

D13/S/a

**NHS STANDARD CONTRACT
FOR SPINAL CORD INJURIES (ALL AGES)**

SCHEDULE 2 – THE SERVICES A. SERVICE SPECIFICATION

Service Specification No.	D13/S/a
Service	Spinal Cord Injuries (All Ages)
Commissioner Lead	
Provider Lead	
Period	12 months
Date of Review	

Abbreviations used in this document

SCI = Spinal Cord Injury
SCIC = Spinal Cord injury Centre

1. Population Needs

1.1 National/local context and evidence base

The service provides care to people who have sustained an injury to the spinal cord as a result of injury or disease. It encompasses acute care following the injury, surgical or non-surgical stabilisation of the spine, rehabilitation and reintegration into the community, life-long follow-up of people living with spinal cord injury, and further admission if necessary for medical or surgical management. Ventilation is provided to people with higher level injuries. The service provides a wide range of services to meet the special needs of people with spinal cord injury, including urology, respiratory, psychology, physiotherapy, occupational therapy, sexual and fertility advice, reintegration planning, and the management of spasticity, pressure ulcers and other complications.

The service is described in the National Care Pathways for Spinal Cord Injury, on www.nscisb.nhs.uk

Incidence of SCI in the UK has been difficult to obtain due to a number of factors. However, from the available data from the UK specialised Spinal Cord Injury Centres estimate an incidence of 12 – 16 per million of the population, a wide range in age from infants to the elderly and a majority of injuries caused by trauma.

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	✓

The following metrics are taken from the 13/14 Spinal Cord Injury Quality Dashboard

- The Mean time from Injury to referral (newly injured patients) (days)
- The Mean time from referral to admission into SCI Centre Trust under the care of SCI Consultant (newly injured patients) (days)
- Mean LOS in acute phase for level of injury C1-C4 (days)
- Mean LOS in acute phase for level of injury C5-C8 (days)
- Mean LOS in acute phase for level of injury T1-T12 (days)
- Mean LOS in acute phase for level of injury L1 and below (days)
- Mean LOS in acute phase for level: central cord syndromes (days)
- Mean LOS in rehab for level of injury C1-C4 (days)
- Mean LOS in rehab for level of injury C5-C8 (days)
- Mean LOS in rehab for level of injury T1-T12 (days)
- Mean LOS in rehab for level of injury L1 and below (days)

- Mean LOS in rehab for level: central cord syndromes (days)
- % of newly injured patients with traumatic and non-traumatic spinal cord injury will receive a face to face outreach visit from the SCIC acute outreach team within 5 days of the referral of the patient to the SCIC, to support the patient and the treating team.
- % of SCI bed days occupied by non-clinical delayed discharge patients - newly injured ventilated
- % of SCI bed days occupied by non-clinical delayed discharge patients - newly injured non-ventilated
- % of SCI bed days occupied by non-clinical delayed discharge patients - further admissions ventilated
- % of SCI bed days occupied by non-clinical delayed discharge patients - further admissions non-ventilated
- % of newly injured SCI patients admitted to SCIC who had Grade 3 or 4 pressure sore on admission
- % of newly injured SCI patients admitted to SCIC who acquired a Grade 3 or 4 pressure sore after admission to the SCIC
- % of further admission SCI patients admitted to SCIC who had Grade 3 or 4 pressure sore on admission
- % of further admission SCI patients admitted to SCIC who acquired a Grade 3 or 4 pressure sore after admission to the SCIC
- % of patients for whom an up-to-date ASIA and SCIM III assessment, as described in the Dashboard specification approved by the NSCISB on 25th November 2011, has been made available to commissioners by 15th day of the month following the end of the quarter

3. Scope

3.1 Aims and objectives of service

The aim of the service is:

- To provide acute management and rehabilitation of people with spinal cord injury.
- To provide on-going management of people with spinal cord injury.
- To promote optimal outcomes, leading to reduced mortality and morbidity.
- To support patients to maximise their potential for independent living, and for return to employment or education, hobbies and activities of daily living.
- To optimise autonomy and health in people with spinal cord injury.

Definition of Spinal Cord Injury

Specialised Services National Definition Set no 6 part 1 Version 3 defines Specialised Spinal Cord Injuries as follows:

- Specialised spinal cord injuries encompass any traumatic insult to the spinal column at cervical (neck), thoracic (chest), thoracolumbar, lumbar, lumbo-sacral (lower back) or multiple levels which causes complete or partial interruption of spinal cord function.

For the avoidance of doubt, Specialised SCI Services include patients who have experienced Spinal Cord Injury resulting either from a traumatic cause or a non-traumatic cause.

Explanatory Note: When such injury results from an accident such as a road traffic accident or a fall it is referred to as “traumatic” SCI. When it results from disease or infection it is referred to as a “non-traumatic” SCI.

Explanatory Note: The National Spinal Cord Injury Strategy Board and the National SCI Pathways concern themselves with the care of patients with spinal cord injury in all contexts, whether in primary care, secondary care, trauma centres or specialised services. The scope of specialised spinal cord injury services is set out below.

Summary Description of Specialised Spinal Cord Injury Services

The service will deliver the aims above by:

- providing high quality and cost-effective treatment and care.
- providing appropriate psychological and mental health support to patients.
- working with other healthcare providers to promote understanding of the special needs of people with spinal cord injury.
- working with patients and those caring for them in the community to promote good health, and avoid complications and hospital admissions.
- providing outreach services to patients with spinal cord injury in other settings.
- ensuring effective communication between patients, families, service providers, and local commissioners.
- providing a personal service, sensitive to the physical, psychological and emotional needs of the patient and his or her family.
- participating in national programmes of clinical audit and outcomes data collection to improve the effectiveness and efficiency of the service.
- working towards full compliance with the National Care Pathways for Spinal Cord Injury www.nscisb.nhs.uk
- cherishing and using the National Spinal Cord Injury Database.

Services which are within the Scope of the Specialised SCI Service and this Contract

The Scope of Specialised SCI Services is defined, for this contract and for the National SCI Currencies and Tariffs, as follows:

Services provided to adults and children with Spinal Cord Injury by recognised Specialised Spinal Cord Injury Centres in any location.

And

Services provided to adults and children with Cauda Equina Syndrome which results in

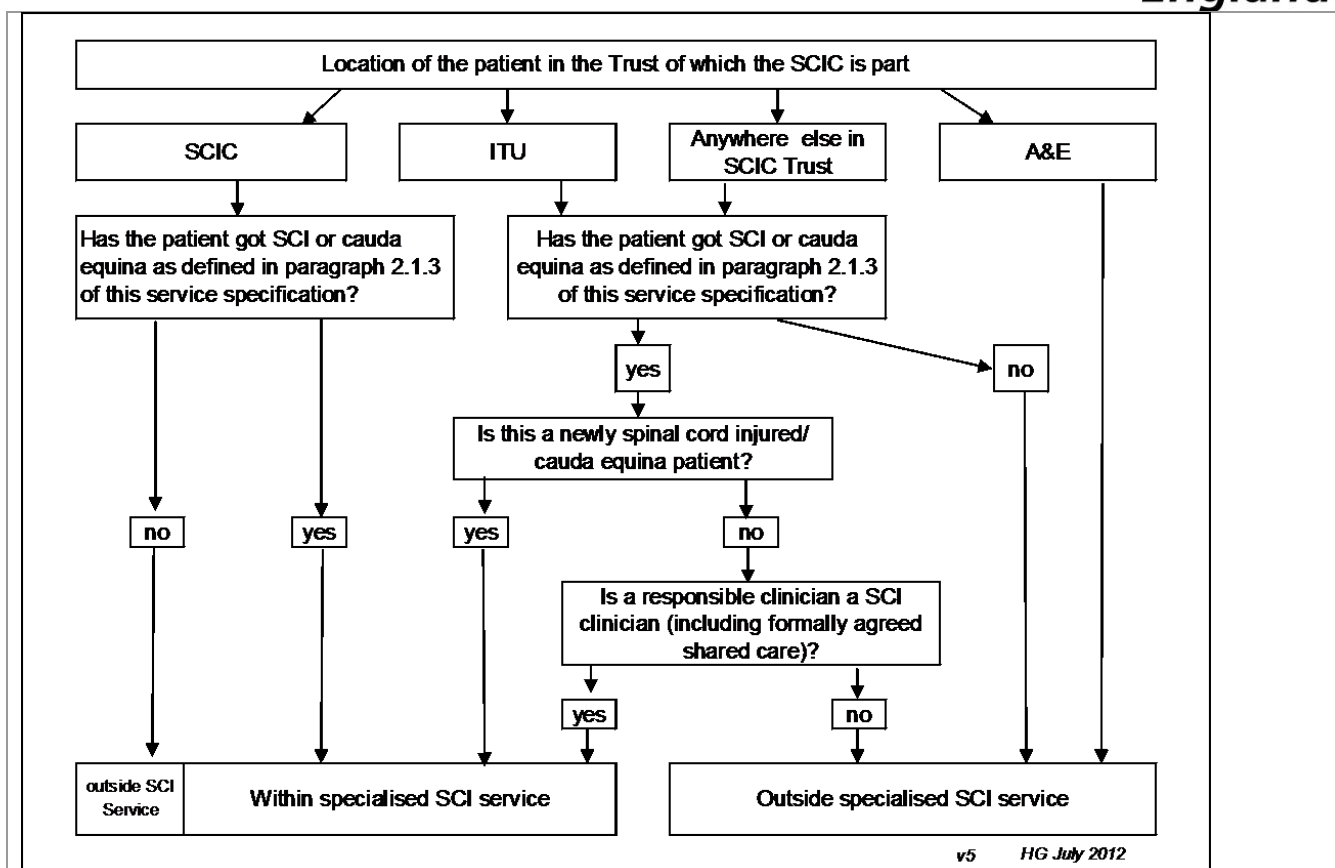
- **Either** Motor and sensory effects on bowel and bladder function resulting in retention/incontinence of bowel and/or bladder
- **Or** Loss of safe upright mobility.

by recognised Specialised Spinal Cord Injury Centres in any location.

The general principle, to which there are exceptions as set out in section 3.4 is that Specialised SCI Services encompass all activity for SCI patients provided by the host Trust of the SCIC, including:

- any part of the initial admission to the SCIC's host Trust following injury, wherever in the Trust the patient is situated.
- any part of the initial admission to the SCIC's host Trust following injury, even if the patient is treated for another related or non-related condition during that spell (eg hand injury, epilepsy). Occasionally the initial admission may be interrupted by a temporary transfer to another setting.
- any readmission or attendance for SCI-related care, wherever the treatment is located in the Trust (eg cystoscopy, tendon transfer), where an SCI consultant is responsible for the patient's care, either solely or as part of a formally agreed joint care arrangement.
- any further admission of a SCI patient for non-SCI-related care, if an SCI consultant is responsible for the patient's care, either solely or as part of a formally agreed joint care arrangement.

The following algorithm is used to determine, within a Trust which has a Specialised SCI Centre, which services are classified as Specialised SCI Services.



3.2 Service description/care pathway

The service shall comprise:

- Acute outreach to newly injured patients with SCI in other settings
- Acute inpatient care following injury, comprising surgical or non-surgical management of the injury, and the period of recovery before the patient is fit for rehabilitation
- Restorative rehabilitation and re-enablement, and reintegration into the community
- Lifelong follow-up
- Admission as necessary for further treatment
- Outreach to patients with SCI in other healthcare and community settings

National Spinal Cord Injury Pathways

Spinal Cord Injury Services are described in the National Spinal Cord Injury

- Pathways, launched in September 2012 which are on www.nscisb.nhs.uk

During 2014/15 the Provider shall agree with Commissioners a plan to progress towards full compliance with the National Spinal Cord Injury Pathways in respect of all Specialised SCI Services provided in or by the Trust.

Care in the Spinal Cord Injury Centre will be delivered by a multi-disciplinary team (MDT) of

highly specialist healthcare professionals. Individual patients will have their needs formally assessed by the MDT on admission and these will be reviewed at specified intervals throughout their acute and rehabilitation stay, as described in the National Care Pathways (reference website), or at the request of a member of the multi disciplinary team to discuss particular issues.

The MDT within the SCIC consists of :

- Medical staff - consultants, Specialist Registrars, specialty doctor, staff grade or other medical professional in the Centre. They provide medical advice, prognosis and overall management.
- Ward nursing staff provide bowel and bladder care and day to day assistance with rehabilitation with dressing, washing and other activities of daily living.
- Speciality nurses provide advice on specialist areas such as bladder or bowel, managing pain relief, pressure area care, promoting & managing continence, personal hygiene, nutritional and emotional support. They have a substantial educational role and also provide outreach to home on discharge.
- Physiotherapists provide physical rehabilitation.
- Occupational therapists often manage hand function and provide occupational advice.
- Discharge coordinator/centre social worker liaises with outside agencies and advises on benefits etc.
- The clinical psychologist advises on strategies to assist with coping and adjustment and addresses any specific mental health issues.
- The dietician identifies those at risk of malnutrition including both under and over nutrition (obesity) and plans specific nutritional interventions to maximize outcomes

Range of Services to be Provided by all Specialised SCICs

The Provider of Specialised Spinal Cord Injury Services is required to deliver, to adult SCI traumatic and non-traumatic patients, ALL the following services (see National Spinal Cord Injury Strategy Board Commissioning Classifications Coding Handbook for full definitions of codes):

- Acute Outreach, both face to face and by telephone, to newly injured patients with SCI or traumatic or non-traumatic origin in other settings
- Surgical Management of the newly injured patient: codes 322.1, 322.2, 322.3, 322.4, 322.5, 323.1, 329
- Non-Surgical Management of the newly injured patient: codes 331.1, 331.2, 331.3, 331.4, 331.5, 332.1, 339
- Rehabilitation of the newly injured patient: Sub-Section 34 – all codes
- Further Admissions of people living with SCI: Section 4 – all codes
- Outpatient Services: Section 6 – all codes
- Outreach Visits: Section 8 – all codes
- Outreach Clinics: Section 7, as required to suit the geography and configuration of the catchment area
- Life-long follow-up at regular intervals of patients living with SCI, as described in the Pilot Pathways

- Telephone SCI outreach services to patients living with SCI who have been admitted to a hospital which is not a SCIC, at the request of the responsible clinician.
- Outcomes assessment of all newly injured patients at 6 months, 12 months and 24 months following injury, using American Spinal Injury Association (ASIA) impairment scale and Spinal Cord Independence Measure for adults, and ASIA for children.

The services provided by the provider will comply with principles which apply to the treatment of people with new spinal cord injury resulting from trauma, as described in:

- Management of People with Spinal Cord Injury [pdf / 89KB] NHS Clinical Advisory Groups Report August 2011

<http://www.excellence.eastmidlands.nhs.uk/EasysiteWeb/getresource.axd?AssetID=42332&type=full&servicetype=Attachment>

and

- The Initial Management of Patients with Spinal Cord Injuries, approved by the National Spinal Cord Injury Strategy Board on 18th May 2012. www.nscisb.nhs.uk

The SCIC will be formally linked to one or more Major Trauma Network, and will participate fully in local structures for planning and strategy.

The Provider will have jointly agreed Pathways and Protocols with linked Trauma Networks which cover the key management considerations set out in:

- The Initial Management of Patients with Spinal Cord Injuries, approved by the National Spinal Cord Injury Strategy Board on 18th May 2012. www.nscisb.nhs.uk

Following the referral of newly injured patients who have experienced traumatic SCI, the SCIC will be responsible for providing ongoing advice, guidance and appropriate support to the patient and referring hospital through its outreach service until such time as the patient is transferred to a SCIC, or agreed destination.

Explanatory Note. The Major Treatment Centre or Trauma Unit retains legal responsibility for the patient until he/she is transferred

SCICs which are not co-located with one or any of the services listed in section 3.5 will agree, with an appropriate provider, protocols for the provision of that service or those services to patients with SCI.

Where a patient requires, during their SCI admission, treatment for any condition (including other injuries or health conditions) not available within the SCIC's host Trust, the patient will be transferred under pre-agreed protocols.

The SCIC will provide SCI outreach services, including advice on weaning ventilated patients, to newly injured traumatic and non-traumatic patients referred to it, unless the SCIC has received confirmation in writing that another SCIC has taken responsibility for providing outreach.

Where a SCIC is currently unable to admit or provide outreach to ventilated patients, the Trust will agree with the Commissioner during 2013/14 a plan to meet the needs of patients requiring ventilation.

SCICs may be accredited to treat adolescents and/or children with SCI if they have the appropriate experience, facilities and staffing.

General Paediatric care

When treating children, the service will additionally follow the standards and criteria outlined in the Specification for Children's Services (attached as Annex 1 to this Specification)

SCICs will additionally follow the standards and criteria in the Service Specification for Complex Maternity Services.

- The provider will adhere to the Common Admissions Policy approved by the National Spinal Cord Injury Strategy Board on 10th February 2012 www.nscisb.nhs.uk in respect of all patients referred with a new spinal cord injury.

A programme to formally link NHS hospitals to a SCIC is under development by the NSCISB. The provider will, during 2013/14, agree with commissioners a programme to develop training, joint protocols and outreach links with the hospitals to which it is formally linked, in respect of newly injured non-traumatic patients, and patients living with SCI who are being treated by the linked hospital.

The provision of Phrenic Nerve Stimulation is under review and will be commissioned, pending the development of a NHS England Policy, only from established providers at 2010/11 volumes.

Intrathecal drug delivery pumps will be commissioned at 2010/11 levels until a new NHS England Policy is issued.

Sacral nerve stimulators will be commissioned only from established providers at 2010/11 levels until a new NHS England Policy is issued.

Spinal Cord nerve stimulators will be commissioned only from established providers at 2010/11 levels until a new NHS England Policy is issued.

Botulinum Toxin will be commissioned at 2010/11 levels until a new NHS England Policy is issued.

National Commissioning Classifications - Codes

The Specialised SCI Service consists of items of service, which are referred to as "packages". Each package has a code. These are listed in Appendix 4.

Explanatory Note: The code numbers, definitions and rules attached to the codes and

packages are under continuous review and improvement and are contained in the latest version of the National Spinal Cord Injury Strategy Board Commissioning Classifications Handbook. A copy of the current version can be downloaded from www.nscisb.nhs.uk

National Commissioning Classifications – Inclusions

In all cases, the services defined by the SCI Commissioning Classifications codes include all equipment, staffing, surgery, outpatient procedures, drugs, devices, orthotics, functional electrical stimulation (FES), consumables and costs, including items required to treat co-morbidities, required by in-patients and patients being followed up by the SCIC, unless:

- Additional payment is explicitly allowed under the National Spinal Cord Injury Strategy Board Commissioning Currencies Coding Handbook, or
- The item is outside the scope of the specialised SCI service as defined in paragraph 2.4

National Commissioning Classifications – Inclusions (Data Collection)

In all cases, the Service described by the SCI Commissioning Classifications codes includes submission of data, by means and to timetables specified by commissioners, including:

- Submission to the National SCI Database of the data describing the Patient Pathway, including ASIA, SCIM and other outcome measures.
- Submission to the National SCI Database of data required for classification of activity into National SCI Commissioning Classifications.
- Data requested by commissioners for validation of contract activity.
- Data required to monitor quarterly performance against the measures in the Quality Dashboard approved by the NSCISB on 26th August 2011 or subsequent revisions, and the Specialised Services Quality Dashboard 2012/13.
- Data required to monitor performance against the national Quality, Innovation, Productivity and Prevention (QIPP) programme for spinal cord injury.
- Data required to monitor performance against the 2013/14 Commissioning for Quality and Innovation (CQUIN) framework.
- Submission to the National SCI Dashboard of data required to produce waiting list reports as specified in 2012/13 CQUIN scheme and the NSCISB Common Admissions Policy 2012.

National Commissioning Classifications – Inclusions (Discharge Planning)

Planning for the discharge of the patient to the community is an important component of the service.

For newly injured patients and for emergency or urgent admission of people living with SCI for further treatment, the planning process will commence on admission. For patients living with SCI who are to be admitted for further treatment, the planning process will commence

before or as soon as the decision to admit is made.

Individual discharge plans will be determined through goal planning with the patient and SCIC multi-disciplinary team and relevant community teams at the start of rehabilitation. Each patient will have an individual discharge plan identifying care requirements and medical and equipment provision.

In all cases, the services to in-patients, both newly injured and further admissions, as defined by the National SCI commissioning classifications, include a full Discharge Planning and Reintegration Service, and compliance with the agreed schedule of communications with local commissioners, as described in Appendix 2.

See Section 2.4 and Appendices 1, 2 and 3 for information about non-clinical delayed discharges.

Services delivered outside the Trust

The Services will be delivered mainly in the Spinal Cord Injury Centre and its host Trust.

Additionally the Provider will support SCI patients and those caring for them in other healthcare settings, through Outreach services. This includes:

- Acute outreach, both face to face and by telephone, to newly injured patients and those caring for them in other healthcare settings.
- Outreach, both face to face and by telephone, to people with existing SCI who are being treated in other healthcare settings.
- Visits to the patient's home, local area and local services, as part of planning for reintegration.

The Services may include, where appropriate, non-admitted care carried out by the SCIC in outreach outpatient clinics in suitable locations.

Patients and Carers

The importance of timely and appropriate information to SCI patients, families and carers is reflected in the National SCI Pathways, where detailed requirements are described for each step in the pathway.

3.3 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 GP Practice in Wales, but INCLUDES

patients resident in Wales who are registered with a GP Practice in England.

Specifically, this service is for adults and children with spinal cord injury, as outlined within this specification.

3.4 Any acceptance and exclusion criteria and thresholds

Acceptance criteria

The following may refer patients to the specialised SCI service:

- People who have suffered new SCI of traumatic cause will normally be referred directly from the Major Trauma Centre or the receiving Trauma Unit. Additionally some patients will be referred from abroad.
- People who have suffered new SCI with non-traumatic cause will be referred from a variety of sources. In most cases the referral will be made by a hospital consultant.
- In cases of both traumatic and non-traumatic new SCI, the referring hospital will be expected to refer and register the patient through the National SCI Database, in line with Management of People with Spinal Cord Injury [pdf /89KB] NHS Clinical Advisory Groups Report August 2011
<http://www.excellence.eastmidlands.nhs.uk/EasysiteWeb/getresource.axd?AssetID=42332&type=full&servicetype=Attachment>
- People living with SCI may be referred to the SCIC by their GP or community services for issues requiring SCIC specialist advice or intervention.
- Healthcare professionals treating the SCI patient for conditions not directly related to SCI should make contact with the patient's SCIC to discuss the special SCI care needs of the patient.

Criteria for referral to the specialised SCI service:

- The patient has spinal cord injury; or
- The patient has cauda equina syndrome which results in
 - **Either** Motor and sensory effects on bowel and bladder function resulting in retention/incontinence of bowel and/or bladder
 - **Or** Loss of safe upright mobility

Services which are outside the scope of the Specialised SCI Service:

- People treated in or by SCI Centres who do not have SCI, or Cauda Equina as defined in Section 2.1

Explanatory Note: Some SCI Centres currently treat in their beds or clinics a range of patients who do not fall under the scope of the specialised SCI service.

- Examples (not an exhaustive list) of people outside the scope of SCI, who may be found in a SCIC:
 - People with congenital long-term conditions like spina bifida.

- People having treatment for pressure sores.
- People with multiple sclerosis.
- People on pain or spasticity programmes

The principle which applies is that patients are classified by their illness or condition, and not by the bed they occupy or the clinic they attend.

If the patient or service provided to them falls within the scope of another specialised service, the activity will be classified to that service. If outside the scope of any specialised service, they will be the commissioning responsibility of the patient's ordinary responsible commissioner as defined in guidance (i.e. the responsible local Clinical Commissioning Group).

Patients admitted to SCI Centres with injury to the spinal column but intact neurology (with the exception of up to two nerve roots).

Explanatory Note: Although these patients may be at risk of cord injury until stabilised, and require careful management, they do not have cord injury and are not paralysed.

In cases of spinal cord injury of iatrogenic origin which have occurred in the SCI's host Trust, the period between admission and the date on which the patient is first fit to "sit out", as defined in the Commissioning Currencies Handbook.

People with progressive disease.

Explanatory Note: Spinal tumours are classified as Specialised Cancer Services, not Specialised SCI. However if spinal cord dysfunction has arisen from the effects of a benign tumour which has been primarily dealt with by an appropriate specialty, or from a tumour which has been adequately treated and is now deemed to have a benign course, or if the patient has a significant life expectancy, the patient may transfer to the Spinal Cord Injury Service for rehabilitation and life-long follow up. At this point they will come under the scope of Specialised SCI.

A&E attendance following spinal cord injury up until a decision to admit.

Explanatory Note: This part of the patient pathway is classified as Major Trauma or Trauma, even if the receiving emergency department is part of the same Trust as the SCIC.

Services involving the use of sperm, eggs and embryos which are regulated under the Human Fertilisation and Embryology Act 1990 (HFE Act) (as amended by the Human Fertilisation and Embryology Act (Quality and Safety) Regulations 2007), with the exception of electro-ejaculation, which is not outside the scope of the specialised SCI service.

Explanatory Note: Advice on fertility to SCI patients and their partners, and treatment of the SCI patient at the equivalent of primary or secondary level care, are appropriate component parts of Specialised SCI programmes. However any regulated assisted conception procedures are outside the scope of the specialised SCI service.

Any further admission or attendance of a person with SCI for non-SCI related care when the

patient is treated by a clinician who is not a SCI clinician and there is no shared care agreement. Such treatment will be the responsibility of the patient's ordinary responsible commissioner as defined in guidance (i.e. the responsible local Clinical Commissioning Group), unless it falls within the scope of another specialised service.

People with SCI treated in centres (specialised or non-specialised) which are not recognised SCI Centres, except where commissioners have agreed in contracts that services may be sub-contracted. Treatment at a centre which is not a recognised SCI Centre will be the responsibility of the patient's ordinary responsible commissioner as defined in guidance (i.e. the responsible local Clinical Commissioning Group), unless it falls within the scope of another specialised service.

Patients who remain in a specialised SCI Centre after they are clinically fit for discharge. Where such a delay in discharge occurs for non-clinical reasons, the daily delayed discharge tariff approved by the specialised commissioners as part of the SCI tariff is chargeable to the patient's ordinary responsible commissioner as defined in guidance (i.e. the responsible local Clinical Commissioning Group).

See Appendix 1 for further details.

Delivery (obstetrics) and the care of the new-born.

The implications of new Payment by Results arrangements for maternity services from 2013/14 are under consideration and may necessitate an adjustment to the Scope of the Specialised SCI Service.

Care in the community, including the provision, maintenance and replacement of equipment required to support the patient in the community.

If an item essential to support the patient safely in the community has not been provided by the date on which the SCIC deems the patient to be fit for discharge, the

SCIC may supply the item and re-charge the Clinical Commissioning Group the purchase price. Essential items to which this applies are described in Appendix 3.

Explanatory Note: In some circumstances, specialised equipment for Physical Disability, such as communication aids and environmental controls, is within the scope of the NHS England "prescribed" service for Complex Disability Equipment.

The supply and maintenance of less specialised equipment required by the patient in the community is the responsibility of the patient's ordinary responsible commissioner as defined in guidance (i.e. the responsible local Clinical Commissioning Group).

Wheelchairs

Explanatory Note: In some circumstances, wheelchairs are within the scope of the NHS England "prescribed" service for Complex Disability Equipment. The supply and maintenance of any wheelchairs which fall outside the scope of Specialised Complex

Disability Equipment is the responsibility of the patient's ordinarily responsible commissioner as defined in guidance (i.e. the responsible local Clinical Commissioning Group).

Prosthetics

Explanatory Note: Specialised prosthetics are within the scope of the NHS England "prescribed" service for Complex Disability Equipment . The supply and maintenance of any prosthetics which fall outside the scope of Specialised Complex Disability Equipment is the responsibility of the patient's ordinary responsible commissioner as defined in guidance (i.e. the responsible local Clinical Commissioning Group).

Non-Emergency Patient Transport

Explanatory Note: Patient Transport Services for eligible people are the responsibility of the patient's ordinary responsible commissioner as defined in guidance (i.e. the responsible local Clinical Commissioning Group).

The National Spinal Cord Injury Strategy Board has issued advice to Clinical Commissioning Groups on applying eligibility criteria for PTS to patients with SCI. This can be downloaded from:

<http://www.secscg.nhs.uk/home/national-spinal-cord-injury-strategy-board/>

Hospital Travel Costs Scheme

Explanatory Note: HTCS for eligible people is the responsibility of the patient's ordinary responsible commissioner as defined in guidance (i.e. the responsible local Clinical Commissioning Group).

3.5 Interdependencies with other services/providers

Co-located Services

Ideally a SCIC will be co-located with:

Essential:

- Accredited Specialised Spinal Surgery Service (orthopaedic or neurosurgical)
- Accredited Critical Care Service
- Imaging
- Urology
- Plastic Surgery
- Liaison Mental Health Services
- Pain Management o Care of the Elderly o Dietetics
- For those SCICs delivering a service to children with SCI, an accredited provider of Specialised Paediatrics

Desirable:

- A Major Trauma Centre, recognising that not every Major Trauma Centre will be co-located with a SCIC
- Accredited Specialised Neurosurgery Service

- Speech and Language Therapy
- Microbiology

It is recognised that existing SCICs do not meet all these criteria in their current locations. However any plan for re-design or relocation of an existing SCI service will be expected to move the service towards improved compliance with the list of essential services above.

Any plans for development of a new SCI service will be expected to achieve full compliance with the list of essential and desirable services above.

Where a patient requires, during their SCI admission, treatment for any condition (including other injuries or health conditions) not available within the SCIC's host Trust, the patient will be transferred under pre-agreed protocols.

Inter-dependent Services

- Gynaecology and Maternity
- Hand and upper limb surgery
- Specialised complex disability equipment services
- Orthotics
- Peer support
- Fertility services
- Providers of other Specialised and non-specialised healthcare services not otherwise listed in the co-located services above

Clinical Commissioning Groups

Local commissioners are responsible for:

- Appropriate participation in discharge planning, particularly where the patient is likely to have continuing care needs.
- Preventing delays in the discharge of patients by :
 - Intervening with other agencies such as Social Services and Housing to ensure packages of care are in place.
 - Where unavoidable delays occur, arranging and funding an interim placement for the patient, so as to free up the specialist spinal bed.
- Providing the appropriate wheelchair when it is needed by the patient, if the wheelchair falls outside the scope of the NHS England "prescribed" services.
- Ensuring that any equipment needed by patients is available when it is needed, except when the equipment falls within the scope of NHS England "prescribed" services.
- Maintaining and replacing any equipment.

Related Services

Play an essential role in the timely reintegration of the patient, and in minimising the need for hospital admission.

These include:

- Clinical Commissioning Groups
- General Practice and Community Health Services including District Nursing, Community Mental Health Services, Occupational Therapy, Physiotherapy, Wheelchair Services,).
- Social Services Departments and Housing Departments
- Care agencies
- Education and further education, Driving Ability Assessment Centres, Disability Employment Advisory Services
- Financial and legal advice services
- Advocacy Services
- Charities, Self-Help Groups and Voluntary Agencies

4. Applicable Service Standards

4.1 Applicable national standards e.g. NICE

The following core requirements were developed by the Spinal Cord Injury Clinical Reference Group and endorsed and adopted by NHS England

- The Spinal Cord Injury Centre can demonstrate they have a minimum of 20 beds dedicated exclusively for the treatment and rehabilitation of spinal cord injured patients.
- The Spinal Cord Injury Centre can demonstrate the service is provided by a Multi-disciplinary team specifically trained in the management and care of spinal cord injured patients, consisting of; at least two consultants in spinal injuries, specialist nurses, physiotherapists and occupational therapists, outreach staff, a clinical psychologist, dedicated discharge staff.
- The Spinal Cord Injury Centre can demonstrate there is provision of a goal orientated programme of care and education for all patients with access to user groups and peer support.
- The Spinal Cord Injury Centre can demonstrate there is provision of a specialist continence service, specialist posture and seating assessment.
- The Spinal Cord Injury Centre can demonstrate
 - Compliance with National SCI Database by end of second quarter 13/14.
 - There is a programme of clinical audit and governance is undertaken, including collection of nationally agreed measures – AIS chart, SCIM III and CHART.
- Agreed, written protocols for management and referral of newly injured patients with each linked MTC

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

The provider will submit data to the National SCI Database, as described in more detail in Section 3.2.

The provider will participate in the National Spinal Cord Injury Strategy Board and its sub-groups and work programmes, as described in its Terms of Reference.

The provider will participate in the Implementation Phase of the National SCI Care Pathways Project, as follows, and will appoint Pathways Champions. Outline Project Plan for Pathways Implementation

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See Schedule 4 Parts A-D)

5.2 Applicable CQUIN goals (See Schedule 4 Part E)

6. Location of Provider Premises

The Provider's Premises are located at:

7. Individual Service User Placement

Appendix

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			
Agreed, written	Yes or No	Evidence provided to	Action plan to meet

Quality Requirement	Threshold	Method of Measurement	Consequence of breach
protocols for management and referral of newly injured patients with each linked Major Trauma Centre		the commissioner	the standard
Domain 2: Enhancing the quality of life of people with long-term conditions			
Provision of a specialist continence service and specialist posture and seating assessment	Yes or No	Evidence provided to the commissioner	Action plan to meet the standard
Provision of a goal orientated programme of care and education for all patients with access to user groups and peer support	Yes or No	Evidence provided to the commissioner	Evidence provided to the commissioner
Domain 3: Helping people to recover from episodes of ill-health or following injury			
The service is provided by a Multi-disciplinary team specifically trained in the management and care of spinal cord injured patients, consisting of; at least two consultants in spinal injuries, specialist nurses, physiotherapists and occupational therapists, outreach staff, a clinical psychologist, dedicated discharge staff	Yes or No	Evidence provided to commissioner	Action plan to meet standard
Domain 4: Ensuring that people have a positive experience of care			
Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm			

ANNEX 1 TO SERVICE SPECIFICATION

PROVISION OF SERVICES TO CHILDREN

Aims and objectives of service

This specification annex applies to all children's services and outlines generic standards and outcomes that would be fundamental to all services.

The generic aspects of care:

The Care of Children in Hospital (HSC 1998/238) requires that:

- Children are admitted to hospital only if the care they require cannot be as well provided at home, in a day clinic or on a day basis in hospital.
- Children requiring admission to hospital are provided with a high standard of

medical, nursing and therapeutic care to facilitate speedy recovery and minimize complications and mortality.

- Families with children have easy access to hospital facilities for children without needing to travel significantly further than to other similar amenities.
- Children are discharged from hospital as soon as socially and clinically appropriate and full support provided for subsequent home or day care.
- Good child health care is shared with parents/carers and they are closely involved in the care of their children at all times unless, exceptionally, this is not in the best interest of the child; Accommodation is provided for them to remain with their children overnight if they so wish.

Service description/care pathway

All paediatric specialised services have a component of primary, secondary, tertiary and even quaternary elements.

The efficient and effective delivery of services requires children to receive their care as close to home as possible dependent on the phase of their disease.

Services should therefore be organised and delivered through “integrated pathways of care” (National Service Framework for children, young people and maternity services (Department of Health & Department for Education and Skills, London 2004)

Interdependencies with other services

All services will comply with Commissioning Safe and Sustainable Specialised Paediatric Services: A Framework of Critical Inter-Dependencies – Department of Health

Imaging

All services will be supported by a 3 tier imaging network (“Delivering quality imaging services for children ”DOH 13732 March2010). Within the network:

- It will be clearly defined which imaging test or interventional procedure can be performed and reported at each site
- Robust procedures will be in place for image transfer for review by a specialist radiologist, these will be supported by appropriate contractual and information governance arrangements
- Robust arrangements will be in place for patient transfer if more complex imaging or intervention is required
- Common standards, protocols and governance procedures will exist throughout the network.
- All radiologists, and radiographers will have appropriate training, supervision and access to CPD
- All equipment will be optimised for paediatric use and use specific paediatric

software

Specialist Paediatric Anaesthesia

Wherever and whenever children undergo anaesthesia and surgery, their particular needs must be recognised and they should be managed in separate facilities, and looked after by staff with appropriate experience and training. All UK anaesthetists undergo training which provides them with the competencies to care for older babies and children with relatively straightforward surgical conditions and without major co-morbidity. However those working in specialist centres must have undergone additional (specialist) training and should maintain the competencies so acquired³ *. These competencies include the care of very young/premature babies, the care of babies and children undergoing complex surgery and/or those with major/complex co-morbidity (including those already requiring intensive care support).

As well as providing an essential co-dependent service for surgery, specialist anaesthesia and sedation services may be required to facilitate radiological procedures and interventions (for example MRI scans and percutaneous nephrostomy) and medical interventions (for example joint injection and intrathecal chemotherapy), and for assistance with vascular access in babies and children with complex needs such as intravenous feeding.

Specialist acute pain services for babies and children are organised within existing departments of paediatric anaesthesia and include the provision of agreed (hospital wide) guidance for acute pain, the safe administration of complex analgesia regimes including epidural analgesia, and the daily input of specialist anaesthetists and acute pain nurses with expertise in paediatrics.

*The Safe and Sustainable reviews of paediatric cardiac and neuro- sciences in England have noted the need for additional training and maintenance of competencies by specialist anaesthetists in both fields of practice.

References

1. Guidelines for the Provision of Anaesthetic Services (GPAS) Paediatric anaesthetic services. Royal College of Anaesthetists (RCoA) 2010
www.rcoa.ac.uk
2. Certificate of Completion of Training (CCT) in Anaesthesia 2010
3. CPD matrix level 3

Specialised Child and Adolescent Mental Health Services (CAMHS)

The age profile of children and young people admitted to specialised CAMHS day/in-patient settings is different to the age profile for paediatric units in that it is predominantly adolescents who are admitted to specialised CAMHS in-patient settings, including over-16s. The average length of stay is longer for admissions to mental health units. Children and young people in specialised CAMHS day/in-patient settings generally participate in a structured programme of education and

therapeutic activities during their admission.

Taking account of the differences in patient profiles the principles and standards set out in this specification apply with modifications to the recommendations regarding the following

- Facilities and environment – essential Quality Network for In-patient CAMHS (QNIC) standards should apply (<http://www.rcpsych.ac.uk/quality/quality,accreditationaudit/qnic1.aspx>)
- Staffing profiles and training - essential QNIC standards should apply.
- The child/ young person's family are allowed to visit at any time of day taking account of the child / young persons need to participate in therapeutic activities and education as well as any safeguarding concerns.
- Children and young people are offered appropriate education from the point of admission.
- Parents/carers are involved in the child/young persons care except where this is not in the best interests of the child / young person and in the case of young people who have the capacity to make their own decisions is subject to their consent.
- Parents/carers who wish to stay overnight are provided with accessible accommodation unless there are safeguarding concerns or this is not in the best interests of the child/ young person.

3. Applicable Service Standards

3.1 Applicable national standards e.g. NICE, Royal College

Children and young people must receive care, treatment and support by staff registered by the Nursing and Midwifery Council on the parts of their register that permit a nurse to work with children (Outcome 14h Essential Standards of Quality and Safety, Care Quality Commission, London 2010)

- There must be at least two Registered Children's Nurses (RCNs) on duty 24 hours a day in all hospital children's departments and wards.
- There must be an Registered Children's Nurse available 24 hours a day to advise on the nursing of children in other departments (this post is included in the staff establishment of 2RCNs in total).

Accommodation, facilities and staffing must be appropriate to the needs of children and separate from those provided for adults. All facilities for children and young people must comply with the Hospital Build Notes HBN 23 Hospital Accommodation for Children and Young People NHS Estates, The Stationary Office 2004.

All staff who work with children and young people must be appropriately trained to provide care, treatment and support for children, including Children's Workforce Development Council Induction standards (Outcome 14b Essential Standards of

Quality and Safety, Care Quality Commission, London 2010).

Each hospital who admits inpatients must have appropriate medical cover at all times taking account of guidance from relevant expert or professional bodies (National Minimum Standards for Providers of Independent Healthcare, Department of Health, London 2002). “Facing the Future” Standards, Royal College of Paediatrics and Child Health.

Staff must carry out sufficient levels of activity to maintain their competence in caring for children and young people, including in relation to specific anaesthetic and surgical procedures for children, taking account of guidance from relevant expert or professional bodies (Outcome 14g Essential Standards of Quality and Safety, Care Quality Commission, London 2010).

Providers must have systems in place to gain and review consent from people who use services, and act on them (Outcome 2a Essential Standards of Quality and Safety, Care Quality Commission, London 2010). These must include specific arrangements for seeking valid consent from children while respecting their human rights and confidentiality and ensure that where the person using the service lacks capacity, best interest meetings are held with people who know and understand the person using the service. Staff should be able to show that they know how to take appropriate consent from children, young people and those with learning disabilities (Outcome 2b) (Seeking Consent: working with children Department of Health, London 2001).

Children and young people must only receive a service from a provider who takes steps to prevent abuse and does not tolerate any abusive practice should it occur (Outcome 7 Essential Standards of Quality and Safety, Care Quality Commission, London 2010 defines the standards and evidence required from providers in this regard). Providers minimise the risk and likelihood of abuse occurring by:

- Ensuring that staff and people who use services understand the aspects of the safeguarding processes that are relevant to them.
- Ensuring that staff understand the signs of abuse and raise this with the right person when those signs are noticed.
- Ensuring that people who use services are aware of how to raise concerns of abuse.
- Having effective means to monitor and review incidents, concerns and complaints that have the potential to become an abuse or safeguarding concern.
- Having effective means of receiving and acting upon feedback from people who use services and any other person.
- Taking action immediately to ensure that any abuse identified is stopped and suspected abuse is addressed by:
 - having clear procedures followed in practice, monitored and reviewed that take account of relevant legislation and guidance for the management of alleged abuse

- separating the alleged abuser from the person who uses services and others who may be at risk or managing the risk by removing the opportunity for abuse to occur, where this is within the control of the provider
- reporting the alleged abuse to the appropriate authority
- reviewing the person's plan of care to ensure that they are properly supported following the alleged abuse incident.
- Using information from safeguarding concerns to identify non-compliance, or any risk of non-compliance, with the regulations and to decide what will be done to return to compliance.
- Working collaboratively with other services, teams, individuals and agencies in relation to all safeguarding matters and has safeguarding policies that link with local authority policies.
- Participates in local safeguarding children boards where required and understand their responsibilities and the responsibilities of others in line with the Children Act 2004.
- Having clear procedures followed in practice, monitored and reviewed in place about the use of restraint and safeguarding.
- Taking into account relevant guidance set out in the Care Quality Commission's Schedule of Applicable Publications
- Ensuring that those working with children must wait for a full CRB disclosure before starting work.
- Training and supervising staff in safeguarding to ensure they can demonstrate the competences listed in Outcome 7E of the Essential Standards of Quality and Safety, Care Quality Commission, London 2010

All children and young people who use services must be

- Fully informed of their care, treatment and support.
- Able to take part in decision making to the fullest extent that is possible.
- Asked if they agree for their parents or guardians to be involved in decisions they need to make.

(Outcome 4I Essential Standards of Quality and Safety, Care Quality Commission, London 2010)

4. KEY SERVICE OUTCOMES

Evidence is increasing that implementation of the national Quality Criteria for Young People Friendly Services (Department of Health, London 2011) have the potential to greatly improve patient experience, leading to better health outcomes for young people and increasing socially responsible life-long use of the NHS. Implementation is also expected to contribute to improvements in health inequalities and public health outcomes e.g. reduced teenage pregnancy and Sexually Transmitted Infections (STIs), and increased smoking cessation. All providers delivering services to young people should be implementing the good practice guidance which delivers compliance with the quality criteria.

Poorly planned transition from young people's to adult-oriented health services can be associated with increased risk of non-adherence to treatment and loss to follow-up, which can have serious consequences. There are measurable adverse consequences in terms of morbidity and mortality as well as in social and educational outcomes. When children and young people who use paediatric services are moving to access adult services (for example, during transition for those with long term conditions), these should be organised so that:

- All those involved in the care, treatment and support cooperate with the planning and provision to ensure that the services provided continue to be appropriate to the age and needs of the person who uses services.
- The National Minimum Standards for Providers of Independent Healthcare, Department of Health, London 2002) require the following standards:
- **A16.1** Children are seen in a separate out-patient area, or where the hospital does not have a separate outpatient area for children, they are seen promptly.
- **A16.3** Toys and/or books suitable to the child's age are provided.
- **A16.8** There are segregated areas for the reception of children and adolescents into theatre and for recovery, to screen the children and adolescents from adult patients; the segregated areas contain all necessary equipment for the care of children.
- **A16.9** A parent is to be actively encouraged to stay at all times, with accommodation made available for the adult in the child's room or close by.
- **A16.10** The child's family is allowed to visit him/her at any time of the day, except where safeguarding procedures do not allow this
- **A16.13** When a child is in hospital for more than five days, play is managed and supervised by a qualified Hospital Play Specialist.
- **A16.14** Children are required to receive education when in hospital for more than five days; the Local Education Authority has an obligation to meet this need and are contacted if necessary.
- **A18.10** There are written procedures for the assessment of pain in children and the provision of appropriate control.

All hospital settings should meet the Standards for the Care of Critically Ill Children

(Paediatric Intensive Care Society, London 2010).

There should be age specific arrangements for meeting Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These require:

- A choice of suitable and nutritious food and hydration, in sufficient quantities to meet service users' needs;
- Food and hydration that meet any reasonable requirements arising from a service user's religious or cultural background
- Support, where necessary, for the purposes of enabling service users to eat and drink sufficient amounts for their needs.
- For the purposes of this regulation, "food and hydration" includes, where applicable, parenteral nutrition and the administration of dietary supplements where prescribed.
- Providers must have access to facilities for infant feeding, including facilities to support breastfeeding (Outcome 5E, of the Essential Standards of Quality and Safety, Care Quality Commission, London 2010)

All paediatric patients should have access to appropriately trained paediatric trained dietitians, physiotherapists, occupational therapists, speech and language therapy, psychology, social work and CAMHS services within nationally defined access standards.

All children and young people should have access to a professional who can undertake an assessment using the Common Assessment Framework and access support from social care, housing, education and other agencies as appropriate

All registered providers must ensure safe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines (Outcome 9 Essential Standards of Quality and Safety, Care Quality Commission, London 2010). For children, these should include specific arrangements that:

- Ensure the medicines given are appropriate and person-centred by taking account of their age, weight and any learning disability
- Ensure that staff handling medicines have the competency and skills needed for children and young people's medicines management
- Ensure that wherever possible, age specific information is available for people about the medicines they are taking, including the risks, including information about the use of unlicensed medicine in paediatrics.

Many children with long term illnesses have a learning or physical disability.

Providers should ensure that:

- They are supported to have a health action plan
- Facilities meet the appropriate requirements of the Disability Discrimination Act 1995
- They meet the standards set out in Transition: getting it right for young people.

Improving the transition of young people with long-term conditions from children's to adult health services. Department of Health, 2006, London

SERVICE SPECIFICATION – SPINAL CORD INJURY (SCI) SERVICES

APPENDIX 1

Non-Clinical Delayed Discharges

1. Background

Spinal Cord Injury Centre (SCIC) beds are a precious and expensive resource. Specialised Commissioners aim to minimise delayed discharges, because every delayed discharge prevents or delays the admission of another newly injured patient, resulting in blockage in the Trauma pathway, poorer outcomes and additional cost. When the delayed admission is blocking an Intensive Therapy Unit (ITU) bed, the financial consequences for the NHS can be very high.

Once patients with SCI have reached their rehabilitation goals they need to put into practice what they have achieved. A protracted delay in returning to the community, or an inappropriate placement where maximum independence is not achieved, are effectively a waste of the combined hard work of the patient and the SCIC, and a waste of NHS investment. It is essential therefore that all stakeholders work together to minimise delayed discharges.

Because the patient has no clinical need to be in the SCIC, the period of delayed discharge is not classified as a specialised service, and is therefore chargeable to the patients ordinary responsible commissioner (i.e. local Clinical Commissioning Group). This will apply whatever the reason for the delay.

The daily rate charged for non-clinical delayed discharges is banded according the level of dependency, and is set as part of the national SCI tariffs.

2. Prevention of Delays

There are cases where the delayed discharge results from a delay in providing housing adaptations, or the patient has unrealistic expectations about where they wish to live. Nevertheless the SCIC will charge the patients ordinary responsible commissioner (i.e. local Clinical Commissioning Group)

The SCICs have teams of staff who work on discharge planning / reintegration. Unless the discharge is very straightforward one, the SCIC team depends on the co-operation of the patient's GP and the local commissioning body. The local commissioning body can expect to be notified and kept informed by the SCIC of any patient who is newly injured, or readmitted with a pressure sore, and anyone who may be at risk of becoming a delayed discharge.

Partnership working is essential to the prevention of delayed discharges. The patient's local

commissioning body is best placed to intervene with the other agencies involved to achieve a prompt discharge.

3. Billing under The Community Care (Delayed Discharges etc.) Act 2003

Commissioners sometimes query whether the SCIC has fulfilled its obligation to charge Social Services Departments under The Community Care (Delayed Discharges etc.) Act 2003, as described in para. 2.4.6.

The discharge co-ordinators in the SCICs advise that this charge, which was introduced specifically to ensure that older people should not be delayed in an acute hospital bed once they have been declared safe for discharge, is rarely applicable to patients experiencing delays in the SCICs. In particular, rehabilitation beds are specifically excluded from the provisions of the Act, so most newly injured patients and many subsequent admissions to SCICs are outside the scope of the Act. The usefulness of this legislation as a lever for encouraging Social Services to provide for the needs of SCI patients is therefore limited, particularly since the charge which can be levied is often less than the cost of a care package.

This paper is not intended to advise on the 2003 Act. Useful information can be found at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008734

This includes a paragraph about delays attributable to housing and adaptations.

The daily rate under the 2003 Act is a fraction of the daily cost of a specialised bed in a SCIC. Where the SCIC has established that billing under the 2003 Act is appropriate, the SCIC host Trust will undertake the billing, and the amount billed to the Clinical Commissioning Group for the delayed discharge will be discounted by that amount.

SERVICE SPECIFICATION – SPINAL CORD INJURY (SCI) SERVICES

APPENDIX 2

DISCHARGE PLANNING

1. Introduction

Planning for the discharge of the patient to the community is an important component of the service.

For newly injured patients and for emergency or urgent admission of people living with SCI for further treatment, the planning process will commence on admission. For patients living with SCI who are to be admitted for further treatment, the planning process will commence before or as soon as the decision to admit is made.

Individual discharge plans will be determined through goal planning with the patient and SCIC multi-disciplinary team and relevant community teams at the start of rehabilitation. Each patient will have an individual discharge plan identifying care requirements and medical and equipment provision.

The purpose of this Appendix is to describe:

- The procedures and processes which the Spinal Cord Injury Centre will undertake to plan for the reintegration of the patient into the community.
- The additional formal communication which will take place between the Spinal Cord Injury Centre and officers of the patient's local responsible commissioner, in order to prevent delayed discharges.

It applies to:

- All newly injured patients with spinal cord injury
- All further admissions where the primary reason for admission is further rehabilitation
- All further admissions where the primary reason for admission is treatment of a pressure ulcer
- All other further admissions, unless the SCIC has assessed that the risk of delayed discharge is minimal

2. Summary of Discharge Planning Process

Under Development

The Clinical Reference Group for SCI has set up a Sub-Group to develop this section.

It will be placed on www.ncisb.nhs.uk

3. Communications Schedule

This sets out the dates and content of communications to be sent by SCICs to Clinical Commissioning Groups. It applies to:

- All newly injured patients
- All further admissions where the primary reason for admission is further rehabilitation
- All further admissions where the primary reason for admission is treatment of a pressure sore
- All other further admissions unless the SCIC has assessed that the risk of delayed discharge is minimal

Letter 1 should be sent in all cases, unless the patient has already been discharged or there are exceptional circumstances. Letter 5 should be sent in any case where Letter 1 has previously been sent.

Letter 1a is only sent if necessary.

Letter 2 will be applicable in most cases.

Letters 3 and 4 are only used if difficulties arise in engaging with local agencies

Ref	Timing / Circumstances	Information	Main recipient	Copies to
1	Within 2 weeks of admission	<ul style="list-style-type: none"> • Patient details, including NHS number, and GP. • When and (briefly) how injured. When admitted and from where. Any special needs (inc. paediatric, other injuries, etc.) • Any special circumstances, such as homeless etc. • Anticipated discharge date, as discussed with patient. If patient is not fit for this discussion, advise typical length of stay for this type of injury. • Estimate of expected level of need post-discharge • Name of key worker and contact details. 	Patient's CCG Director of Commissioning	Patient's CCG Contact for Continuing Care (if known) Specialised Commissioning Lead

		<ul style="list-style-type: none"> Explain about funding of delayed discharges. 		
1a	Only required if full patient details and/or case conference date were not available when Letter 1 Sent.	<p>Now writing to confirm details:</p> <ul style="list-style-type: none"> patient details planned discharge date package of care needed confirmation/change of attribution of patient to primary care organisation <p>Reminder about funding of delayed discharges.</p>	CCG - Director of Commissioning	<p>Continuing Care or any other known contact</p> <p>Social Services</p>
2	Following case conference(s)	<ul style="list-style-type: none"> Update and brief summary of any issues identified in Case Conference, particularly those that may extend rehabilitation or delay discharge, and any action required. Confirm anticipated “fit for discharge” date Reminder about funding of delayed discharges 	CCG - Director of Commissioning	<p>Continuing Care or any other known contact</p> <p>Social Services</p>
3	If no satisfactory response, 10 days later	<p>From General Manager/equivalent</p> <ul style="list-style-type: none"> Formal letter. Details of patient anonymised. Actions / assistance required Explain about funding of delayed discharges. 	CCG Director of Finance	<p>CCG Director of Commissioning</p> <p>Chief Officer CCG</p> <p>Commissioning Lead, SCIC Trust</p> <p>Chief Exec, SCIC Trust</p>
4	As often as	<p>From Trust Chief Executive</p> <ul style="list-style-type: none"> Personal letter explaining 	CCG Chief Executive	CCG Director of Commissioning

	necessary	<p>issues</p> <ul style="list-style-type: none"> • Confirm anticipated “fit for discharge” date • Actions / assistance required • Explain about funding of delayed discharges. 		<p>ning.</p> <p>CCG Director of Finance</p>
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SERVICE SPECIFICATION – SPINAL CORD INJURY (SCI) SERVICES

APPENDIX 4

A fully formatted and indexed version of this document, with any further amendments, can be downloaded from www.nscisb.nhs.uk

National Spinal Cord Injury Strategy Board
 Commissioning Classifications Sub-Group Specialised
 Spinal Cord Injury
 CODING HANDBOOK Second
 Edition

Containing Definitions of Commissioning Classifications (Currencies)
 for Commissioning and Procurement of Spinal
 Cord Injury Services
 provided by Specialised Spinal Cord Injury Centres in England

Version 21 draft 7
 18th September 2012
 FOR USE in CONTRACTS 2013/14

Introduction

Purpose of this Handbook

Because of the complexity and range of the service, Specialised Spinal Cord Injury is outside the scope of Payment by Results. PbR tariffs, rules, inclusions and exclusions do not apply to the service.

The purpose of this Handbook is to set out the national codes to be used in classifying activity in the Specialised Spinal Cord Injury Service, with definitions and rules.

This will be the final version for use in 2013/14 Contracts.

Why is such a complex coding system required?

The specialised Spinal Cord Injury Service provides not only care following injury, which usually lasts many months, but life-long care for patients living with spinal cord injury. In people with no sensation below the level of injury, the body learns to function in unusual ways. Illness can go undiagnosed, and problems which would not be serious in another patient can become life-threatening. The spinal cord injury centres therefore provide an extensive range of medical and allied health services to patients, not only those which are obviously related to the spine.

In effect, the SCICs provide a microcosm of the NHS to a small set of people whose medical needs differ significantly from those of the general population.

Most SCICs “entered” the market on block or simple bed-day contracts, and had not progressed beyond that point. None of the SCICS had a tariff system that was fit for good-quality commissioning. There was little data collection in most SCICs. This situation put the service outside the Scope of PbR, yet it badly needed a payment system which linked payment to need, cost and quality, and removed perverse incentives.

With the endorsement of the Department of Health PbR Team, the Currencies Group embarked on the task, initially of classifying SCIC activity into clinically meaningful codes, and then of developing tariffs, for use as the National Tariffs for the Specialised SCI Service.

Scope, Inclusions and Exclusions

The codes in this Handbook apply to all activity within the Scope of the Specialised Spinal Cord Injury Service as defined in the 2013/14 Service Specification. For full details of the Scope of the Specialised Spinal Cord Injury Service please refer to the 2013/14 Service Specification.

In order to assist in development and costing, some items which are outside the scope of the specialised Spinal Cord Injury Service have SCI codes.

This is explained further in Sections 1, 2 and 9.

Accountability

This Handbook has been developed by the Commissioning Classifications (Currencies) Sub-Group of the National Spinal Cord injury Board, with the participation of the eight specialised Spinal Cord Injury Centres, Commissioners and service users. The NSCISB is accountable to the National Specialised Commissioning Group.

This project is a DH PbR Development Site.

The Second Edition of this Handbook was approved by the **National Spinal Cord Injury Strategy Board** on 24th August 2012 as reflecting progress to that point. It was approved by the **SCI Clinical Reference Group** on 21st August 2012 for procurement of the service in 2013/14.

Development

The Handbook been changed many times during development, and this has resulted in some anomalies in the numbering of codes. It has been agreed that it would be inconvenient to change these codes at the present time, but it may be possible to rationalise them when the National SCI Database begins to produce the reports. A few codes are shown in large font to highlight this.

There is a separate Costing Handbook which was written for this project by the DH PbR Team.

The Commissioning Classifications (Currencies) Sub-Group is allowed by its Terms of Reference to make continuous improvements to reflect development and refinement of

the codes and definitions. It is expected that as the body of activity and cost data increases, changes will be made to the codes for 2014/15 Contracts and beyond.

The Packages

In-patient activity has been classified into clinically meaningful “packages” which are not necessarily the equivalent of a “spell”. A patient may have more than one package during an admission.

There are also packages for non-admitted care.

Details of what is included in the packages are set out in the main body of the Service Specification. For the avoidance of doubt everything required to treat the patient is included in the package and tariff, unless the Service Specification states that the item is chargeable as a separate SCI package, or chargeable to a different specialised service or purchaser.

Where an item is not expected to be provided from within the package tariff, it has been given a separate code. Example: certain implantable devices can be charged to SCI contracts at purchase price, but the procedure and bed days required to implant the device will be included in the relevant inpatient package.

Tariffs

This Handbook does not include tariffs, which are listed separately. In 2013/14, contracts will be based on national commissioning classifications, and local tariffs (meaning tariffs specific to the individual provider).

The use of local tariffs recognises that there are historic differences in the model of service in the different SCICs. However, the aim is to work towards common tariffs, in parallel with progress towards full compliance with the model of care set out in the National SCI Pathways, and a programme to measure outcomes.

Some notes about tariff methodology are provided within the Sections.

Contracting in 2013/14

The packages and codes in this Handbook will be used in contracts for specialised spinal cord injury services in 2013/14. There will be no local variations to the codes, definitions, rules, inclusions or exclusions, unless formally approved by the NHS England and the Currencies Sub-Group.

The codes and definitions in this Handbook will cover most activity. Occasionally a patient may follow an exceptional pathway. In such cases either the provider or the commissioner may refer the case to the Coding Panel, which will advise the most appropriate code.

The Terms of Reference of the Coding Panel are attached as Appendix 1.

National SCI Database

In the development stage, activity has been assigned to the codes “manually” by staff in the Spinal Cord Injury Centres.

The SCI codes cannot currently flow through the NHS Secondary Uses Service, and are unlikely to do so in the near future. The DH PbR Team therefore recommended that a database be built to capture and classify the data.

One of the primary functions of the National SCI Database, now under development by the National Spinal Cord Injury Strategy Board, is to act as the “grouper” and produce contract activity reports.

Abbreviations

SCI	Spinal Cord Injury
SCIC	Spinal Cord Injury Centres
PbR	Payment by Results
NSCISB	National Spinal Cord Injury Strategy Board

Summary of Sections

ADMITTED CARE

Section 1

Contains codes for services which are provided in the SCIC but are outside the Scope of Specialised SCI.

The codes cover people with conditions which are outside the scope of the specialised SCI service. In many cases these patients are within the scope of another specialised service, and they will be classified and charged accordingly.

In other cases these patients are not within the scope of any specialised service and they will be “put through the grouper” and charged at the PbR tariff.

These codes are used for costing and administrative purposes only and will not appear in contracts.

Section 2

Contains codes for services which are provided in the SCIC but are outside the Scope of Specialised SCI.

The codes cover non-clinical delayed discharges ie people who have completed their treatment and are clinically fit for discharge. The Currencies Group will set a daily tariff for these which will be charged to the local responsible commissioner.

Further information about the prevention of non-clinical delayed discharges is contained in Appendix 2 of the Service Specification.

These codes are used for costing and administrative purposes only and will not appear in contracts.

Section 3

This section covers the initial admission of the patient to a SCIC after their injury. It contains

Acute management, which can be either

- 32. Surgical
- 33. Non-surgical
- 34. Rehabilitation
- 35. ITU (which can also be used in further admissions)
- 36. Ventilation (which can also be used in further admissions)

Section 4

Further admissions, ie the admission of a person living with spinal cord injury.

These are grouped into several types.

NON ADMITTED CARE

Section 5

Not in use

Section 6

Outpatient attendances

Section 7

Outreach clinics

Section 8

Outreach visits

Section 9

Outside the scope of the specialised SCI service. Used for classifying transport costs.

These codes are used for costing and administrative purposes only and will not appear in contracts.

Section 10

Not in use

Section 11

Not in use

Section 12

Restricted list of items or services which can be charged to SCI contracts but which would not be “Exclusions to PbR”. Some conditions apply.

Section C

Restricted list of items which can be charged to SCI contracts. Includes some items corresponding to the current national “PbR Exclusions” list. Some conditions apply.

General Rules

The following rules apply to all SCI codes.

Contracts in 2012/13

Until commissioners and providers formally change to contracting in the new currencies, existing contracting arrangements and tariffs apply.

Shadow monitoring of activity in the new currencies is taking place throughout 2012/13.

Banding

The codes and bandings attributed to the patient are derived from the condition of the individual patient, and never from the bed or ward in which the patient is accommodated.

Children and Adolescents

The suffix P is added to codes to indicate the patient is under 19 years at the commencement of the package, but only if:

- The child was accommodated in a dedicated paediatric or adolescent environment

And

- The service was delivered in compliance with the Service Specifications for Specialised Paediatric Services.

To avoid repetition, the definitions are not shown against the P codes. The definition and any rules applying the adult code also applies to the P Code. This is not intended to imply that the same tariff will apply to adults and children.

Where no P code is shown in the Handbook, children will be coded to the adult code.

Age of Patient

Wherever the age of the patient is a factor, the age at **commencement of the package** will apply.

Currently the only codes dependent on age are the assignment of P codes to patients under 19.

Age is reported for all packages, as it may be required for further analysis of data, and tariff development.

Definition of 'Fit for Rehabilitation'

For the purposes of these classifications rehabilitation packages will commence when the patient is:

- Able to sit up in a wheelchair for four hours
- and fit for rehabilitation
- and has
- either been weaned (if previously ventilated)
- **or** has ventilation requirements which permit full participation in rehabilitation.

Definition of Ventilation and Tracheostomy

For the purposes of these classifications

SCI Ventilation

means respiratory support delivered to a person with SCI, who is not in intensive/critical care (as defined for code 350), by any mechanical/electronic means, regardless of whether the air/oxygen is delivered via tracheostomy or mask, or with the assistance of a phrenic nerve stimulator.

Not ventilated, but is dependent on tracheostomy

means the patient is not ventilated, but is entirely dependent on the tracheostomy for breathing and would die at once without it. Such cases are expected to be rare.

Definition of Central Cord Syndrome

For the purposes of these classifications, Central Cord Syndrome is marked by a disproportionately greater impairment of motor strength in the upper extremities than in the lower ones, (ie a difference equal to or greater than 10 in the ASIA motor score), as well as by bladder dysfunction and a variable amount of sensory loss below the level of injury.

Definition of Cauda Equina

Patients with Cauda Equina will only be classified to codes in this Handbook, if:

They meet the criteria set out in the Service Specification for Spinal Cord Injury, which are:

Services provided to adults and children with Cauda Equina Syndrome which results in

Either Motor and sensory effects on bowel and bladder function resulting in retention/incontinence of bowel and/or bladder

Or Loss of safe upright mobility.

And they are treated by the specialised Spinal Cord Injury Service

Inclusions

The services defined by the SCI Commissioning Classifications codes include all equipment, staffing, surgery, outpatient procedures, drugs, devices, orthotics, functional electrical stimulation (“FES”), consumables and costs, including items required to treat co-morbidities, required by in-patients and patients being followed up by the SCIC, unless:

- Additional payment is explicitly allowed under the latest version of this Handbook
- Or
- The item is outside the scope of the specialised SCI service as defined in paragraph 2.4 of the Service Specification.

No package (apart from 350 ITU, Sub-Section 36 Ventilation and items classified to Section 12 and Section C) can occur at the same time as another package.

For all packages, except 350, and devices and drugs in Section 12 and Section C:

Commencement will be the date on which the patient commenced the package. End date will be the date on which the patient ended the package. The duration of the package (or length of stay) will be the latter, minus the former.

This method will also apply to counting for any package or top-up for which the tariff is a daily rate, such as Section 2, Sub-Section 36, Sub-Section 45 and code 124, but **not** to 350 ITU.

Example:

	Start Date	End Date	Total Length of Stay
First package	01/01/2009	05/01/2009	4
Second package	05/01/2009	07/01/2009	2
Third package	07/01/2009	01/02/2009	<u>25</u>
			31

Packages during which the patient was transferred to ITU package 350

These will be counted as follows: Example:

	Start Date	End Date	Total Length of Stay
343	01/01/2009	31/01/2009	30-8=22
350	10/01/2009	17/01/2009	8

This is consistent with the way ITU is reported under PbR.

Devices and drugs in Section 12 and Section C

The date reported will be the date on which the device or drug was supplied. This will enable reconciliation with any associated admission or attendance.

Additional Rules

Where rules apply only to a Section, or to a Code, they are set out in the relevant Section or Sub-Section.

Section 1: Non SCI Patients

Not within the Scope of Specialised SCI.

Advice

Contains codes for services which are provided in the SCIC but are outside the Scope of Specialised SCI. These codes are used for costing and administrative purposes only and will not appear in contracts.

These patients are treated by the SCI service in some locations, and may have been charged to SCI contracts prior to 2013/14.

Section Rules (see also General Rules)

In many cases these patients are within the scope of another specialised service, and they will be classified and charged accordingly.

In other cases these patients are not within the scope of any specialised service and they will be “put through the grouper” and charged at the PbR tariff.

Codes

100/ 100P Patients with injury to spinal column but intact neurology (with the exception of up to two nerve roots) admitted to spinal cord injury departments.

101/ 101P

10 Non-admitted care by the spinal cord injury centre of patients who are outside the scope of specialised SCI.

Tariffs

There are no SCI tariffs for this Section. Activity in this section is classified to the appropriate codes and tariffs for the diagnosis and activity, and charged to the appropriate specialised or non-specialised services contracts.

Section 2: Non-Clinical Delayed Discharge Bed Days

Not within the Scope of Specialised SCI.

Advice

Contains codes for services which are provided in the SCIC but are outside the Scope of Specialised SCI. These codes are used for costing and administrative purposes only and will not appear in contracts.

The codes cover non-clinical delayed discharges ie people who have completed their treatment and are clinically fit for discharge. The Currencies Group will set a daily tariff for these which will be charged to the local responsible commissioner.

Further information about the prevention of non-clinical delayed discharges is contained in Appendix 2 of the Service Specification.

Section Rules (see also General Rules)

These classifications commence on the day on which the patient became fit for discharge.

The package is a single day, and patients are banded according to their condition and age at 00.01 am on that day.

For counting of bed days, see General Rules,

If a delayed discharge patient becomes unwell to the extent that it would not be safe to discharge him/her, he/she will be coded to the appropriate Section 4 package until he/she is fit for discharge again.

Codes

201/201 P

202/202P Delayed discharge bed-day – patient on SCI Ventilation but not in ITU. **Patient is ventilated for less than 24 hours in 24**

203/203P Delayed discharge bed-day – patient not in ITU - Patient is not ventilated, but is **dependent on tracheostomy**. Only used in the rare circumstances where a patient is not ventilated, but is entirely dependent on the tracheostomy for breathing and would die without it.

204/204P Delayed discharge bed-day – tetraplegic C8 and above

205/205P Delayed discharge bed-day – paraplegic and cauda equina

Tariffs

Per bed-day. Chargeable to local commissioner at tariffs set by Currencies

Group. See Service Specification for details.

Section 3: Newly Injured Patients

Multidisciplinary management of newly injured SCI patients from admission until the end of the rehabilitation phase.

Advice

Because a patient may join the pathway at various points, depending on the treatment provided in a previous setting, Section 3 is broken down into sub- sections.

There are two possible pathways in the acute recovery phase – surgical and non-surgical: the patient will not have both.

Surgical management implies that the spine has been surgically stabilised / re-aligned / decompressed, and a period of **recovery** follows before the patient commences **rehabilitation**.

Non-surgical management means the patient has been stabilised by bed rest and/or external fixation.

The surgical and non-surgical pathways converge when the patient has recovered sufficiently to commence rehabilitation.

Rehabilitation should strictly commence almost immediately after injury, but for the purposes of this document there is a rule which defines the commencement of the rehabilitation. The full wording is in the General Rules.

The packages in this Section are broken down further to reflect the different dependency levels of different levels of injury. These distinctions are referred to as “bandings”.

The use of codes 329, 339 and 349 prevents double charging for interrupted packages. There will be £0 tariffs for these code, as the costs will be recovered in the tariff for the recovery package. There is therefore no need to split the “interrupted” codes into levels of injury, adult/child etc.

Section Rules

Only newly spinal cord injured patients and patients with new cauda equina syndrome meeting the criteria in the SCI Service Specification will be coded to Section 3 codes.

A patient will only experience the Section 3 pathway once in their life-time. The only exception to this rule is the use of code 350 ITU and codes 360, 365 and 369 Ventilation in further admissions.

A patient will only experience one Section 3 recovery package and one Section 3 rehabilitation package in their lifetime. The only exception is for interrupted packages, as defined in these classifications.

(A possible additional exception to these rules is a patient living with SCI who incurs a second spinal cord injury later in life at a higher level of the spine. Such a case would be referred to the coding panel.)

A patient admitted shortly after injury will usually experience: **either** 321 (surgery) **and** 322/323 (surgical management) **or** 331/2 (non-surgical management).

No patient will be coded to both the pathways above. If there is a change in intended management, it will be necessary to change the code retrospectively.

If admitted after stabilisation/re-alignment/decompression surgery elsewhere and not yet ready for rehabilitation, the patient will experience 322/323.

If the patient arrives at the SCIC ready to commence rehabilitation, the patient will begin with Sub-Section 34. The use of codes 322/323 or 331/2 for a few days between admission and commencement of rehabilitation is not appropriate in these circumstances.

With the exception of 321, any surgery during the first admission following injury is part of the recovery or rehabilitation package, and is included in the tariff for recovery or rehabilitation. This applies whether the surgery is a return to theatre for further spinal surgery or any other kind of surgery.

If it is decided to manage the patient non-surgically, but a decision is taken **later in the recovery period** to stabilise the spine surgically, the coding will be changed retrospectively to 321 and the relevant recovery package.

If the patient is initially managed non-surgically, but it is decided **during the rehabilitation package** to carry out surgical stabilisation of the spine, the coding will be as follows:

33* (* = appropriate banding) Non-surgical management, followed by

34* (* = appropriate banding) Rehabilitation, followed by

321 Spinal Surgery to stabilise the spinal fracture, followed by

349 Continuation of interrupted rehabilitation

Section Tariffs

Surgery to stabilise, re-align or decompress the spine, and surgery for Cauda Equina Syndrome. The tariff will be per package.

There will be four price bands for surgery, and a list will be issued of which procedures map to which bands.

Recovery: The tariff will be per package.

Tariffs will apply to the entire recovery package, including any 329 or 339 “continuation” activity. There will however be an outlier bed day rate for short or long stays. Short stays will be paid at the outlier bed day rate only. Long stays will be paid at the package rate plus the outlier rate for bed-days beyond the threshold.

The tariffs for Section 3 packages include treatment of any pressure sore present on the arrival of the patient in a newly injured patient, including any surgery required, but exclude the daily cost of pumps and consumables for Negative Pressure Wound Therapy (NPWT) which can be classified as **code 124**.

Section Rules for Banding

For recovery packages commencing with the numbers 322, 323, 331 and 332:-

The patient will be assigned to the most appropriate package to reflect his/her level of impairment on the **28th day after the date of his/her injury** or on the final day of the package, whichever is earlier.

Prior to Day 28 patients will be assigned provisionally to the most suitable package, but this will be changed retrospectively to the package corresponding to the condition of the patient at Day 28, or on the final day of the package, whichever is earlier. This will determine the classification at which the patient’s recovery will be charged.

Any admission for recovery after injury commencing within three months of the last day of a previous recovery package is deemed to be Continuation of an interrupted package for the purposes of these Classifications.

For rehabilitation packages commencing with the numbers 342, 343, 344 and 345

The patient will be assigned to the most appropriate package to reflect his/her level of impairment on the **28th day after the date of injury**, or on the final day of the package if this is earlier.

Prior to Day 28 patients will be assigned provisionally to the most suitable package, but this will be changed retrospectively to the package corresponding to the condition of the patient at Day 28 (or the final day of the package if this is earlier), and this will determine the classification at which the patient's rehabilitation will be charged.

For any Interrupted Packages

The rules about banding apply even if the package has been interrupted.

Sub-Section 31

This section was withdrawn in 2011 but code 310 will appear on activity reports for the earlier part of 2011/12.

For coding of ITU please refer to Sub-Section 35, code 350.

Sub-Section 32 – Surgical Management following Injury

This Sub-Section contains:

Surgery to stabilise/re-align/decompress the spine

The “recovery” phase between surgery and rehabilitation.

Sub-Section Rules Banding: see
Section Rules

Package 321

This commences on admission. It ends immediately after surgery.

Code 321 is only used for surgery to stabilise/realign/decompress the spine following spinal cord injury, and surgery for cauda equina syndrome, but not for any other surgery. (See Section Rules). Two-stage fusion is counted as a single procedure and is assigned to the date on which the first stage was carried out.

If a patient experiences spinal surgery within the SCIC host Trust, the surgery will be classified to the codes in this Handbook only if the patient is diagnosed with spinal cord injury or Cauda Equina Syndrome as defined in the Service Specification (see General Rules).

If the spinal cord injury is of iatrogenic origin and occurred in the SCIC's host Trust, the patient will only be classified to a Spinal Cord Injury code at the point at which spinal cord injury rehabilitation commences.

322 and 323 Packages

These commence:

- immediately after spinal surgery to stabilise/re-align/decompress the spine (where undertaken in the SCIC) or Cauda Equina Surgery (where undertaken in the SCIC).

Or

- on admission, if stabilisation/re-alignment/decompression or Cauda Equina Surgery has been undertaken elsewhere.

They end when the patient is fit to commence rehabilitation, as defined in the General Rules, or if the patient is discharged.

They include, where applicable :

- all necessary investigations, full MDT management,
- any surgery other than package 321. This applies whether the surgery is a return to theatre for further spinal surgery or any other kind of surgery.
- any urological procedures
- all investigations and multidisciplinary management
- the management of any co-existing pathology or complications maintenance of any equipment provided

They exclude:

- The definitive spinal column or cauda equina surgery (see 321)
- Items which have been given their own classification in this document (see Sections 12 and C)

See Section Rules for treatment of pressure sores.

Codes

321 /321P Spinal Surgery to stabilise/re-align/decompress the spine or cauda equina surgery. The package includes the surgical procedure including operation, and orthoses used in surgery. It includes bed days between admission and surgery.

There will be four cost bands. A list of which procedures map to which banding will follow.

321-1	High
321-2	Medium High
321-3	Medium Low
321-4	Low
322-2 /322-2P	

322-3 /322-3P Recovery post surgery – low tetraplegic (neurological deficit C5-C8)

323-1 /323-1P Recovery post surgery – paraplegic, AIS D and Cauda Equina
329 Continuation of interrupted recovery package – para or tetra

This code is used in circumstances where the period of recovery from stabilisation surgery (ie 322 or 323) has been interrupted by another event. This could be, for example, transfer out to another hospital for treatment.

Any recovery package commencing within three months of the last day of a previous recovery package is be deemed to be Continuation of an interrupted package for the purposes of these Classifications.

Sub-section 33– Non-Surgical Management of newly injured patients who have not been stabilised surgically

Advice

Non-surgical management is sometimes referred to as “conservative” management.

Sub-Section Rules

Patients with external stabilisation, such as halo or plaster, will be classified as “non-surgical management” (i.e. not Section 32) even if a general anaesthetic is used during stabilisation.

Late decisions to stabilise the spine – see Section Rules

Banding: see Section Rules

331 and 332 packages

These commence on admission.

They end when the patient is fit to sit up in a wheelchair for four hours.

and has

either been weaned (if previously ventilated)

or has ventilation requirements which permit full participation in rehabilitation.

- They include, where applicable: all necessary investigations
- full MDT management,
- any surgery other than package 321. This applies whether the surgery is a return to theatre for further spinal surgery or any other kind of surgery.
- any urological procedures

- all investigations and multidisciplinary management
- the management of any coexisting pathology or complications

They exclude:

- Items which have been given their own classification in this document (see Sections 12 and C)

See Section Rules for treatment of pressure sores.

Codes

331-2 /331-2P

331-3 /331-3P

332-1 /332-1P

339 Continuation of interrupted package of acute non-surgical management (para or tetra)

This code is used in circumstances where the period of conservative management following injury has been interrupted by another event. This could be, for example, transfer out to another hospital for treatment.

Any recovery package commencing within three months of the last day of a previous recovery package is be deemed to be Continuation of an interrupted package for the purposes of these Classifications.

Sub-Section 34 - Rehabilitation following injury

Advice

For definition of commencement of rehabilitation please refer to Section Rules

Sub-Section Rules

Banding: see Section Rules

Section 34 packages will include, where applicable:

- all necessary investigations
- full MDT management,
- any surgery other than package 321. This applies whether the surgery is a return to theatre for further spinal surgery or any other kind of surgery.
- any urological procedures

- all investigations and multidisciplinary management
- the management of any coexisting pathology or complications

They exclude:

- Items which have been given their own classification in this document
 - (see Sections 12 and C)
 -
 - See Section Rules for treatment of pressure sores
 -
 -
 -
 -
 - **Sub-Section Tariffs**
 -
 - Tariffs for this section will apply to the entire rehabilitation package, including any 349 “continuation” activity. There will however be an outlier bed day rate for short or long stays. Short stays will be paid at the outlier bed day rate only. Long stays will be paid at the package rate plus the outlier rate for bed-days beyond the threshold.
 -
 - **Codes**
 -
 - 342-2 /342-2P
 -
 - 342-3 /342-3P
 - 343 /343P Rehabilitation trauma and non trauma – paraplegic
 - 344 /344P Rehabilitation trauma and non trauma – patients assessed as AIS D unless classified as 345 OR patients assessed as Cauda Equina Syndrome as defined in the SCI Service Specification (see General Rules).
 - 345 /345P Rehabilitation trauma and non trauma – patients assessed as AIS D central cord syndrome
 - 349 Continuation of interrupted rehabilitation

This code is used in circumstances where the period of rehabilitation following injury has been interrupted by another event.

This could be for, example **late spinal stabilisation surgery** (see Section Rules)

-
- Any admission for rehabilitation commencing within three months of the last day of a previous rehabilitation package is deemed to be Continuation of an interrupted package for the purposes of these Classifications.
-

- **Sub-Section 35 – ITU (Critical Care)**
-

- **Advice**

- The rules about coding of ITU were changed with effect from 1st November

- 2011, after it became clear that Trusts were defining ITU differently. It was also decided to bring the counting of ITU bed-days more into line with how they are recorded under national PbR.

Prior to October 2011, packages were interrupted when the patient went into ITU. The old codes 310 and 410 will be found on earlier reports. For the earlier rules please refer to Handbook version 19.

“Ventilated beds”, High dependency beds, “Spinal ITU” beds and similar are not counted as ITU, and the costs of treating patients on ventilation are reflected in the top-up in Sub-Section 36.

Sub-Section Rules

ITU is defined within International Critical Care Guidelines as Level 3 care. A different definition is required for patients with spinal cord injury.

For patients in the specialised SCI service, code 350 means:

- **Patients requiring: advanced respiratory support together with support of at least one other organ system**
- **or basic respiratory support together with support of at least two organ systems.**

All patients not covered by this definition will be coded to the appropriate package dependent on their level of impairment.

Code 350 is used for ITU, whether occurring during the first admission following injury or during further admissions.

A patient cannot be coded to 350 and a sub-section 36 (ventilation) code simultaneously.

The “package” for this code is a single bed day.

For counting of ITU activity, please refer to General Rules

Codes

350	ITU bed day as defined in the Sub-Section Rules
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Sub-Section Tariffs

Notes to be added

Sub-Section 36 – SCI Ventilation

Advice

The rules about Ventilation were changed in September 2012. Prior to September 2012, ventilated patients in recovery, rehabilitation and some further

admission packages were banded (as high tetraplegics, low tetraplegics, paraplegics etc continue to be). The old codes will be found on earlier reports. For the earlier rules please refer to Handbook version 21 draft 4.

Sub-Section Rules

For the definition of SCI Ventilation and “dependent on tracheostomy”, please refer to the General Rules.

Sub-section 36 codes are used for ventilation, whether occurring during recovery, rehabilitation or further admissions.

The ventilation codes differ from 350 ITU as they are daily top-ups. They are chargeable in addition to the recovery, rehabilitation or further admission package, for those bed-days on which the patient was ventilated, and do not replace or interrupt the package.

A patient cannot be coded to 350 ITU and a sub-section 36 code simultaneously. The “package” for these codes is a single day.

For counting of Sub-Section 36 activity, please refer to General Rules. Warning: Counting is **not** the same as for 350 ITU.

Codes

Code 360	(Bed-day) is used for patients who are ventilated less than 24 hours in 24.
Code 365	(Bed-day) is used for patients who are ventilated 24 hours out of 24.
Code 369	(Bed-day) is used for a patient who is not ventilated, but is dependent on a tracheostomy. This means the patient is not ventilated, but is entirely dependent on the tracheostomy for breathing and would die at once without it. Such cases are expected to be rare.

Section 4 – Admissions of Patients with Pre-Existing SCI.

These may be referred to as “further admissions”

Advice

Code 110 was withdrawn with effect from 1st November 2011 and all further admissions are now classified to section 4.

Code 410 ITU in further admissions was withdrawn with effect from 1st

November 2011. Please refer to code 350.

Patients in further admissions who are ventilated are eligible for the daily top-ups described in Sub-Section 36.

In many cases these people will have previously been managed as described in Section 3, but prior admission to a specialised SCIC is not a pre-requisite of being coded to Section 4. A person who was spinal cord injured in the past but not admitted to a SCIC at the time will be coded to Section 4.

An algorithm will be required in order for the National SCI Database to assign patients to these groups. It will probably first identify 45s, then 43s, then 44s, then 46s, and others will default to code 420.

Section Rules

These codes apply to people living with spinal cord injury.

Any admission for recovery after injury commencing within three months of the last day of a previous recovery package is deemed to be Continuation of an interrupted package for the purposes of these Classifications. Please refer to Section 3.

Any admission for rehabilitation commencing within three months of the last day of a previous rehabilitation package is deemed to be Continuation of an interrupted package for the purposes of these Classifications. Please refer to Section 3.

No two packages Section 4 packages will occur concurrently.

The patient will not normally have more than one Section 4 package in a spell.

Exceptionally, should two Section 4 packages occur consecutively the commissioner will expect the provider to provide evidence to support classifying the activity to two packages in a single admission.

Sub-Section 42 Other further admissions

Sub-Section Rules

This code is used for all further admissions which are not Sub-Sections 43, 44, 45 or 46

Codes

420 /420P	Further inpatient management of people living with SCI, not covered by Sub-Sections 43, 44, 45 or 46
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Sub-Section Tariffs

The tariff will be per package, with outlier daily rate for short and long stays.

Sub-Section 43 Further Rehabilitation

This may also be referred to as second-stage rehabilitation.

Sub-Section Rules

This code is used only for an elective admission, with a pre-planned duration, and with the primary purpose of working towards defined goals, and which involves daily multidisciplinary input.

Algorithm needed

See Section rules about interrupted packages.

Codes

430 /430P Further rehabilitation.

Sub-Section Tariffs

The tariff will be per week. Stays will be rounded up or down to the nearest week.

Sub-Section 44 Multi-disciplinary Review and Assessment (patient admitted).

This may be referred to as “MOT”

Sub-Section Rules

The patient is admitted, not for clinical need, but to facilitate the Review. This is the equivalent service to code 610 with the addition of “bed and breakfast”

This code will only apply to elective admissions.

This code applies to pre-planned systematic review by:

- one or more doctors

and

- nurses or therapists.

during which the patient experiences invasive and/or exploratory investigations or procedures,

and

- 6 month, 12 month, or 24 month SCIM assessment
- 6 month, 12 month, or 24 month ASIA assessment

and

- any other assessments currently mandated under contractual quality and outcomes programmes.

For patients who are ventilated this additionally includes:

- Formal review of respiratory capacity and ventilation parameters

Algorithm needed

Codes

440 /440P Review / assessment

Sub-Section Tariffs

The tariff will be per package. The rate will be the same as for an outpatient MOT, plus a sum in recognition of the overnight stay.

Sub-Section 45 Pressure Ulcer Management

Advice

The Currencies Group and/or the Clinical Reference Group, will as part of the QIPP programme for 2013/14, develop “unbundling” or further coding to cover situations where the patient is managed in the community, and admitted to the SCIC for active treatment. To facilitate “unbundling” the package for this sub-section is, exceptionally, a bed-day in 2013/14.

Sub-Section Rules

The codes are for patients admitted for the primary purpose of managing a pressure ulcer.

These codes are not used for newly injured patients admitted with a pressure ulcer.

These codes are not used for a patient who has acquired a pressure ulcer whilst an in-patient in the SCIC.

Sub-Section Codes

450 /450/P Patient admitted for pressure sore management (bed-day)

124 (see Section 12) Daily supplement for pumps and consumables used in Negative Pressure Wound Therapy (NPWT)

Sub-Section Tariffs

For 2013/14 the package will be a single bed-day. However there is an expectation that all SCICs will develop plans for more cost-efficient ways of managing pressure sores.

The packages include any surgery, rehabilitation and everything else carried out or provided during the admission, with the exception of 350 ITU, Section

36 Ventilation, any items attributable to Section 12 or Section C, (see code 124).

Sub-Section 46 Urology

Advice

Urological problems are a common complication of spinal cord injury.

Sub-Section Rules

These codes are used for people admitted for the primary purpose of urological assessment and/or treatment.

These codes are not used for people who have urological treatment in the course of a Sub-Section 43, 44 or 45 admission.

The codes include everything else carried out or provided during the admission, with the exception of 350 ITU, Sub-Section 36 Ventilation, or any items attributable to Section 12 or Section C.

Codes

460 /460P Urology, excluding day cases

462 /462P Urology day case

Sub-Section Tariffs

The package will be per package with outlier daily rate for short and long stays.

Sub-Section 47 Maternity

Advice

This code has been added in October 2012 in case it is needed in 2013/14. It is not being used in the costing exercise being carried out in October/November 2012. It may prove necessary to identify this activity, because of the introduction of the proposed single payment for maternity under PbR.

Sub-Section Rules

These codes are used when the primary purpose of the admission is the ante-natal, delivery or post-natal care in a woman with SCI or Cauda Equina syndrome as defined in the General Rules.

Codes

470	Maternity, except day cases
472	Maternity day case

Sub-Section Tariffs

The implications of the new PbR tariff for maternity needs to be investigated, as payment cannot be duplicated.

It appears that where the woman registers for maternity care with the host Trust of the SCI there is no problem, as the Trust will claim the maternity tariff (probably the “Complex Maternity” tariff.) Any cross-charging would be an internal matter.

However if the woman registers with another Trust, the SCIC Trust will need to request unbundling of the tariff from that hospital.

Section 5

Not used

Outpatient multi-disciplinary reviews are now in Section 6.

Section 6 - Outpatient attendances

Advice

It is good practice for the patient to see as many staff as they need to see in one visit, and not to have to make multiple visits.

The four sub-sections 610, 620, 630, and 640 below therefore accommodate patients who may be seen by multiple staff-groups on one occasion. The highest tariff applies to code 610, then 620, then 630, then 640.

The algorithm will sort attendances to identify 610s, then 620s, then 630s, and all attendances not meeting the criteria for higher classification will default to 640.

Section Rules

The services in this Section all apply outpatient activity only.

No patient will experience more than one of the following packages in a day:
610, 620, 630, 640.

All packages include the elements defined in the Sub-Section Rules, or any other services provided to the patient and any other staff seen on that day, unless

The service provided has a Section 12 or Section C code.

Sub-Section 61 Multi-disciplinary Review and assessment.

This may be referred to as “MOT”

Advice

Sub-Section 44 is the same service, when it is necessary for operational reasons to admit the patient.

Sub Section Rules

This code applies to pre-planned systematic review by:

- one or more doctors
- and
- nurses or therapists.

during which the patient experiences invasive and/or exploratory investigations or procedures,

- 6 month, 12 month, or 24 month ASIA assessment
- And 6 month, 12 month, or 24 month SCIM assessment

And any other assessments currently mandated under contractual quality and outcomes programmes.

The code 611/611P additionally includes:

- Formal review of respiratory capacity and ventilation parameters

Codes

610/610P	Multi-disciplinary Review and assessment
611/611P	Multi-disciplinary Review and assessment. in Ventilated Patient. This may be referred to as “MOT Vent”.

Sub-Section Tariffs

Tariffs will be per package

Sub-Section 62 Outcomes Assessment .

Advice

Sub-Section Rules

This is an outpatient visit during which the patient sees at least one consultant, and experiences

- 6 month, 12 month, or 24 month ASIA assessment
- And 6 month, 12 month, or 24 month SCIM assessment

And any other assessments currently mandated under contractual quality and outcomes programmes.

Unless the attendance meets the criteria for Code 610/611

Codes

620 /620P Outcomes Assessment

Sub-Section Tariffs

Tariffs will be per package

Sub-Section 63 Outpatient Visits to Doctor

Sub-Section Rules

This is an outpatient visit during which the patient sees at least one doctor, unless the visit meets the criteria for code 620 or 610.

Codes

630/630P Outpatient Visit – Doctor

Sub-Section Tariffs

Tariffs will be per package

Sub-Section 64 Outpatient Visits to Nurse and/or Therapist

Sub-Section Rules

This is an outpatient visit during which the patient sees at least one nurse or therapist, unless the visit meets the criteria for code 630, 620 or 610.

Codes

640 /640P Outpatient Visit – Nurse or therapist

Sub-Section Tariffs

Tariffs will be per package

Sub-Section 64 Outpatient Visits for Maternity

Sub-Section Rules

See explanation under Sub-Section 47

This is an outpatient visit for ante-natal or post-natal care.

Codes

470 Outpatient visit – Maternity

Sub-Section Tariffs

Under consideration

Section 7: Outpatient Attendances which have taken place at an Outreach Clinic

Advice

It is considered worthwhile, for strategic and planning purposes, to distinguish this activity from activity taking place on SCIC premises.

Section Rules

This applies only to activity which takes place in regular NHS Clinics organised and held by the SCIC outside the premises of the SCIC provider Trust.

Any activity for which the host organisation charges is excluded.

The provider will identify the location of the Clinics to the Commissioner. This section excludes visits to individual patients in the community, or visits to patients who are in-patients in other hospitals.

Codes

This section mirrors Section 6 in all respects, except that 7 is substituted for 6 at the beginning of the code.

Section Tariffs

Tariffs will be per package

Section 8: Outreach Visits

Advice

Consideration will be given, under the QIPP programme for 2013/14, to developing a code and tariff for “intensive” visits to patients being managed in the community for a pressure ulcer, as part of “unbundling” Sub-Section 44.

There is also a proposal to continue in 2013/14 the CQUIN under which outreach visits were incentivised. If this CQUIN is approved for contracts, the tariff for Outreach Visits will remain in the Currencies handbook, but the tariff will be set at £0 for the year.

Section Rules

This section includes face-to-face visits made by SCIC staff to individual patients.

Each visit is counted only once, regardless of the number and grade of staff who visit.

The visit will include any additional visits made to family, carers, employer, GP, health workers etc.

Only one visit will be counted in any 24 hour period.

Codes

810	Visit to newly injured patient in a hospital which is not part of the same Trust as the SCIC
820	Visit to patient living with spinal cord injury who is an in-patient in a hospital which is not part of the same Trust as the SCIC.
830	Visit to patient in the community.

Section Tariffs

Tariffs will be per package

Section 9: Patient Transport

Not within the Scope of Specialised SCI.

Advice

Contains codes for services which are outside the Scope of Specialised SCI. These codes are used for costing and administrative purposes only and will not appear in contracts.

The NSCISB has issued Guidance on applying the national guidelines to people with SCI needing patient transport services.

Rules

Applies to people treated by the specialised SCI service who are eligible for patient transport services or HTCS.

Codes

910	Patient transport services for those with a clinical need for transport.
920 (HTCS)	Reimbursements under the Hospital Travel Costs Scheme

Section 10

Not in use.

Non-admitted care for patients who are outside the scope of the specialised SCI service is now shown in Section 1.

Section 11

Not in use.

All further admissions are now in Section 4

Section 12: Restricted list of items or services which can be charged to SCI contracts

Advice

These items would not be “exclusions to PbR”.

These items have individual codes because the cost would otherwise distort SCI package tariffs.

It should be noted that until commissioners and providers formally change to contracting in the new currencies, existing contracting arrangements and tariffs apply to these items.

National Commissioning Policies are being developed for some of these products/services, and their inclusion in this list is not intended to imply that they will be commissioned in 2013/4 without restrictions.

Section Rules

These devices are charged to contracts at purchase price, but the hospital stay and the procedure to implant the device is included in the relevant inpatient package

Some contractual conditions may apply to the use of these products: please refer to Service Specification.

Any drug or device not listed in this section or Section C is included in package prices.

Codes

122	Artificial sphincter
123	Phrenic nerve stimulator
124	Daily supplement for pump, dressings and associated consumables used in Negative Pressure Wound Therapy (NPWT)

Likely to be a in the region of £24 per day

This code only applies to patients with pressure ulcers present on admission to the SCIC. In the case of pressure ulcers acquired in the SCIC, the cost will be borne by the provider and may not be charged to the commissioner.

Tariffs

The daily supplement for NPWT is likely to be in the region of £24 per day. Implants will be charged at the (reasonable) rate the provider paid. Providers should expect to use the most cost-effective products, and to provide if requested by commissioners a copy invoice or other agreed voucher.

There will be a facility on the National SCI Database to enter, against the patient record, the date an item was provided and the cost. The database will then calculate the sums to be charged to contracts for these codes.

For pressure ulcers, there will be an algorithm in the database.

Section C: Restricted list of items or services which can be charged to SCI contracts

Advice

The items in C2 are items are on the national PbR exclusions list and although PbR does not apply to the specialised SCI tariffs, it was decided to exclude these items from SCI package tariffs, on the basis that the items would otherwise distort package prices.

It should be noted that until commissioners and providers formally change to contracting in the new currencies, existing contracting arrangements and tariffs apply to these items.

National Commissioning Policies are being developed for some of these products/services, and their inclusion in this list is not intended to imply that they will be commissioned in 2013/4 without restrictions.

Additional notes on PbR Exclusions

Currently the entirety of services provided in SCICs is outside PbR, even when the service would attract a PbR tariff if delivered in another setting. So the concept of a PbR exclusion in SCI does not apply.

This means that the annual national list of PBR “Exclusions” comprising services, drugs and devices does not apply to the specialised SCI Service.

The four items listed under C2 below do happen to be in the PbR exclusions list, but that is for the same reasons that they have a C2 code – they would otherwise distort tariff prices.

Section Rules

Code C1 provides for exceptional circumstances, including occasions when it is unavoidable to deploy agency staff to ensure the safety of staff or patient. These cases are expected to occur very rarely. The code is not used when SCI Trust staff are deployed. In all cases the provider will contact the commissioner in advance to discuss the options and to agree the extent and duration of the relevant service. The provider will, if requested by the commissioner, provide copies of invoices paid.

Code C2 devices and drugs are charged to contracts at purchase price, but any related hospital stay or any procedure to implant a device is included in the relevant inpatient package.

Some contractual conditions may apply to the use of these products: please refer to the Service Specification.

Any drug or device not listed in this section or Section 12 is included in package prices.

Codes

- | | |
|----|--|
| C1 | Daily rate.
Exceptional staffing to support patients with severe mental health problems or learning disability of a challenging nature, or posing serious risk to self or others. |
| C2 | Intrathecal drug delivery pumps
Botulinum toxin
Sacral nerve stimulators
Spinal Cord stimulators |

Tariffs

In all cases, items in this section will be charged at the (reasonable) rate the provider has paid. Providers should expect to use the most cost-effective products, and to provide if requested by commissioners a copy invoice or other agreed voucher.

There will be a facility on the National SCI Database to enter, against the patient record, the date(s) the item was provided and the cost. The database will then calculate the sums to be charged to contracts for these codes.

Change Notice for Published Specifications and Products



developed by Clinical Reference Groups (CRG)

Amendment to the Published Products

Product Name	Spinal Cord Injury
Ref No	D13/S/a
CRG Lead	Charles Greenough

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.		To ensure consistency of specification formatting	CRG	October 2013
	The Quality Dashboard indicators, in use during 13/14, have been added to Section 2.1	Section 2.1	Further clarity	CRG	October 2013
	The core requirements developed for the 13/14 Service Specification	Section 4.1	Further clarity	CRG	October 2013

	Compliance Project have been inserted				
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