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British Society of Rehabilitation Medicine

Promoting quality through education and standards

2021 BSRM Standards for specialist rehabilitation for community dwelling adults – update of 2002 standards

Summary as at 1 March 2021

British Society of Rehabilitation Medicine, C/o Royal College of Physicians, 11 St Andrews Place, London NW1 4LE
Tel: 01992 638 865 | Fax: 01922 638 674 | admin@bsrm.co.uk | www.bsrm.org.uk

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2021 BSRM Standards for specialist rehabilitation for community dwelling adults – update of 2002 standards

Specialist Community Rehabilitation Services should be:

- Patient-centred and accessible to all who need them
- Designed to meet clusters of patient presentations and needs rather than diagnosis
- Delivered by specialised Multidisciplinary professional teams with relevant knowledge, training and expertise who meet regularly to ensure shared discussion and coordinated patient care
- Embedded in rehabilitation networks
- Easy to access with a clear referral process and single point of access when possible
- Offering an Initial assessment that includes advice from relevant senior clinicians
- Delivering evidence based holistic, goal focussed rehabilitation in a timely manner
- Seeing patients intensively when appropriate and offering long term support or review as needed
- Well led by senior rehabilitation professionals
- Using rehabilitation prescriptions or other patient and service shared documentation
- Collecting and reporting patient and service level data on needs and outcomes
- Using complex case reviews including all relevant services when needed.

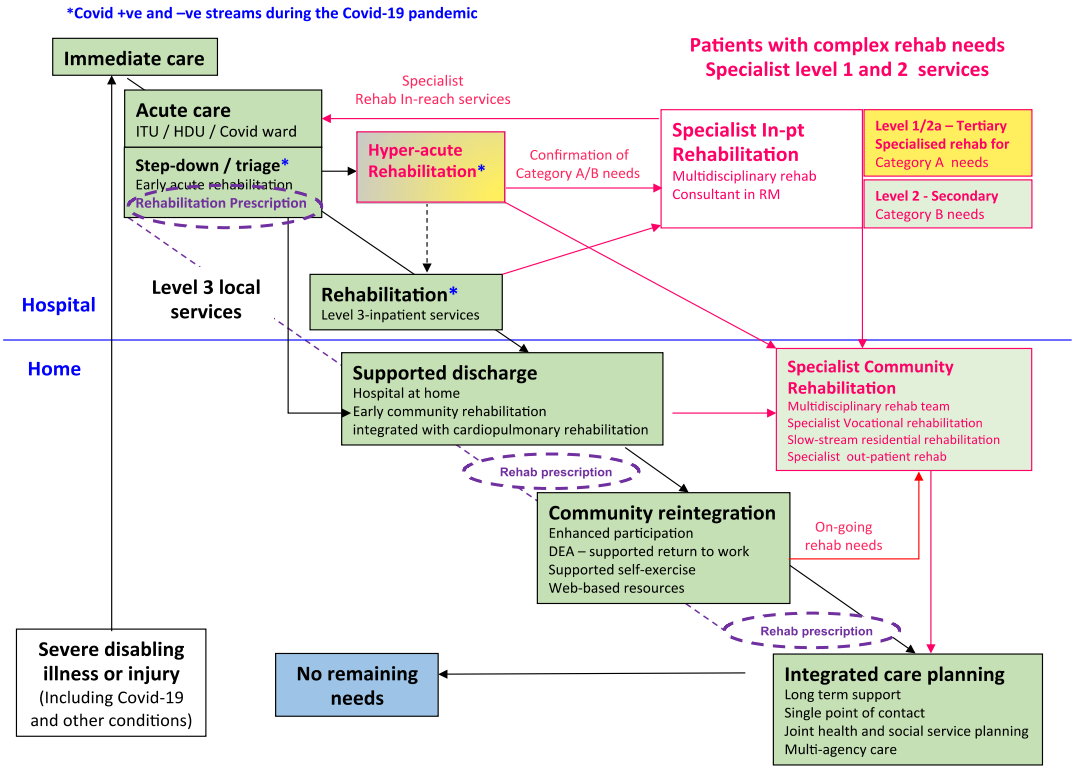
Summary

Specialist rehabilitation is necessary when people have developed loss of function across several domains following illness or injury. This requires coordinated assessment and rehabilitation from several rehabilitation professions with knowledge and expertise in managing their condition.

- It is not only a critical part of the acute care pathway by enabling early discharge, but is also essential for effective rehabilitation of people living in the community, either with long term conditions or following acute onset illness or injury.
- Over the last 20 years, since previous guidelines were published, a considerable body of evidence has accumulated indicating that provision of Specialist Community Rehabilitation can, when available, reduce the length of stay in acute settings and facilitate patients' return to work or other chosen activity, as well as preventing development of long term complications or readmission to hospital. (refer to fig 1 rehab pathway).
- Its development has varied across the UK. Services have evolved to meet the needs of people with a wide range of conditions and depending on local resources and demographics so that a number of different effective service models are currently in use.

- The key component of a specialised rehabilitation service is the formal commissioning of a multidisciplinary team of relevant professionals (including Rehabilitation Medicine), who have specific knowledge and experience in managing complex disabilities, and who work closely together, with service users, in an interdisciplinary manner, to achieve patient directed outcomes/goals.
- In the wake of COVID-19, many people experience a diverse range of impairments that require assessment and active intervention by specialist rehabilitation teams to optimise recovery and restoration of function. The pandemic has highlighted the current dearth of such services and increased public awareness of the need for coordinated rehabilitation services in the community. This is now emphasised in a number of national clinical guidelines (ref BSRM Phoenix from the Ashes and others) but is by no means unique to COVID-19. Any services that we develop in the wake of the pandemic will provide an important legacy for other patients with complex needs going forward.

Fig 1 pathways



- In the past, services have often been focused on specific diagnostic groups (eg head injury, stroke etc) and tightly defined by catchment based on commissioning areas. Current policy aims to move away from this to embrace a more open and flexible approach in which services are centred on patient needs and commissioned in networks to allow greater flexibility, so that patients can access the service that is more suitable for their needs, even if it is out of their local area. Clearly any specialist rehabilitation service must have some specialisation that brings together teams with the relevant specialist skills. This could mean a specialist neuro-rehabilitation team, catering for patients with any complex neurological disability (eg acquired brain injury (any aetiology), spinal cord injury, progressive

neurological condition etc) as opposed to a 'head injury' or 'stroke' service, as long as there is provision within those services to offer condition specific information and interventions when appropriate.

- These guidelines, being developed by a multidisciplinary group of experienced professionals from a range of services and regions of the UK, (see membership below), will support this approach and will describe:
  - Effective service models with examples of good practice
  - The range of rehabilitation techniques offered by specialised teams
  - The role of Rehabilitation Medicine in specialised community rehabilitation
  - Use of new technologies and ways of working; building on learning from the recent Pandemic
  - Importance of specialist community rehabilitation for those left with complex rehabilitation needs after COVID 19 infection or multiple comorbidities
  - Use of data collection at patient and service level to record rehabilitation needs and outcomes
  - Rehabilitation networks
  - Importance and need for wide multi agency working
  - Approaches to commissioning.

It aims to define standards, with reference to relevant research, that are applicable to all community based specialist rehabilitation services. The guidelines supplement existing BSRM standards, BSRM position statements and current national guidelines that are relevant to people needing rehabilitation in the community (links below).

A commonly asked question is how many people are expected to need these services. The short answer is that we have no idea. The community is a comparative data desert and the NHS currently collects no systematic information on the number of patients needing specialist rehabilitation and the capacity to provide for them. There is currently considerable support for research activity to identify COVID-related symptoms, but little documentation of any rehabilitation needs that may result or how well they are being met.

The document will address both the services that are needed and the data requirements to monitor access to and outcomes from specialist rehabilitation in the community.

Standards

1. PERSON CENTRED REHABILITATION

- Patients with complex rehabilitation needs should have access to specialist community rehabilitation that is tailored to their individual requirements. This may involve individual biopsychosocial assessments, information provision, negotiation of goals, specific individual and group interventions and facilitation of referrals to other appropriate services when needed.
- The involvement of family, friends and workplace should be arranged when appropriate with patients consent.
- All patients should have a Rehabilitation Prescription (RP) (or similar) person-centred document, which is updated as they work with services, setting out their rehabilitation needs and the plan for how these will be met.

- The RP is shared between the professionals and agencies involved to optimise coordination and sharing of information as required with the aim of providing seamless care.
- Specialised rehabilitation services should have the ability to support clients living in the community in decision making and be able to act as their advocates..
- Discharge after involvement with the specialist community rehabilitation team should be carefully planned with active help transferring to other services when this is necessary.

2. REHABILITATION PROCESSES

Accurate assessment of individual needs and personalised goal setting form the cornerstone of rehabilitation. A specialised rehabilitation service should deliver the whole process of informed initial assessment, goal-setting, rehabilitation intervention and review cycle. Outcome evaluation is also essential to confirm that goals are continuing to be met and any changing needs reviewed.

Specialised Community Rehabilitation should be individualised, patient centred and goal directed.

Patients should have access to:

- Detailed individual assessments of impairments, abilities, patient's goals and the rehabilitation required.
- Individual professional intervention sessions to facilitate recovery to increase function and participation when needed.
- Domiciliary or work-based visits, arranged for those for whom rehabilitation is more appropriately conducted in the context of their normal home or work environment.
- Group working for developing increased understanding, learning strategies, impairment and condition management, peer support, when appropriate.
- Multiagency case conferences for planning and maintenance with complex presentations.
- Facilitation of links to other services with joint working when appropriate (eg at transitions from children's services, with Drug and Alcohol teams, CMHTs, education, probation services, palliative care).
- Information and support from the time of diagnosis, for themselves and their families, particularly if they have chronic disabling or progressive conditions such as multiple sclerosis, cerebral palsy, muscle disease or polio.
- For patients who lack capacity to make specific decisions for themselves, best interests decision-making in line with the provisions of the Mental Capacity Act 2005 and advocacy to represent their interests to other agencies.
- Sessions for maintenance of independence and prevention or reduction of future disability.
- Team review in response to a crisis, including acute deteriorations in disability and imminent death.
- A clear point of contact with the team , (this may be the admin link or a key worker depending on need).
- Regular team review meetings to evaluate outcome, reflect on progress, review and revise goals and plan for the next stage of care.

3. THE Specialist REHABILITATION TEAM

- Specialist Community Rehabilitation should be delivered by a co-ordinated appropriately experienced multi-disciplinary team who meet regularly and frequently in a structured way, to

ensure shared discussion and decision-making throughout the patient pathway from referral, assessment, rehabilitation interventions, to review, onward referrals or discharge.

- The team may include a range of junior and senior staff, but should include professionals from all relevant disciplines and be led by a senior clinical rehabilitation professional with expertise in the specialty. For example, a community neuro-rehabilitation service should include Neuro Occupational Therapy, Speech and Language Therapy, Neurophysiotherapy, Neuropsychology, Rehabilitation Medicine, Rehabilitation nurse and Neuropsychiatry, and be led /supported by a Consultant in Rehabilitation Medicine.
- Staff numbers, training and experience should be adequate to offer both face to face client working and non face to face working such as team meetings, multiagency liaison, educational and other supporting work.
- Table 1 below – Example of staffing levels for a community specialist service to support people with acquired brain injury that aims to offer early rehabilitation as well as vocational rehabilitation (population 500,000) – chapters in the full document will have details of other models. This would be in addition to staff required for early supported discharge after stroke.

Table 1 – Example of staffing levels for a community specialist rehabilitation team

adapted from Royal College of Physicians and British Society of Rehabilitation Medicine. *Rehabilitation following acquired brain injury: national clinical guidelines 2003*

Discipline	**WTE**
Admin team	1
Consultant in Rehabilitation Medicine	1
Specialist brain injury nurse	1
Physiotherapists	2.5
Occupational therapists	5
Speech and language therapists	2
Clinical (Ideally one neuro) psychologists	2
Links to Specialist social workers (usually employed by non NHS body)	*2*
Dietitian	0.5
Psychology /rehab assistants	3
Neuropsychiatry/ Liaison psychiatry	0.3

In addition to the core clinical team, there should be straight forward and efficient access to other disciplines, such as psychiatry, pain specialists, rehabilitation engineers and orthotists (see section 8).

4. SERVICES should be part of Rehabilitation networks

- A specialist community rehabilitation service should be part of a service network or Rehabilitation network once these are established. The target population should be based on needs rather than diagnosis (eg 'patients with complex neurological needs', rather than 'head injury'). There may be a broadly defined catchment area, but boundaries should be sufficiently flexible to cater for unusual cases where the specialist team are found to be the most appropriate service to meet a person's rehabilitation needs in their area.
- Interagency working with social services and other agencies is crucial for effective rehabilitation. Each service should have an identified system for efficient and timely liaison with social services and all other relevant agencies such as mental health services*. (examples listed below – not exhaustive).*
- This should include clear least restrictive protocols for information sharing, joint working, and uncomplicated processes for interagency referrals. The aim being to minimise repeated assessments for the patient and time taken to be assessed by any receiving team.
- Information about what the service offers and how to refer should be available as part of local NHS services and service directories where they are established.
- Systems should be in place within the Trust or host organisation for quality assurance and clinical governance.
- Patients or clients and carers should be involved in the routine and strategic planning of rehabilitation services in their area.

5. SERVICE PROVISION

- Each service should have systems in place to manage urgent referrals and minimise waiting times for access to the service.
- Co-ordinated service planning and commissioning should ensure that suitable services are available, in a timely fashion, within a reasonable travelling distance and be part of planned pathways of care and delivered within integrated rehabilitation networks.
- In rural areas, this may involve the establishment of satellite services, use of remote ways of working with investment in telehealth, remote assessment and telerehabilitation, in addition to peripatetic teams to reach isolated locations and review people face to face when needed.
- Where gaps exist in local service provision, defined processes for referral and funding should be in place to ensure that individuals can be considered for inclusion in services that are not available in their locality.
- Services should have processes in place to facilitate access for those who might struggle to engage initially (ie "hard to reach" groups of people). For example, offering more than one chance to attend an appointment if a patient does not attend when first invited, ensuring there is access to interpreting services, offering details of patient transport services, including support-workers, case managers or advocates, with patient consent, when appropriate.

6. REFERRAL AND ASSESSMENT

- All services should have a published and clear referral process.
- All referrals should be reviewed by a senior clinical professional in the team and further clinical information requested from other services when needed. This should involve sight of a rehabilitation prescription (RP) or patient passport when available.
- All referrals should then be discussed with the team in a timely manner and initial assessments arranged with the most appropriate professionals for that persons' presentation and probable needs. Using a risk assessment system to triage and prioritise appointments.
- Involvement of a relative or carer in an assessment should be considered and arranged when appropriate.
- Information about the assessment and the specialist rehabilitation team should be given to the individual and/or family at or before an initial assessment. This should include information about the team, and when already confirmed by previous investigation, information about the patient's condition and about other relevant sources of help or information such as societies, self-help groups etc.
- If a service feels unable to meet the needs of the person referred to them, they should ensure that patients are supported to access alternative services.
- The referral should be considered flexibly to avoid patients with uncommon presentations or very complex multidimensional needs falling between services. The team should keep an up to date knowledge of other services available in their locality and how to access them (*eg by accessing a regional directory of services such as the EoE Major trauma network).*
- Following initial assessment, a written summary with recommendations for further assessments and rehabilitation plans should be recorded. This should be copied to the GP and other relevant agencies, including the patient or client, if appropriate.

7. DATA COLLECTION / REHABILITATION PRESCRIPTIONS

All specialised community rehabilitation services should:

- Have clear, accessible and consistent recording of clinical information, patient's level of function and goals, rehabilitation needs and interventions; including use of the Rehabilitation Prescription (RP) to document needs, the plans to provide for them and services delivered. (*ref core standards on BSRM website.*)
- Have clear review process of patient progress (eg system for regular review of case load on a rolling basis, with discussion and update at team meetings.)
- Record and report data on needs, inputs and outcomes at both the patient and service level using nationally-approved measures – see below

Data recording and collation

This information should be recorded through a standardised and consistent tool/platform where data can be collated at a local level for workforce planning and at national level to inform strategic decisions.

Data should be collated through the Community dataset offered by the UK Rehabilitation Outcomes Collaborative (UKROC).

At minimum data should include:

- The Rehabilitation Prescription https://www.kcl.ac.uk/cicelysaunders/resources/tools/post-icu-presentation-screen-picups-and-rehabilitation-prescription-rp
- The Needs and Provision Complexity scale https://www.kcl.ac.uk/cicelysaunders/resources/tools/npcs
- At least one of the UKROC-approved outcome measures, recorded at the start and the end of the programme

The outcome measurement tools used may vary according to individual patient requirements, but should include one or more of the following:

- Goal attainment scaling https://www.kcl.ac.uk/cicelysaunders/resources/tools/gas
- The Northwick Park Dependency Scale and Care Needs Assessment https://www.kcl.ac.uk/cicelysaunders/resources/tools/npds
- The UK Functional Assessment Measure (UK FIM+FAM) https://www.kcl.ac.uk/cicelysaunders/resources/tools/fimfam
- The Mayo-Portland Adaptability Inventory (MPAI4). http://www.tbims.org/mpai/

8. LIAISON and working WITH OTHER SERVICES

The specialist rehabilitation team should be aware of all relevant services in their area and how to facilitate their clients' access to them when needed. This should involve the ability to work concurrently with other teams, including offering joint assessments and interventions to reduce the burden of duplication when appropriate.

- Depending on the community team's remit, they are likely to need to link with some or all of the following specialist health care services in acute, mental health and community sectors:
  - Medical Specialty outpatients such as Neurology and Neurosurgery clinics; MSK clinics; Respiratory teams
  - Clinical Nurse specialists such as Epilepsy nurses and other Long term neurological conditions nurses
  - Continence and tissue viability services
  - Wheelchairs and special seating, Gait labs
  - Environmental control systems, electronic assistive technology (EAT) and assistive communication teams
  - Vocational rehabilitation services if these are not part of the specialist community rehabilitation service
  - Palliative care services
  - Occupational health services
  - Drug and Alcohol services
  - Community Mental health teams.

- Specialised community rehabilitation services should have:
  - Clearly identified policies or pathways for working with general practitioners and primary care teams (generic, locality based community services).
  - Access to in-patient rehabilitation services for re-assessment admissions.
  - Systems in place to support transitions to adult specialist rehabilitation services for children and adolescents with disabilities approaching adult life.
  - Ability to support clients in decision making or act as their advocates when then have reduced capacity.

- In particular there should be identified pathways/named links to facilitate clients access to and support from:
  - Social services teams
  - Housing
  - Care agencies (including training for care staff for patients with complex care needs)
  - Private sector agencies eg nursing homes
  - Education and further education including special needs and out-of-area provision
  - Disability employment advisory services and facilities for preparation for work
  - Benefits Agencies
  - Legal advice (for patients and their families and carers)
  - Advocacy services - representing the individuals' interests for those whose competence to participate in decisions about their care and their future is restricted (both in and out of hospital)
  - Charities, self-help groups and voluntary agencies such as Headway and Stroke groups
  - Driving ability assessment centre(s).

9. STAFF Support, DEVELOPMENT, TRAINING and AUDIT

- There should be a system of regular appraisal for all staff.

- Regular training should be actively encouraged and available both within and between disciplines, within and outside of the service, and time should be allocated for training on a regular basis.

- All services should undertake audit as a routine part of clinical practice. Audit should be undertaken as a multi-disciplinary activity, to encourage dialogue between professions. Audit sessions should be documented, and where change in practice is recommended, a named person should be designated to implement those recommendations, and changes evaluated.

10. Relevant Guidelines, Standards for Specialist Community Rehabilitation + links

Below is a list of relevant guidelines and standards for specialist community rehabilitation with links (please use the control key and select the title)

Rehabilitation in the wake of COVID-19 - A phoenix from the ashes
Commissioning and providing integrated rehabilitation in the context of COVID -19 (draft)
BSRM Core standards for Major Trauma (Rev 2.1-Nov2018)
Rehabilitation for patients in the acute care pathway following severe disabling illness or injury: BSRM core standards for specialist rehabilitation
Vocational Assessment and Rehabilitation for People with Long-Term Neurological Conditions: Recommendations for Best Practice
Prosthetic and Amputee Rehabilitation - Standards and Guidelines (3rd Edition)
Spasticity in adults: management using botulinum toxin - 2nd edition
Specialist Nursing Home Care for People with Complex Neurological Disability: Guidance to Best Practice
Complex regional pain syndrome in adults. UK guidelines for diagnosis, referral and management in primary and secondary care 2018 (2nd edition)

BSRM position statements in preparation for publication in 2021

Palliative Care Interventions for people with long term neurological conditions 2021
Role of Rehab Medicine in Cardiac Rehabilitation
Musculoskeletal Rehabilitation
Chronic Pain management

NHSe, NICE and other agency guidelines

Rehabilitation Networks; what good looks like (Mike Dilley and Naomi Davis 2020)
NHS Right Care Community Rehab Tool Kit
Prolonged Disorders of Consciousness following sudden onset Brain Injury; National Clinical Guidelines. (RCP 2020)
NICE; Rehabilitation after Stroke
NICE Cerebral Palsy in Adults 2019
NICE CFS (in consultation phase)
NICE COVID-19 (2020 rapid guideline)
NHSe Commissioning Guidance for Rehabilitation 2016
NHSe and i Restoring Primary and Community Musculoskeletal services; principles for integrated Musculo skeletal service delivery (From CRG; *in consultation*)

BSRM Standards for Community Rehabilitation Working Party Membership

Name of group member	Role, representing
Dr Judith Allanson	Chair Consultant in Neurological Rehabilitation, Cambridge British Society of Rehabilitation Medicine
Dr John Burn	Consultant in Brain Injury & Rehabilitation, Poole British Society of Rehabilitation Medicine
Dr Barbara Chandler	Consultant in Rehabilitation Medicine, NHS Highland British Society of Rehabilitation Medicine
Dr Tamsin Collins	Consultant in Rehabilitation Medicine, Leeds British Society of Rehabilitation Medicine
Dr Linda Crawford	Consultant Clinical Neuropsychologist, Cambridge
Dr Mike Dilley	Consultant Neuropsychiatrist, London
Dr Fergus Gracey	Senior Research Fellow and Neuropsychologist, University of East Anglia
Kecia Harris	Parkinsons UK - Area Development Manager, East of England
Dr Ines Kander	University of Warwick - Pathways for BI in the community
Dr Ruth Kent	Consultant in Rehabilitation Medicine, Wakefield British Society of Rehabilitation Medicine
Mrs Ashleigh Knowles	Clinical Service Lead - Integrated Stroke and Neurorehabilitation, Northern Care Alliance, Rochdale
Ms Donna Malley	Occupational Therapy Clinical Specialist & Chair of the Royal College of Occupational Therapists Specialist Section Neurological Practice
Prof Diane Playford	Consultant in Rehabilitation Medicine British Society of Rehabilitation Medicine
Dr Juliet Reid	Rehabilitation Medicine Specialty Trainee, Leeds British Society of Rehabilitation Medicine
Dr Krystyna Walton	Consultant in Rehabilitation Medicine, Manchester British Society of Rehabilitation Medicine
Prof Lynne Turner-Stokes	Consultant in Rehabilitation Medicine, London British Society of Rehabilitation Medicine

Independently reviewed by: Dr Margaret Phillips, Consultant in Rehabilitation Medicine & Chair, BSRM Research & Clinical Standards Sub-committee