit should undertake a periodical assessment of progress against pre-agreed goals for its engagement with patients and family/carers, and report this to its Trust Board and to the appropriate Specialised Commissioning Group (the latter through the UKROC database)

There should be an independent audit of individual providers' performance on PPE matters

Data reporting

Activity and benchmarking (needs inputs and outcome) data is routinely reported for each case episode to the UKROC dataset and is a condition for reimbursement under this definition. The resources for data collection and reporting should be built into the contract pricing arrangements. Providers will ensure that data are submitted in a timely manner. UKROC is currently grant funded and has agreement with NHS England to provide

collation of activity and commissioning data, annual reporting benchmarking analysis and feedback to commissioners and providers according to an agreed specification.

3.2 Population Covered

The service outlined in this specification is for patients ordinarily resident in England*; or otherwise the commissioning responsibility of the NHS in England (as defined in Who Pays?: Establishing the responsible commissioner and other Department of Health Guidance relating to patients entitled to NHS care or exempt from charges).

*Note: for the purposes of commissioning health services, this EXCLUDES patients who, whilst resident in England, are registered with a General Practitioner (GP) Practice in Wales, but INCLUDES patients resident in Wales who are registered with a GP practice in England.

The SSNDS defines four categories of patients (A,B,C,D) with different levels of rehabilitation need. **Category A patients** are those with **complex needs** who require specialised rehabilitation services. (See Annex 1 for more details).

NHS England will commission:

- All category A patients from Level 1 and 2a specialist rehabilitation service providers (as determined by UKROC)
- All Inpatient, ITU, Day case, and outpatient (including outreach activity) associated with the category A patient (as determined by UKROC) will require identification in trust systems and activity attributed to commissioners of prescribed specialised services.
- All health care organisations providing specialist rehabilitations are required to record patient information in UK Rehabilitation Outcomes Collaborative (UKROC) database as population of the database will determine the category of the patient.

Patients with Category A needs who require rehabilitation in Tertiary specialised services typically require one or more of the following:

- Intensive, co-ordinated interdisciplinary intervention from 4 or more therapy disciplines, in addition to specialist rehabilitation medicine/nursing care in a rehabilitative environment
- Longer programmes - typically 3-4 months, but sometimes up to 6 months (and occasionally up to 12)
- Very high intensity input – e.g. 1:1 nurse “specialing”, or 2-3 trained therapists at one time
- Highly specialist clinical skills (see table 1 for details)
- Neuropsychiatric care, including risk management, treatment under the Mental Health Act (This definition may include treatment under MHA section for short periods, usually up to 2-3 months. Patients requiring longer term treatment insecure settings are covered under the specialist mental health definitions)

- Higher level facilities /equipment such as bespoke assistive technology
- Complex multi-agency vocational rehabilitation /support
- On-going management of complex / unstable medical problems in an acute hospital setting

Patients requiring specialist **neuro-palliative** rehabilitation services are typically those with profound or total disability (e.g. vegetative or low awareness states).

- Their needs are often substantial and on-going and typically include support for family members as well as the patient him/herself.
- The Level 1 unit team often works closely with community rehabilitation teams, specialist nursing homes and palliative care services to support individuals during the later stages of their condition.

Children may require tertiary specialised rehabilitation services to establish a window of opportunity which allows normal development to progress, including learning through play as well as integration into a peer group, into the community and local schools. Adolescents and young adults (e.g. 16-25 years) may have particular needs with regard to safeguarding and consent issues, and may require tertiary specialised services which combine rehabilitation with on-going education and development across the transition to adulthood.

3.3 Any acceptance and exclusion criteria and thresholds

Acceptance Criteria

Services provided under the scope of the current definition of 'Specialised rehabilitation for patients with highly complex needs' are:

Tertiary specialised rehabilitation delivered in **designated services** which may include:

Level 1 units – serving a catchment >1 million population

- With a very high proportion (>85%) of patients with Category A needs. (Because nearly all patients are category A and geographic distribution is wide, all patients in Level 1 services will be included, provided they demonstrate on an annual basis that the proportion is >85%)

Level 2a units – particularly where there is insufficient coverage/capacity in Level 1 services

- for category A patients only
- Providing the unit has appropriate facilities, expertise and staffing ratios to meet the needs of their caseload, and meets the required criteria. Level 2a services will typically have a catchment of ≥750K population

Under this definition, services are registered and activity identified through the UK Rehabilitation Outcomes Collaborative (UKROC) Database, which is also the vehicle for administration of the multi-level weighted bed day tariff (the commissioning currency for

specialist rehabilitation services). **Confirmation of eligibility for Level 1/2a status requires submission of the full UKROC dataset for all directly commissioned cases.**

The separation of this activity from acute care therefore does not present a problem as there is a defined point of admission to the unit or transfer of care to the RM Consultant, and a defined point of discharge home or to another programme of care, with UKROC data collection at each point.

Services are commissioned on the basis of named designated units, identified through their registration with the UK Rehabilitation Outcomes Collaborative (UKROC) Database.

NB Submission of the full UKROC dataset for each case episode is a mandatory requirement for reimbursement under direct NHS England commissioning within the designated level 1 and 2a services. This is essential to avoid any possibility of double charging

Requests for extension

Anticipated programme length will be agreed with the provider at an early stage in the programme.

- Lengths of stay for this type of service are typically 3-4 months, but depend on the trajectory for recovery and the goals for rehabilitation
- The maximum length of stay will normally be 6 months.

In exceptional cases it may be reasonable to extend the programme, so long as there are clearly defined goals that are agreed by both provider and commissioner to be of significant benefit to the patient, their carers or on-going care providers. Under these circumstance a request is made in writing at least 2 weeks prior to the planned discharge date, detailing:

- The reasons for the request
- Confirmation that they still have category A needs that cannot be met by their local specialist or general rehabilitation services
- Progress to date and the anticipated additional gains to be derived from the extension
- A specified goal set for the extension period
- How outcomes from the extension will be evaluated using an agreed set of outcome measures.

The process for applying for and agreeing extensions is further defined in the Notification procedures for Specialised Rehabilitation (Appendix 3).

- The commissioner will set up an independent Clinical Advisory Panel to review requests for extension.
- After the final discharge, the provider must supply an extension report, documenting the extent to which the stated goals were achieved, and an evaluation of progress against the outcome measures that were agreed at the

point of granting the extension.

3.4 Exclusion Criteria

Rehabilitation services that are outside the scope of this definition are delivered by:

- Non-category A patients in designated Level 2a units
- Level 2b units - these provide 'local specialist rehabilitation' service mainly to patients with Category B needs. (It is expected that Level 2b services will have a small proportion of patients with Category A needs (<30% at any one time), where the patient's rehabilitation needs are best met locally and the unit has the appropriate skills and facilities to manage them)
- Level 3 services - these provide rehabilitation in the context of acute or intermediate care services to Category C and D patients.

The following activity is excluded from the definition:

- Long-term care/support (such as that offered in specialist nursing homes or slower stream rehabilitation facilities over periods of 12 months or more)
- Purely community/ out-patient programmes
- Rehabilitation for patients with category B-D rehabilitation needs
- Rehabilitation delivered in local or non-specialist (Level 2b or 3) services
- Case episodes not meeting the data reporting requirements (full UKROC dataset)
- Children who may have complex rehabilitation needs but also require management in the context of a paediatric neuroscience centre. (These children fit better under definition 'Paediatric Neurosciences')
- Specialist equipment for on-going care needs and post-discharge

Exclusion criteria are set for the individual services, and depend on the particular nature of the service provided and the local availability of other more suitable services

- Certain conditions that may be better treated in other specialist services e.g.
    - Complete spinal cord injury (require dedicated spinal injuries unit),
    - Very severe challenging behaviour or forensic problems
    - Those requiring longer detention under Mental Health Act
- Medical instability that would require an acute general hospital setting
- Those under a threshold age for adult services (<16 years), or over a ceiling age limit for children's services
- Frail elderly patients with multiple comorbidities

3.5 Provision of Specialist Equipment

NHS England commissions complex disability equipment to support patients with complex physical disabilities (including those with a combination of physical, sensory, intellectual, learning or cognitive disabilities) include the specialist assessment for, and provision of (if indicated)[1]. Equipment for on-going needs and post-discharge is outside

[1] D01a,b,c,d Complex Disability Equipment

the scope of NHS England, but is essential to ensure that the gains from SPECIALISED rehabilitation are carried over after discharge

CCGs should be informed of any on-going equipment needs as soon as they are identified. It is expected that the CCGs will be responsible for ensuring that essential equipment to meet on going needs for 24 hour positioning/ postural management (in particular appropriate special seating, wheelchair, standing frame, pressure management etc.) is provided in a timely manner to support discharge and so avoid delayed discharges.

3.6 Interdependencies with other services/providers

Specialised rehabilitation services share service co-dependencies with a number of specialities, including:

- Imaging and diagnostic services
- Expertise from other medical specialties including neurology, neurosurgery, neuropsychiatry, stroke services, cardiovascular services, PEG and tracheostomy services, trauma and orthopaedics, maxillary facial services, paediatrics
- Acute emergency medical and surgical cover out of hours.
- Tertiary specialised rehabilitation services provided under this definition have inter-relationships with other SSNDS definitions - notably:
- Paediatric Neuroscience
- Spinal injury
- Adult neurosurgery
- Burns care
- Major Trauma
- Complex disability Equipment
- Neurosciences
- Specialist rheumatology
- Specialist Pain
- Specialist orthopaedic services
- Specialist mental health services

Service Providers will ensure that there is effective communication and a common understanding of working practices between specialised rehabilitation services and primary and secondary health care agencies, specialised equipment services, social services, the voluntary sector, and education, strategic clinical networks, and Local Authorities.

NB This specification includes short term neuro-behavioural rehabilitation for patients with moderate to severe challenging behaviours in programmes of up to 6 months, subject to the conditions described above including full data reporting to UKROC.

Extension requests for up to 6 months may be supported if accompanied by documented evidence of functional gain and cost-benefits confirmed through post-hoc evaluation[2].

Longer term 'slow-stream rehabilitation' or containment in programmes > 1 year are not covered by this specification but will be commissioned through the Long-term conditions commissioning pathway. Patients requiring longer term treatment in secure settings under section of the Mental health Act are covered under the specialist mental health definitions

NHS England Clinical Commissioning policies and Statements
None

4. Applicable Service Standards

4.1 Applicable national standards e.g. NICE

Core requirements of the service

Providers of tertiary specialised rehabilitation services should demonstrate that their services are based upon accepted good practice. The following national guidelines and standards are commended:

- National Service Framework for Long Term Conditions (in particular Quality requirement 4 which provides evidence based markers of good practice)
- Standards for specialist in-patient and community rehabilitation services – British Society of Rehabilitation Medicine BSRM 2002 www.bsrm.co.uk/ClinicalGuidance
- Referenced recommendations for best practice in cognitive rehabilitation, Kit Malia 2002
- Rehabilitation following acquired brain Injury: national clinical guidelines. (Turner-Stokes Ed.) BSRM / RCP London 2003.
- NICE guidelines for the Management of Multiple Sclerosis in Primary and Secondary Care in the National Health Service

Service requirements are to:

- Provide an interdisciplinary assessment as early as possible
- Deliver well planned, goal oriented specialist rehabilitation at the appropriate intensity for the person
- Support the person, their family and carers to contribute to planning the rehabilitation process
- Provide an appropriate environment and infrastructure, including any specialist

[2] Turner-Stokes L. Brain Injury 2007 21(10):1015-21; Oddy M and Ramos S. The clinical and cost-benefits of longer stay neurobehavioural rehabilitation. Brain Injury. in press 2013

health equipment required to meet the needs and goals of the client group
- Be able to meet the spiritual and cultural needs of individuals.
- Have strong links to the community, including social services and housing departments to provide a co-ordinated transition of care
- Work with wheelchair centres and integrated community equipment services to co-ordinate provision of specialist equipment
- Plan and effect a coordinated discharge to an appropriate location with adequate support involving housing, social services and other relevant agencies in early discharge planning.

In addition services should:
- Inform commissioners at regular agreed intervals about an individual's progress to enable forward planning
- Use a key worker system i.e. each individual is allocated a named person as their main point of contact and communication with the rest of the team
- Provide information on the services and support available for service users and their carers, to assist them in meeting rehabilitation goals and to manage the impact of the condition on their lives
- Have measures in place to avoid delayed discharges.
- Have strong links to the community, including social services and housing departments to provide a co-ordinated transition of care
- Work with wheelchair centres and integrated community equipment services to co-ordinate provision of specialist equipment
- Plan and effect a coordinated discharge to an appropriate location with adequate support involving housing, social services and other relevant agencies in early discharge planning.

In addition services should:
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- Provide information on the services and support available for service users and their carers, to assist them in meeting rehabilitation goals and to manage the impact of the condition on their lives
- Have measures in place to avoid delayed discharges.

Core Standards

The **key criteria that identify a tertiary specialised (Level 1) service** are as follows(2):

	Criterion – Level 1 tertiary specialised services	**How identified**
1	It is **led by a consultant trained and accredited in RM**, and/or neuropsychiatry depending on caseload	UKROC registration • Service profile
2	It covers a **population of >1 million** patients, therefore requires **collaborative commissioning**	UKROC dataset – Clinical

		Commissioning Groups (CCG) code (or equivalent)
3	It caters for people whose needs are beyond the scope of their local specialist services and therefore has a **high proportion of patients with very complex rehabilitation needs (category A patients)** who typically require **longer lengths of stay** than in local services.	UKROC dataset: • 60-70% patients with Rehabilitation Complexity scale (RCS) score ≥10 • Patient categorisation tool > 85% Category A
4	It provides a **higher level of service** in terms of specialist staff numbers and expertise, facilities and programme intensity to meet those needs and is therefore a **high cost service**	UKROC registration • Service profile in comparison with standards (Annex 2&3)
5	It is registered with the UKROC and contributes the full UKROC dataset for every patient enrolled for treatment within the rehabilitation programme under the specialist commissioning programme	UKROC dataset: • Complete data submission for each completed episode • Activity reporting at 1-3 mth intervals
6	It also plays a recognised **Networking role** which includes • Supporting local specialist and general teams in the management of complex cases and • Acting as resource for **research and development,** as well as education and training.	UKROC registration • Service profile • Publication record, • R&D activity

It is recognised that services meeting the full criteria for Level 1 status do not currently provide full coverage for all parts of England. In areas of the country where there are no services that meet all the Level 1 criteria, or Level 1 services lack sufficient capacity to meet demand, some **level 2a services may qualify for designation as a tertiary specialised service, for category A patients only**.

Key identifying features of a qualifying level 2a service are laid out in the following table. Criteria 1, 5 and 6 are as for the level 1 services, criteria 2,3 and 4 (shown in blue) are adapted

	Criterion – Level 2a services	**How identified**
1	It is **led by a consultant trained and accredited in RM**, and/or neuropsychiatry depending on caseload	UKROC registration • Service profile
2	It covers an **extended catchment population** (600K-1m).	UKROC dataset –CCG code (or equivalent)

3	Has a mixed case load that includes **a proportion of patients with very complex rehabilitation needs (category A patients)** who typically require **longer lengths of stay** than in local services.	UKROC dataset: • >50% patients with RCS score ≥10 • Patient categorisation tool >50% category A
4	It has the appropriate facilities, expertise and staffing ratios to manage its proportion of category A patients. (Provision will be somewhere between the standard requirements for a level 1 and 2 service, depending in the proportion of category A patients and the overall complexity of the caseload)	UKROC registration • Service profile
5	It is registered with the UKROC and contributes the full UKROC dataset for every patient enrolled for treatment within the rehabilitation programme under the specialist commissioning programme	UKROC dataset: • Complete data submission for each completed episode • Activity reporting at 1-3 month intervals
6	It also plays a recognised **Networking role** which includes • Supporting local specialist and general teams in the management of complex cases and • Acting as resource for **research and development (R&D),** as well as education and training.	UKROC registration • Service profile • Publication record, • R&D activity

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

References

- National Definition Set for Specialised Services No 7: "Complex specialised rehabilitation for brain injury and complex disability (Adult)". Third Edition. London: Department of Health 2009.
- Specialist neuro-rehabilitation services: providing for patients with complex rehabilitation needs. London: British Society of Rehabilitation Medicine2010.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See Schedule 4 Parts A-D)
5.2 To be inserted when agreed for 14/15

5.3 Applicable CQUIN goals (See Schedule 4 Part E)
6. Location of Provider Premises
The Provider's Premises are located at: UKROC provides a list of providers with services suitable for designation as level1 / 2a and 2b, based on their service profiles and caseload complexity data reviewed annually.
7. Individual Service User Placement
NA

Annex 1: Categories of patient need and Levels of service

This service specification leans on the 3rd Edition Specialised Service National Definition Set (SSNDS) definition No 7: "Brain Injury and Complex Rehabilitation." [1]

The SSNDS definition No 7 defines

- Four categories of rehabilitation need (categories A-D) and
- Three different levels of service provision (Levels 1-3)
- These have been further defined by the British Society of Rehabilitation Medicine (BSRM) 2010 (2)

Following brain injury or other disabling conditions,

- The majority of patients have category C or D needs and will progress satisfactorily down the care pathway with the help of their local non-specialist (Level 3) rehabilitation services.
- Some patients with more complex needs (Category B) may require referral to local specialist rehabilitation services
- A small number of patients with highly complex needs (Category A) will require the support of tertiary 'specialised' services which are the services covered by this definition.

Patients with Category A rehabilitation needs (requiring Level 1 specialised services)

- Patients have complex or profound disabilities e.g. severe physical, cognitive communicative disabilities or challenging behaviours.
- Patient goals for rehabilitation may include:
  - improved physical, cognitive, social and psychological function / independence in activities in and around the home
  - participation in societal roles (e.g. work / parenting / relationships)
  - disability management e.g. maintain existing function; manage unwanted behaviours / facilitate adjustment to change
  - improved quality of life and living including symptom management, complex care planning, support for family and carers, including neuro-palliative rehabilitation.
- Patients have highly complex rehabilitation needs and require specialised facilities and a higher level of input from more skilled staff than provided in the local specialist rehabilitation unit. In particular rehabilitation will usually include one or more of the following:
  - intensive, co-ordinated interdisciplinary intervention from 4 or more therapy* disciplines, in addition to specialist rehabilitation medical / nursing care in a rehabilitative environment
  - medium length to long term rehabilitation programme required to achieve rehabilitation goals – typically 2-4 months, but up 6 months or more, providing this can be justified by measurable outcomes
  - very high intensity staffing ratios e.g. 24 hour 1:1 nurse "specialling", individual patient therapy sessions involving 2-3 trained therapists at any one time
  - highest level facilities / equipment e.g. bespoke assistive technology / seating systems, orthotics, environmental control systems / computers or communication aids, ventilators
  - complex vocational rehabilitation including inter-disciplinary assessment / multi-agency intervention to support return to work, vocational retraining, or withdrawal from work / financial planning, as appropriate.
- Patients may also require:
  - highly specialist clinical input e.g. for tracheostomy weaning, cognitive and / or behavioural management, low awareness states, or dealing with families in extreme distress
  - ongoing investigation / treatment of complex / unstable medical problems in the context of an

acute hospital setting
    - neuro-psychiatric care including: risk management, treatment under sections of the Mental Health Act
    - support for medico-legal matters including mental capacity and consent issues.
- Patients are treated in a specialised rehabilitation unit (i.e. a Level l unit).
- Patients may on occasion be treated in a Level 2 unit depending on the availability of expert staff and specialist facilities as well as appropriate staffing ratios.

Patients with Category B rehabilitation needs

- Patients have moderate to severe physical, cognitive and / or communicative disabilities which may include mild-moderate behavioural problems.
- Patient goals for rehabilitation may be as for Category A patients.
- Patients require rehabilitation from expert staff in a dedicated rehabilitation unit with appropriate specialist facilities.
- In particular rehabilitation will usually include one or more of the following:
    - intensive co-ordinated interdisciplinary intervention from 2-4 therapy disciplines in addition to specialist rehabilitation medical / nursing care in a rehabilitative environment
    - medium length rehabilitation programme required to achieve rehabilitation goals – typically 1-3 months, but up to a maximum of 6 months, providing this can be justified by measurable outcomes
    - special facilities/ equipment (e.g. specialist mobility / training aids, orthotics, assistive technology) or interventions (e.g. spasticity management with botulinum toxin or intrathecal baclofen)
    - interventions to support goals such as return to work, or resumption of other extended activities of daily living, e.g. home-making, managing personal finances, etc
- Patients may also have medical problems requiring ongoing investigation / treatment.
- Patients are treated in a local specialist rehabilitation unit (i.e. a Level 2 unit).

Patients with Category C rehabilitation needs

- Patient goals are typically focused on restoration of function / independence and co-ordinated discharge planning with a view to continuing rehabilitation in the community.
- Patients require rehabilitation in the context of their specialist treatment as part of a specific diagnostic group (e.g. stroke).
- Patients may be medically unstable or require specialist medical investigation / procedures for the specific condition.
- Patients usually require less intensive rehabilitation intervention from 1-3 therapy disciplines in relatively short rehabilitation programmes (i.e. up to 6 weeks).
- Patients are treated by a local specialist team (i.e. Level 3a service) which may be led by consultants in specialties other than Rehabilitative Medicine (e.g. neurology / stroke medicine) and staffed by therapy and nursing teams with specialist expertise in the target condition.

Patients with Category D rehabilitation needs

- Patient goals are typically focused on restoration of function / independence and co-ordinated discharge planning with a view to continuing rehabilitation in the community if necessary.
- Patients have a wide range of conditions but are usually medically stable.
- Patients require less intensive rehabilitation intervention from 1-3 therapy disciplines in relatively short rehabilitation programmes (i.e. up to 8 weeks)
- Co-ordinated discharge planning is a key goal for the rehabilitation programme.

- Patients receive an in-patient local non-specialist rehabilitation service (i.e. Level 3b) which is often led by non-medical staff.

* Therapy disciplines include: physiotherapy, occupational therapy, speech and language therapy, psychology, dietetics, social work, orthotics, rehabilitation engineering, vocational / educational support (including play therapy in children's settings).

A patient categorization tool has also been developed as a checklist to identify patients' as category A, B or C, and is included within the UKROC dataset. This tool may also be used to identify the Type of needs (i.e. high physically dependency or high risk cognitive behavioural) within Level 1 services.

The SSNDS definition No 7 also set criteria for three levels of service:

- Level 1 services - providing specialised rehabilitation services serving a catchment population > 1 million and taking a selected population of patients with highly complex needs (>85% category A).
- Level 2 units - providing 'local specialist rehabilitation' for a catchment population of circa 500K and taking a mixed group of patients but predominantly category B needs
- Level 3 services - these provide rehabilitation in the context of acute or intermediate care services to Category C and D patients. These include:
    - Level 3a – rehabilitation provided in the context of other specialist services
    - Level 3b - rehabilitation provided by local generic services.

However Level 1 services did not exist in all areas of the country and in some regions, an intermediate level of service had developed serving a 'supra-district' population circa 750K, and taking a higher proportion (50%) of category A patients. These were classified by the BSRM as Level 2a services to distinguish them from local (Level 2b) services. Further information on defining criteria and staffing levels for level 1 and 2 services may be found in Annex 2 and 3 [2]

Under this current specification, tertiary specialised rehabilitation encompasses all activity in Level1 services and Category A activity in Level 2 services. This is an interim scope for 3 years. During this period it is expected that some Level 2a services will increase their catchment and caseload complexity to fulfil the criteria for designation as a Level 1 service, whilst others will establish a more local commissioning pattern

Identification of activity and commissioning

All specialist rehabilitation services (Level 1 and 2) in England are required to be registered with the UK Rehabilitation Outcomes Collaborative (UKROC) database and to submit the UKROC dataset for all in-patient episodes.

- From April 2013, the UKROC database provides the commissioning dataset for specialist rehabilitation services in England
- The PbR guidance for 2013/14 mandates a 5-tier weighted per diem commissioning currency for level1/2a services
- UKROC is the vehicle through which this currency is operated, providing monthly activity reports to NHS England for all level 1/2a activity.

- Only activity counted through UKROC is eligible.

References

1. National Definition Set for Specialised Services No 7: "Complex specialised rehabilitation for brain injury and complex disability (Adult)". Third Edition. London: Department of Health 2009.
2. Specialist neuro-rehabilitation services: providing for patients with complex rehabilitation needs. London: British Society of Rehabilitation Medicine 2010. http://www.bsrm.co.uk/ClinicalGuidance/Levels_of_specialisation_in_rehabilitation_services5.pdf

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Annex 2: Defining Criteria for 'Local Specialist' and 'Tertiary Specialised' (Level 1) rehabilitation services (BSRM 2010 (2))

Criterion	Local specialist rehabilitation service (Level 2)	Tertiary specialised rehabilitation service (Level 1)
National standards	Meets the national standards for specialist rehabilitation laid down by the Royal College of Physicians and the British Society of Rehabilitation Medicine (BSRM).	
Specialist team	Rehabilitation is provided by a multi-professional team of nurses, allied health professionals (AHPs) and doctors who have undergone recognised specialist training in rehabilitation.	
Inter-disciplinary working practice	The team works in an inter-disciplinary, coordinated fashion towards an agreed set of goals to assist them to achieve their desired level of independence, autonomy and participation in society.	
RM Consultant leadership	Led or supported by a consultant, trained and accredited within the specialty of rehabilitation medicine with input from other specialists (e.g. neurology, psychiatry) as required.	Led by a consultant, trained and accredited within the specialty of rehabilitation medicine and/or neuropsychiatry.
Catchment	Catchment population typically 250-500 K (Level 2a: 600K-1m)	Catchment population typically ≥1 million
Complex caseload	Carries a more complex caseload than non-specialist services, as defined by agreed criteria (eg the Rehabilitation Complexity Scale (RCS) or equivalent)	Takes a selected group of patients with complex rehabilitation needs beyond the scope of their local general and specialist rehabilitation services (category A). These include patients with severe physical, cognitive communicative disabilities or challenging behaviours – (or other highly complex needs defined by NPDS/NPTDA scores),
Facilities	Has specialist facilities as appropriate to the caseload – e.g. assistive technology, specialist orthotics, special seating, spasticity management programmes	In addition to facilities for specialist rehab services, has higher level facilities as appropriate to caseload eg bespoke assistive technology, ventilators, acute/ specialist medical facilities, rehab engineering, etc.
Staffing	Has appropriately skilled staff in numbers sufficient to provide rehabilitation at a level of intensity commensurate with the patient's needs (see BSRM minimum standard staffing levels.)	Has higher level skilled staff and increased staff numbers to cope with complex case load.
Monitoring	It routinely monitors casemix and outcome data for the purpose of benchmarking and quality monitoring.	
	Systematically reports minimum mandatory Dataset for Specialist Rehabilitation Services through the national database (see Annexe 3)	Systematically reports full Dataset for tertiary specialised (Level 1) Rehabilitation Services through the national database (see Annexe 3)
Networking	Acts as a resource for advice and support to other professional staff in local general and community rehabilitation services	Acts as a resource for advice and support to local specialist, as well as general and community rehabilitation teams in the management of patients with complex disabilities.

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Education and training	Serves a recognised role in education, training for development of specialist rehabilitation in the field	Serves a recognised role in education, training and publishes audit/ research/development in the field of specialist rehabilitation	

Annex 3:

Minimum staffing provision for specialist in-patient rehabilitation services (BSRM 2010 (2))

	Local specialist rehabilitation service (Level 2)	**Tertiary Specialised rehabilitation service (Level 1)**	**For both types of service**
	For every 20 beds:	**For every 20 beds**	
Medical staff	1.2-1.5 Whole Time Equivalent (WTE) Consultant accredited in rehabilitation medicine 2 WTE training grades (above Foundation Year (FY)) and/or 1.5 WTE Trust Grade doctors	2-2.5 WTE Consultant accredited in rehabilitation medicine and/or neuropsychiatry, depending on nature of caseload 2-3 WTE training grades (abov FY) and/or 1.5 WTE Trust Grade doctors	**Plus** Trained therapy assistants, technicians. Access to rehab engineers and other professions as appropriate to caseload
Nurses	24-30 WTE (varies with dependency, but at least 1/3 should have specific rehab training)	25-35 WTE (varies with dependency, but at least 1/3 should have specific rehab or mental health training, depending on caseload)	
Physiotherapists	4 WTE	5-6 WTE (depending on physical demands of caseload)	
Occupational therapists	4 WTE	5-6 WTE	
Speech and language therapists	1.5-2.5 WTE (depending on whether patients with tracheostomy are accepted)	2-3.5 WTE (depending on proportion of patients with dysphagia, communication deficits and tracheostomy/ ventilation)	
Clinical psychologist/ counselling	1.5-2 WTE	2-3 WTE (depending on whether patients with severe behavioural problems are accepted)	
Social Worker / discharge co-ordinator	1-1.5 WTE	1.5-2 WTE (depending on catchment area)	
Dietician	0.5-0.75 WTE (depending on the proportion of patients on enteral feeding)	0.5-1.0 WTE (depending on the proportion of patients on enteral feeding / complex nutrition needs)	
Clerical staff	3.0 WTE, but dependent on caseload and throughput		

Note: These staffing levels support both the inpatient activity and associated out-reach work including assessments home-visits, follow-up, case-conferences etc. Additional resources are required if the services also offers community rehabilitation services

Tertiary specialised services taking patients with more complex needs the skill mix is adjusted to cater

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for the specific group of patients they serve – for example a cognitive behavioural rehabilitation services would require:

- A higher proportion of psychology / counselling staff
- Consultant neuropsychiatrist support
- A proportion of registered mental health nurses, and sufficient staffing levels to provide a safe environment for high risk patients, including 1:1 supervision when needed.
- Level 2a services, will require staffing levels somewhere between those of a Level 1 and 2 service, depending on the complexity of their mixed caseload
- A range of dependency tools to evaluate caseload complexity and staffing needs are currently in place and undergoing further development (e.g. the Northwick Park Nursing and Therapy Dependency Assessments).

(These recommendations are adapted from the RCP/BSRM National Guidelines for rehabilitation following Acquired Brain Injury 2003)

Appendix One

Quality standards specific to the service using the following template:

Quality Requirement	Threshold	Method of Measurement	Consequence of breach
Domain 1: Preventing people dying prematurely			
Insert text			
Domain 2: Enhancing the quality of life of people with long-term conditions			
All patients have a defined set of person-centred goals with a record of achievement Patients should have a planned timely discharge to home/an on-going care facility/within 6 months	Documented goals for rehabilitation and goal attainment in 90% admissions LOS<6 months (Or within approved extension period) for 100%	Patient record audit or GAS recorded via UKROC UKROC LOS	General conditions 8 and 9
Domain 3: Helping people to recover from episodes of ill-health or following injury			
Patients will be assessed within 10 days of referral by a senior member of the specialist	90% patients are assessed within 10 working days of referral	UKROC referral to assessment (days)	General conditions 8 and 9

Quality Requirement	Threshold	Method of Measurement	Consequence of breach
rehabilitation team Patients will be admitted to a facility assessed as being best to meet their needs within 6 weeks of being fit for transfer All patients will have achieved gain some measurable gain or goal achievement (NB These may be process goals in pts admitted for disability management or neuropalliative rehabilitation	90% Patients are admitted within 6 weeks of being fit for transfer 90% Patients have achieved gain on at least one standardised measure recorded on admission and discharge from the programme	UKROC – assessment (or fit for transfer) to admission (weeks) UKROC: UK FIM+FAM, NPDS or GAS T score (or other approved measure)	
Domain 4: Ensuring that people have a positive experience of care			
Patients and/or their families are satisfied with their care Constructive feedback is recorded, reviewed and acted upon	Response rate >50% 90% overall positive Mechanism in place for team reflection on feedback	Feedback gathered by a validated technique (with facilitation of communication if necessary) Evidence of reflection and action	General conditions 8 and 9
Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm			
No needless harm from pressure ulcers	New incidence of harm from Category II-IV	NHS Safety Thermometer	

Quality Requirement	Threshold	Method of Measurement	Consequence of breach
No needless harm from VTE	Pressure Ulcers Completed VTE decision charts for all patients	Record of VTE decision chart NHS Safety Thermometer	General conditions 8 and 9
Safe staffing levels	Service meets at least the minimum standards for safe and effective staffing levels as laid down in the BSRM standards	UKROC Registration service profile	

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Appendix 2

Discharge Planning

Discharge planning should start immediately following multidisciplinary assessment within the unit. If the individual is to be discharged to their home, a home visit should be conducted as appropriate to establish access and equipment needs.

Providers and commissioners will work closely together to ensure that:
The individual's needs for equipment and seating are drawn up as soon as needs are established and ordered as soon as provision and funding has been agreed.

- If required a care manager is identified within the individual's local health or social care agencies to coordinate their care following discharge.
- A care plan is produced.

Before discharge [agreed number of weeks] a discharge planning meeting should be organised involving the:

- Key worker
- Commissioner
- Care manager, if required
- Individual
- Family

The family and other carers should be involved in discharge planning throughout.
Family/ carers should receive advice and/or training with respect to managing on-going needs as appropriate including:

- Physical management - positioning, transfer methods, nutrition, continence management communication methods etc.
- Dealing with cognitive and behavioural problems.
- Communications needs

Discharge reporting

A comprehensive discharge report should be produced. This should include:

- An evaluation of progress during rehabilitation, and continuing needs for intervention, equipment and care
- Summary reports from each discipline involved in the client's care
- A joint therapy report summarising reports from each discipline involved
- An indication of future plans - how the person is likely to spend their days and their life
- What the input from professional carers should be
- What the role of the family carers should be
- A schedule of the anticipated future needs and recommendations for on-going care.

A copy of the discharge report should be given to the individual, wherever appropriate, and their family, subject to issues of consent, with an explanation by the key worker or someone

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else in the rehabilitation team who has been involved in the person's care. This should include

- Information about voluntary organisations and support services and signpost to other services which may be required, including further rehabilitation services
- Practical information to assist carers (for instance pictures and videos to show correct moving and handling of the individual).

The individual's GP should be informed about the discharge and a brief summary of the discharge report should be given to the GP on the day of discharge.

The GP and all other professionals involved in their on-going care, should be sent a full summary of the discharge report within five working days.

A brief report should be sent to the commissioners including:

- A brief statement regarding the attainment of goals
- Arrangements for follow-up or continuing management.
- Recommendations for anticipated future care needs.

Where is it considered likely that the individual will have further continuing healthcare needs on discharge (e.g. nursing home placement or on-going rehabilitation in a different type of service), commissioners should be informed of this in order to be able to plan provision for on-going care. In some cases, it may be appropriate to negotiate agreement for on-going support in advance of admission, to ensure smooth discharge planning.

Appendix 3

Notification procedures for Specialised Rehabilitation

1. Routine notification to Clinical Commissioning Groups of assessment /admission to Level 1 service

Access to complex specialist inpatient neuro-rehabilitation will primarily be expected to be via consultant-to-consultant referrals, although in the context of established pathways (eg Major Trauma, acute neuro-rehabilitation) referral may be instigated by the Multi Disciplinary team on behalf of the consultant.

Exceptional referrals originating from non-acute or non-tertiary settings will need to be channelled via local consultant-led community rehabilitation teams for an initial review and determination of the most appropriate care pathway.

Local Clinical Commissioning Groups (CCGs) retain overall responsibility for patients admitted to the service **in collaboration with** the Local Area Team commissioners for tertiary neuro-rehabilitation.

- CCG commissioners must be involved in the key aspects of patient referral, assessment, admission, review and discharge.
- Involve CCGs in their patients' care by ensuring they are, kept informed of referrals to a tertiary neuro-rehabilitation centre.
- Level 1/2a providers should keep CCGs advised with respect to all assessments, admissions and discharges.
- CCGs can ensure key local professions are involved in the case management of patients and support for local onwards placement i.e continuing healthcare assessment, identification of a social worker

This is done using **Form A.**

Failure to use the appropriate form and follow the agreed procedure might result in the care cost reimbursement claim being challenged

UKROC Dataset

All Level 1 and 2a Specialised Services commissioned by NHS England must report the full national dataset for specialist rehabilitation services. The data is collected through the NHSE commissioning dataset via the UK Rehabilitation Outcomes Collaborative (UKROC database).

All providers of Level 1 and 2 specialist rehabilitation services are required to submit the **full dataset** for each inpatient episode as part of their contract. This will cover discharged, deceased, onward transfers for further rehabilitations as well as assessed but not admitted patients, where assessments are undertaken as part of the NHSE-funded activity.

Please note that the UKROC database is the vehicle for implementation of the mandated 5-tier multi-level payment model. Only activity counted through UKROC is eligible for payment under this model. Fortnightly RCSE scores must be submitted on all patients to qualify.

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1.1.1 Form A: Routine Notification (Assessment, Admission, Discharge)

Patient details	Identifier		
	DOB		
	Address		
CCG and Provider	CCG		
Diagnosis			
Notification of ASSESSMENT:	Date:	Unit assessing patient:	
	Brief summary of assessment findings: (See attached report for details)		
	Principal recommendations of assessment: • Admit to: • Alternative management suggestions:		
COMMISSIONING	*Acknowledged by:*	*Date:*	
Notification of ADMISSION:	Date of admission:	Treating Unit:	
	Proposed LOS category:		
	Anticipated end of programme date:		
COMMISSIONING	*Acknowledged by:*	*Date:*	
Notification of DISCHARGE:	Date of discharge:		
	Discharged to: ☐ previous address, ☐ new address ☐ nursing/care home, ☐ transitional living unit, ☐ other rehabilitation, ☐ referring hospital, ☐ other:		
	Address:		

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COMMISSIONING	*Acknowledged by:*	*Date:*

2. Delayed Discharge & Trim Point Notification

The trim point notification for anticipated delayed discharges is triggered when a patient is deemed to be ready for discharge. This is when the patient is clinically fit for discharge and has either achieved their rehabilitation goals or s/he does not have the potential to make further rehabilitation gains in that environment, or can have their rehabilitation goals met in a less specialist setting (eg: home or nursing home), and the centre identifies problems that could potentially cause a delay in carrying out a timely discharge.

Where the patient becomes a 'delayed discharge', the NHSE will continue to fund the placement for 14 days, with funding responsibility transferring to the responsible CCG from day 15. The 14 days "grace period" clock starts ticking from the proposed discharge date up to day 14 (meaning that the count is inclusive of both days).

The aim is to incentivise timely discharge or transfer of care to further rehabilitation or continuing care settings (including home discharge) and incentivise stronger local partnerships between CCGs and the relevant local government departments through closer seamless joint working across organisational boundaries.

- The multi-agency joined-up working would be achieved through more inclusive dialogue and liaison around a case between CCG commissioners, community/ primary care health services, social services, housing and the patient's carers.
- CCGs have a responsibility to maximise the outcome of rehabilitation provided through the NHSE.
- In some instance this may entail passing patients on to further delineated periods of rehabilitation in local or community-based services, or to slow-stream rehabilitation in specialist nursing homes, to ensure timely throughput of patients down the rehabilitation pathway.

Routine discharge notifications to a CCG should be made using Form A – Routine CCG Notification Form (Assessment, Admission & Discharge).

For delayed discharges, form "DDTPN" (Delayed Discharge & Trim Point Notification Form) would be suitable. Form DDTPN should be served to the responsible CCG (and copied to the LAT commissioners) ideally at least 4 weeks in advance or as soon as the provider becomes aware of the problem.

Delayed Discharge / Trim Point Notification (DDTPN) form

2 Section 1 – Notification of delayed discharge

Patient ID:…… **DOB**:……..

NHS No:…… **GP Code**:……

Responsible CCG:…… **Admission date**: ..……

Treating Neuro-Rehabilitation Centre: ……

Proposed Discharge Date: ……..…

Date notified of Delayed discharge: ……

Reason for Delay, Clinical/Social/Health: ……

Details:……
……
……
……

Revised Date (Where clinically appropriate): ……

3 Section 2 – Notification of funding transfer to CCG

Agreed discharge date	**Provider notifies CCG & LAT commissioner of delayed discharge**	**Date NHS-Efunding expires**	**Date CCG becomes liable for full cost of patient** (from day 15 of discharge date)

CCG confirms funding responsibility on: ……

CCG funding responsibility confirmed by: ……

4 Section 3 – Discharge confirmation

Date patient discharged on: ……

NHS England/D02/S/a
Gateway Reference 01366

3. Extension of Stay Process

Typical length of stay is capped at 6 months under this service specification with regular periodic reviews.

Evidence suggests that prolonged neuro-rehabilitation can sometimes be cost-effective for patients with very complex needs, providing there are clear goals for treatment which are agreed (by clinicians, commissioners and the patient/family) to be important both from a clinical and value for money perspective. However, in view of the large costs of longer term rehabilitation and the pressure on Level 1 beds, each longer-stay inpatient must be justified on a case by case basis ensuring this is based on clinical needs and not a result of poor discharge planning or other non-clinical reasons.

Extension of length of stay beyond 6 months may be warranted under certain circumstances eg:

- A patient who is in a low awareness state for the first half of the admission, emerges to a level where they can now engage in rehabilitation
- A patient has a significant medical event (eg recurrent stroke, surgery etc) which involves a significant disruption to programme.
- A patient makes slower than expected progress, but there are clearly identified goals agreed by all parties to be appropriate to achieve.
- The expected outcomes and how they will be evaluated are clearly identified – this will usually involve the demonstration of cost efficiency (ie significant cost savings in terms of ongoing care that will off set the initial investment in further rehabilitation)
- The arrangement will have to be closely monitored and have a built-in termination option in case the expected progress is not occurring.
- To ensure effective use of this facility, requests for extension may be turned down if a given provider is persistently overoptimistic.

Procedure:
Where a patient requires an extension to their individual rehabilitation programme beyond the original proposed discharge date, an application will be submitted to the clinical advisory sub-group (CAG) Chair person and copied to the LAT commissioners The CAG will consider referred applications in collaboration with the patient's responsible CCG and the LAT commissioner.

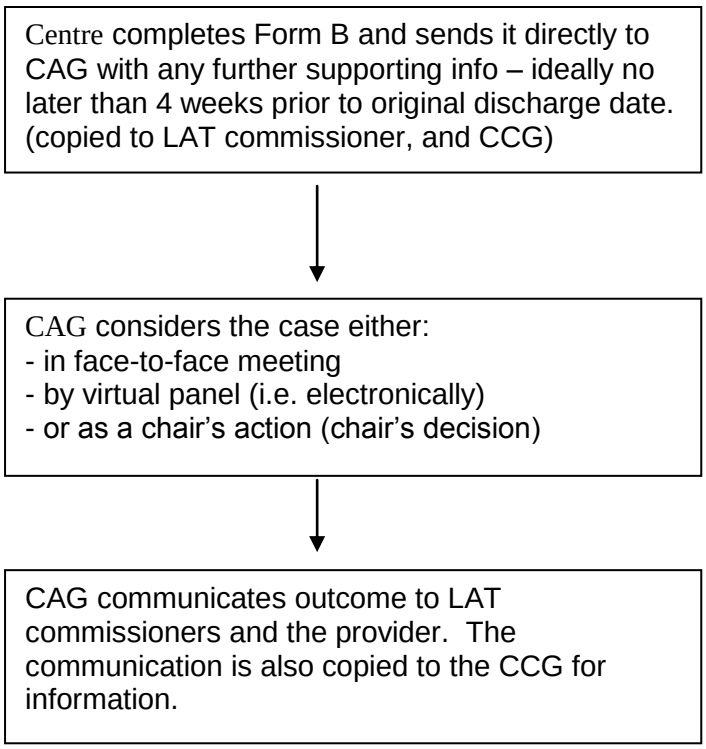
The appropriate form "Form B" (attached as Appendix 2 – Notification of Change Form) should be used in all relevant cases. Form B should include as a minimum:

- Justification that the patient still has complex needs requiring rehabilitation in a level 1 tertiary neuro-rehabilitation setting, and that other less expensive options (eg a level 2 service) are not appropriate
- Clearly defined, clinically important goals for the proposed period
- Clear indicators of a successful outcome (eg goal attainment or other measure) and also
    - Itemised FIM FAM scores for admission, current situation and goal condition for discharge
    - Itemised NPDS/NPCNA scores for admission, current situation and goal condition for discharge, including total NPDS, weekly care hours (RCH) and estimated weekly costs
- A clear timescale for the requested additional stay and the associated reviews.
- A identification of a CCG caseworker to commence work with the unit for discharge planning and interface to local key workers e.g social workers

If an extension of more than 3 months is requested, providers will be asked to provide a review report at least on a 3 monthly intervals basis to confirm that the intended goals are being met as anticipated. Providers will also be asked to provide a final report after discharge, confirming whether or not the

intended goals during extension were achieved.

4.1 Extension of stay process:



NB: We appreciate that this is a detailed process which requires considerable effort on the part of provider. However, it is considered that the bar for these extensions should reasonably set quite high to manage the pressure on the tertiary beds.

Tertiary services should be part of a network, and after 6 months it is very often the case that the patient's needs can actually be met elsewhere. Experience in London suggests that working through the application in itself is often quite helpful for informing the thought processes of the treating team to consider other options, thereby avoiding the need even to process the application.

4.1.1 Form B: Notification of change – Extension of Stay

Patient details	Identifier	
CCG and Provider	CCG	
	Treating unit	
Diagnosis		
Admission date		
Original discharge date		
Admission category	Current LOS category	
	Proposed LOS category	
	Proposed new discharge date	
Brief summary of medical condition		

4.1.2 1. Request for extended admission:

Reasons for extending admission (Justify using eligibility parameters)	
Principal goals for the further admission period (What further benefits will be achieved for the patient / family / CCG?)	
What indicators of successful outcome will be recorded?	This should include as minimum: • An agreed set of goals • Itemised FIM+FAM and NPDS scores for admission, current and anticipated end of extension dates, entered into the UKROC software. With computation of care hours (RCH) and estimated weekly costs of care
What alternatives have been considered and why rejected?	

Request from:		

NHS England/D02/S/a
Gateway Reference 01366

COMMISSIONING	*Request acknowledged*	
If referred to CAG, give reason		

An exemplar summary at discharge is given below.

Patient Name:	Patient – age 57 years
Diagnosis:	Severe subarachnoid haemorrhage with hydrocephalus
Admission Dates:	2.9.09 – 1.4.2010
Length of Stay:	7 months (initial 24 weeks with extension 10 weeks)
Discharge destination:	Home

Reason for Admission/Medical History

Patient X, aged 57, was working as an IT manager. He enjoyed motor cycling, painting and he went to the gym regularly. His partner was a consultant haematologist who worked full time.

Admission to the RRU

X suffered a large acute hypertensive left intra-cerebral haemorrhage with mass effect, midline shift and extension into both ventricles and the subarachnoid space. He was managed conservatively on the intensive care unit at Charing Cross Hospital. He required intensive care and prolonged ventilation. He had a stormy clinical course complicated by pseudomonas respiratory tract infection, paralytic ileus and severe hypertension. He was admitted to the RRU on 2.9.09 for intensive rehabilitation.

On admission he was alert with a Glasgow coma scale of 14/15 (E4 M6 V4). He had the following neurological deficits:
Dense right-sided spastic hemiparesis (upper limb MRC grade 2/5 proximally and 3/5 distally; low limb 4/5 throughout)
Moderate right sided sensory inattention and somatic neglect
Marked expressive and receptive dysphasia
Dyspraxia, impaired and attention memory deficits.
Right shoulder pain
He was observed to have two complex partial seizures which were self-limiting, but after the second he was started on anticonvulsant therapy (sodium valproate 400mg bd)
He also presented with troublesome right sided spastic shoulder pain and was found to have a partial thickness rotator cuff tendon tear.

Treatment and Progress

On admission, X was wheelchair bound, requiring hoisting by two people for all transfers. He required an intensive inter-disciplinary rehabilitation programme.
He was reviewed by Mr Simon Lambert, Royal National Orthopaedic Hospital with a view to surgical repair of his rotator cuff. However, by this time his shoulder pain was settling with conservative management on the RRU Shoulder Pain integrated care pathway (ICP) and he opted for continued medical management.

Discharge

He made very good progress during his admission. By discharge he was
Able to walk short distances indoors with close supervision of one person, an ankle-foot orthosis and a quad stick. However his balance remained inconsistent and put him at risk of falls.
He was able to use his right upper limb as a prop during bimanual tasks and for writing. He was able to use upper limb more selectively i.e. eating with a knife and fork, spreading butter etc.

He was able to prepare his own breakfast, including coffee and toast independently if all items in fridge/surface within reach
He was able to speak fluently and to hold a normal conversation
Despite on-going cognitive impairments with dyspraxia and memory deficit, he was able to participate more in the planning and organisation of his daily routine
He was discharged home to live with his partner. On-going community-based rehabilitation has been arranged with the Hounslow Community Rehabilitation Team.

Outcome data

Total cost of admission: £87, 364.40
Weekly saving in cost of care from admission to discharge £932
Time to offset cost of admission: 23 months

	Admission	Discharge	Change
Dates	2.9.2009	01.4.2010	212 days
RCS	11 (C2 N3 T4 M2)	11 (C1 N2 T6 M2)	↓C+N ↑T
NPDS score	44	21	↓23
Weekly care hours	70	42	↓28
Weekly care costs	£1900	£968	↓£932
UK FIM+FAM	60	139	↑79
Barthel Index	2	9	↑ 7

RCS = Rehabilitation Complexity Score; NPDS = Northwick Park Dependency Score

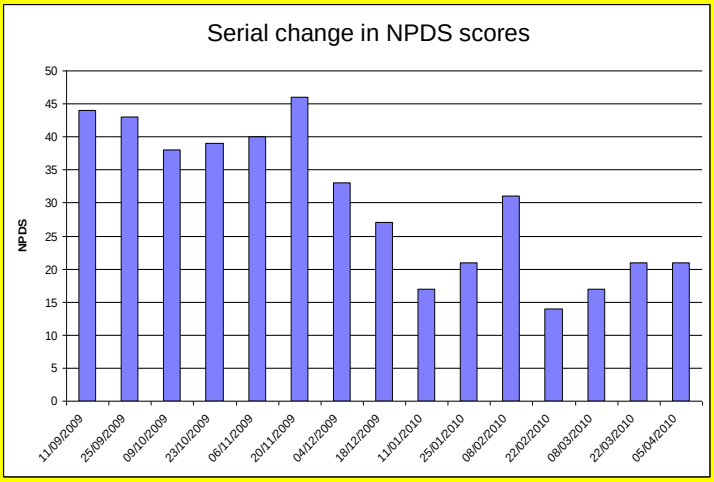


Photo of patient on admission - removed for confidentiality

Change in FIM+FAM

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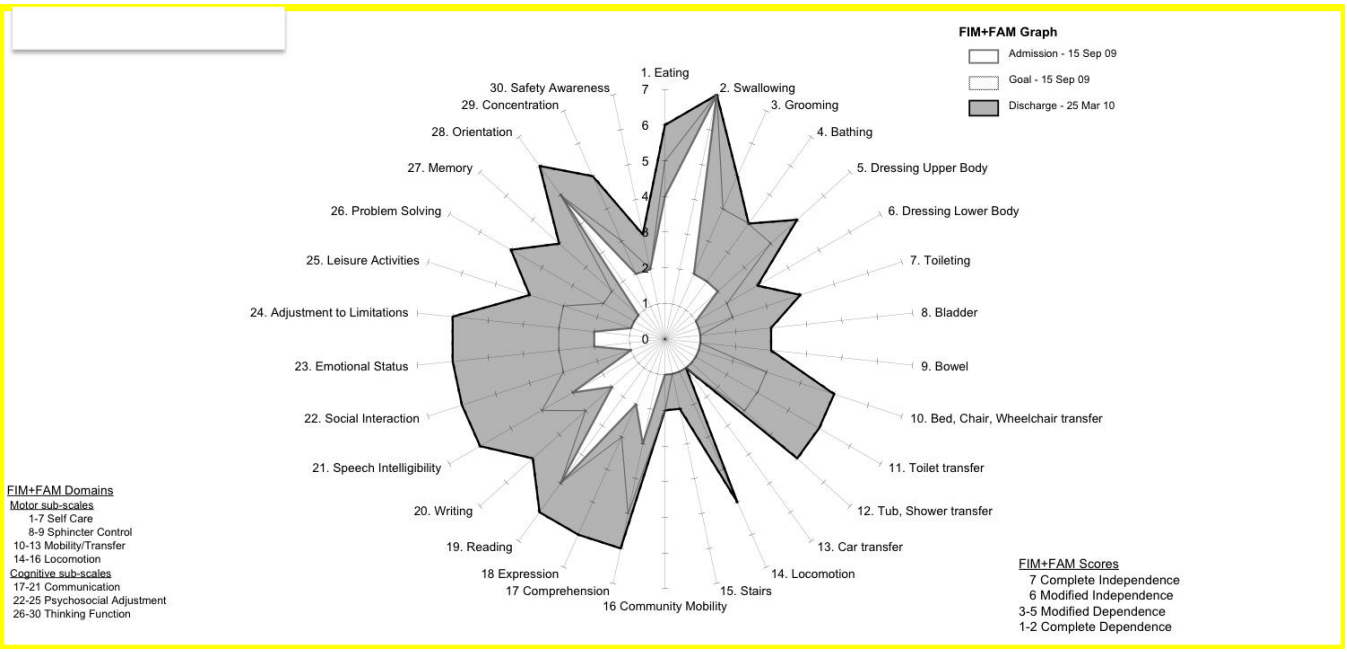

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Details of extension: (Requested 24.1.10)
His initial planned date of discharge was 22.2.10 (6 month admission).
In the early stage of admission, independence within tasks was limited due to significant cognitive deficits. We anticipated that he would require a live-in carer on discharge (his partner works full time).

On 24.1.2010, an extension of 10 weeks was requested on the following **patient-related grounds**:

- During the last 6 weeks, his cognitive ability improved. He has become more orientated. His ability to remember tasks and instructions improved.
- This had a positive effect on his ability to learn. He was participating more actively in rehabilitation and had started to work on undertaking basic self-care tasks without supervision.
  If he could be left alone for short periods (1-2 hours) at home, this would mean that he would be able to manage with a visiting care package, as opposed to a live-in carer, so reducing the cost of his on-going care
- In his therapy sessions, he had started to walk with the help of 2 people. It was envisaged that he may be able to walk short distances indoors with the assistance of just one person,
  This would reduce carer burden at home and improve his opportunities for participation in the community (for example it would enable him to walk into a restaurant with the help of his partner).

Specific goals for extension:

Goal	Baseline	Achieved
1. To be able to be left alone at home during the day with care calls twice a day, while his partner is out at work	**-1**	**0**
2. To be able to call for help in an emergency and to help himself to a snack	**-1**	**+1**
3. To be able to transfer independently using a low pivot transfer	**-1**	**-1**
4. To be able to walk indoors with a quad stick AFO and the assistance of one person	**-1**	**+1**
5. To be able to use a urine bottle independently during the day and with the assistance of his partner at night	**-1**	**0**
6. To be able to complete grooming aspects of his care independently,	**-1**	**0**
7. To be able to complete the remainder of his morning care routine with the assistance of one carer within 45 minutes.	**-1**	**0**

The table below summarises the anticipated changes in dependency and those actually achieved

	24.1.10	Anticipated	Change	Actual	Change
RCS	9 (C1 N2 T5 M1)			11 (C1 N2 T6 M2)	↑2
NPDS score	23	12	↓11	21	↓2
Weekly care hours	42	28	↓14	42	0
Weekly care costs	£1876	£1576	↓£300	£968	↓£908
GAS	33.8			62.5	28.8

Change Notice for Published Specifications and Products

developed by Clinical Reference Groups (CRG)

Amendment **to the Published Products**

Product Name	Specialised Rehabilitation for Patients with highly complex needs
Ref No	**D02/S/a**
CRG Lead	Lynne Turner Stokes

Description of changes required

Describe what was stated in original document	Describe new text in the document	Section/Paragraph to which changes apply	Describe why document change required	Changes made by	Date change made
	Put the previous year's specification in the new specification template, this has created a new section that needed populated linked to the National Outcome Framework and domains	Section 2 and Appendix 2	To ensure consistency of specification formatting	CRG	October 2013
	To ensure consistency of format across our specification through using	Section 3.4 and 6.0 and Section 3.3	To ensure consistency of specification formatting	CRG	October 2013

	common sub headings, ensuring words of scope and IR are included in the exclusion and acceptance area. Clarity added on population covered.				