

Specialist neuro-rehabilitation services: providing for patients with complex rehabilitation needs

Background

Specialist rehabilitation services play a vital role in management of patients admitted to hospital by taking patients after their immediate medical and surgical needs have been met, and maximising their recovery and supporting safe transition back to the community. In doing so they help reduce the burden on acute and front line services and indeed are a critical component of the acute care pathway, without which networks for trauma, stroke, neurosciences etc will inevitably fail and patient outcomes will be compromised.

Evidence

There is now a substantial body of trial-based evidence and other research to support both the effectiveness and cost-effectiveness of specialist rehabilitation⁽¹⁻⁶⁾. Despite their longer length of stay, the cost of providing early specialist rehabilitation for patients with complex needs is rapidly offset by longer-term savings in the cost of community care, making this a highly cost-efficient intervention^(7, 8).

Coordinated networks

The Department of Health Specialist Services National Definition Set (SSNDS) 3rd edition published in 2009 defined four categories of patient need (A,B,C,D) (see Table 1) and three levels of specialist service (1, 2 and 3). These form a useful framework for planning and commissioning of specialist rehabilitation services.

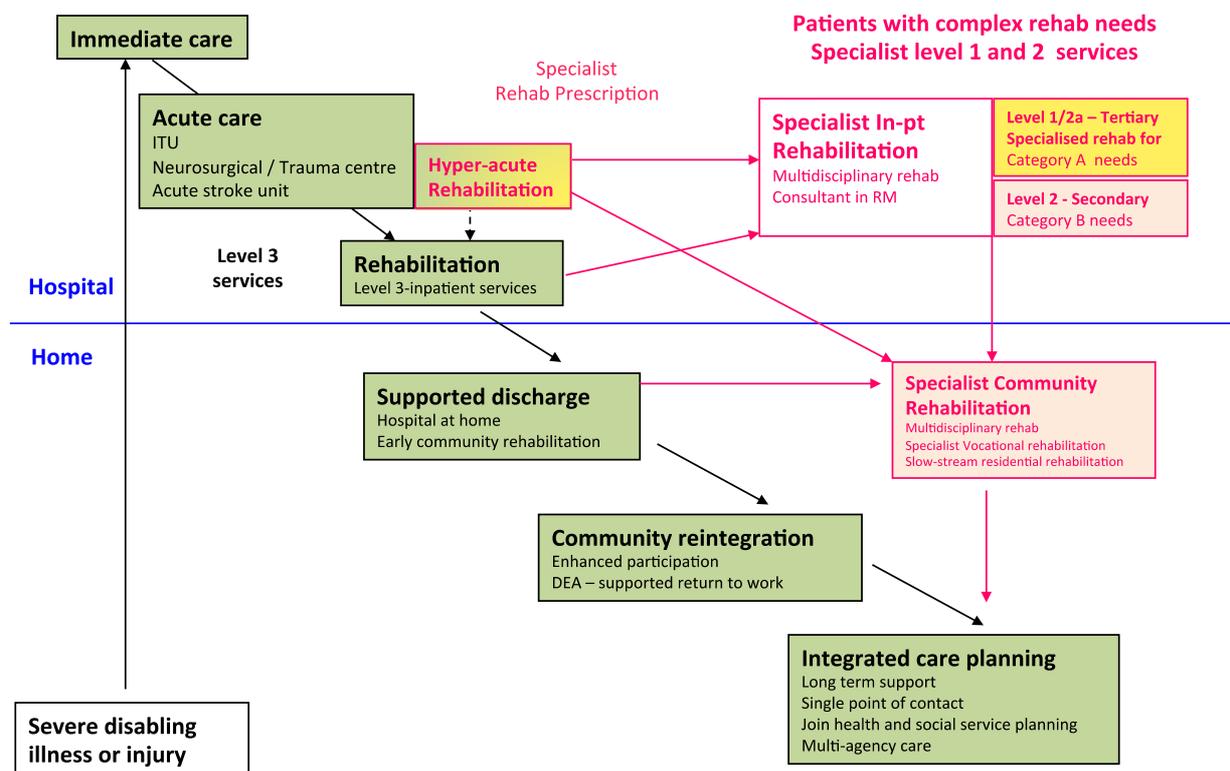
After severe disabling illness or injury many patients have category C or D rehabilitation needs and will progress satisfactorily down the pathway to recovery with the support of the local recovery, rehabilitation and re-enablement (R R & R) Level 3 services. (See Figure 1)

A significant number of patients will have more complex (Category B) needs requiring more prolonged treatment in a specialist (Level 2) rehabilitation service. The British Society of Rehabilitation Medicine (BSRM) Standards⁽⁹⁾ recommend that there should be a local specialist rehabilitation service, led by a consultant trained and accredited in rehabilitation medicine, for every 250-350K population

A small number will have very complex needs requiring the special skills and facilities of a tertiary (Level 1) specialised rehabilitation service. Very highly trained rehabilitation professionals are in short supply in the UK, and it is not feasible or economical to duplicate these high cost/low volume services in every locality. The Warner Report on specialised commissioning (2006) recommended that these specialised services should be planned over a suitable geographical area (approximately 1-3 million population in this case), and therefore require collaborative commissioning arrangements⁽¹⁰⁾.

The National Services Framework (NSF) for Long Term neurological Conditions⁽¹¹⁾ emphasises the need for provision at all levels, planned and delivered through co-ordinated networks in which specialist neuro-rehabilitation services work both in hospital and the community to support local rehabilitation and care support teams.

Figure 1: Pathways for rehabilitation following illness or injury



What is specialist rehabilitation?

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

Specialist rehabilitation is the total active care of patients with a disabling condition, and their families, by a multi-professional team who have undergone recognised specialist training in rehabilitation, led /supported by a consultant trained and accredited in rehabilitation medicine (RM).

Generally, patients requiring specialist rehabilitation are those with complex disabilities. Such patients typically present with a diverse mixture of medical, physical, sensory, cognitive, communicative, behavioural and social problems, which require specialist input from a wide range of rehabilitation disciplines (eg rehabilitation-trained nurses, physiotherapy, occupational therapy, speech and language therapy, psychology, dietetics, orthotics, social work etc.) as well as specialist medical input from consultants trained in rehabilitation medicine, and other relevant specialties eg neuro-psychiatry).

A subgroup of patients will have 'profound disability'; these are more severely affected patients who require help for all aspects of their basic care, as well specialist interventions e.g. spasticity management, postural support programmes and highly specialist equipment.

Specialist rehabilitation services may be provided along three main (frequently overlapping) pathways:

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

Rehabilitation Service provision in the UK

Since the reorganisation of the NHS following the Health and Social Care Act 2012, tertiary specialist rehabilitation for patients with highly complex (category A needs) are commissioned directly by NHS England. Local specialist and general services are commissioned by the Clinical Commissioning Groups (CCGs)

1. Within each locality (Level 3):

Local non-specialist rehabilitation teams provide general multi-professional rehabilitation and therapy support for a range of conditions within the context of acute services (including stroke units), intermediate care or community services.

2. Local (district) specialist rehabilitation services (Level 2) are typically planned over a district-level population of 350-500K, and are led or supported by a consultant trained and accredited in Rehabilitation medicine (RM), working both in hospital and the community setting. The specialist multidisciplinary rehabilitation team provides advice and support for local general rehabilitation teams.

3. Tertiary 'specialised' rehabilitation services* (Level 1) are high cost / low volume services, which provide for patients with highly complex rehabilitation needs that are beyond the scope of their local and district specialist services. These are normally provided in co-ordinated service networks planned over a regional population of 1-5 million through specialised commissioning arrangements. These services are sub-divided into:

- **Level 1a** - for patients with high physical dependency
- **Level 1b** - mixed dependency
- **Level 1c** - mainly walking wounded patients with cognitive/behavioural disabilities.

4. Hyper-acute Specialist Rehabilitation services. Since development of the Major Trauma Networks, a new category of 'Hyper-acute rehabilitation' unit has been developed. These units are sited within acute care settings. They take patients at a very early stage in the rehabilitation pathway when they still have medical and surgical needs requiring continued active support from the trauma, neuroscience or acute medical services.

Tertiary specialised rehabilitation services are thinly spread and, in some areas of the UK where access is poor, local specialist rehabilitation services have extended to support a **supra-district** catchment of 750K-1m, and take a higher proportion (at least 50%) of patients with very complex needs. These are **Level 2a** services.

In addition, local services which 'specialise' in certain conditions and include a significant component of rehabilitation (for example stroke, or care of the elderly) may act as a local source of expertise, even though they do not meet the full standards for a 'specialist rehabilitation service' (These are **Level 3a** services). These developments have led to a 5-tier system as shown in Figure 1.

* Previously known as 'Complex specialised rehabilitation services' in the National Definition Set version 2.

What is a specialist rehabilitation service?

Defining criteria for 'local specialist' and 'tertiary specialised' services are detailed in Annexe 1 and 2.

Key features of any specialist rehabilitation service are:

- The multi-professional team has undergone recognised specialist training in rehabilitation
- Led or supported by a consultant trained and accredited in Rehabilitation Medicine
- A co-ordinated inter-disciplinary team-working towards an agreed set of goals
- Take patients with more complex rehabilitation needs than non-specialist services
- Have specialist equipment, facilities and staffing levels to meet those needs
- Clinical data as defined by the UK National Dataset for Specialist Rehabilitation Services (including complexity and outcome data) are routinely collected and reported annually for all patients
- Meet the national BSRM standards for specialist rehabilitation services
- Support local rehabilitation teams in hospital and community
- Have a recognised role in education, training in the field of rehabilitation.

The **definition of a 'tertiary specialised' rehabilitation service** is based on five main criteria:

1. It is **led by a consultant trained and accredited in RM**, and/or neuropsychiatry depending on caseload
2. It covers a **population of >1 million** patients, therefore requires **collaborative commissioning**
3. It caters for people whose needs are beyond the scope of the local specialist services and therefore has a **high proportion of patients with very complex rehabilitation needs**
4. It provides a **higher level of service** in terms of specialist expertise, facilities and programme intensity to meet those needs (see Annexe 1 and 2)
5. It also plays a recognised **Networking role** which includes
 - a. supporting local specialist and general teams in the management of complex cases and
 - b. acting as resource for **research and development**, as well as education and training.

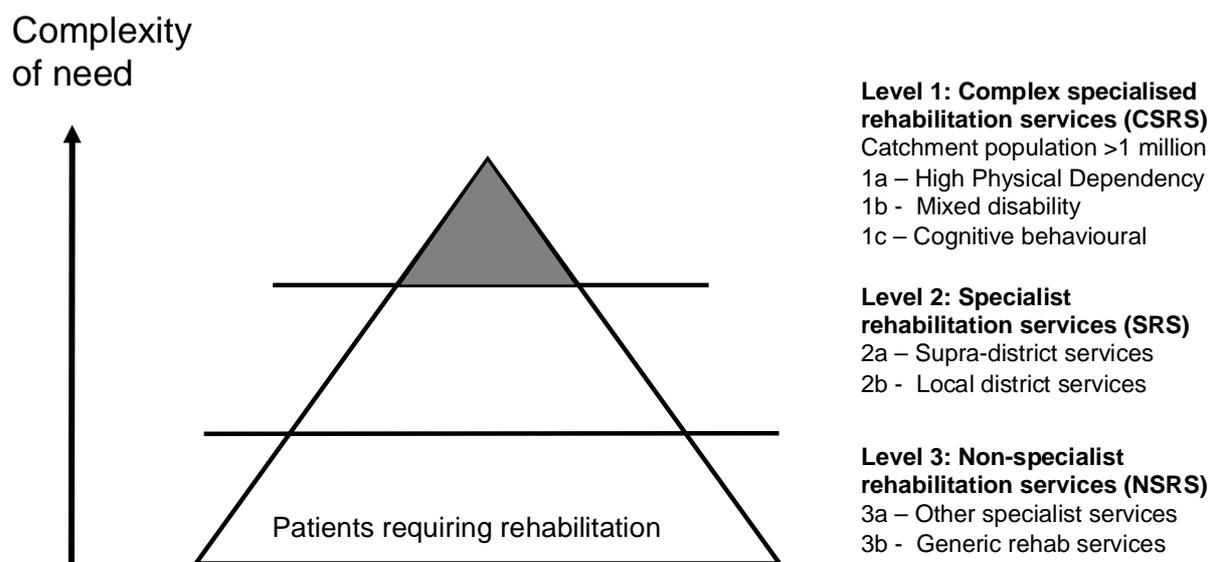
UK Rehabilitation Outcomes Collaborative (UKROC)

The UK Rehabilitation Outcomes Collaborative (UKROC) programme was established in 2008 with funding from an NIHR Programme Grant (RP-PG-0407-10185)⁽¹²⁾ to establish a national clinical database for specialist rehabilitation. The UKROC database is held at Northwick Park as part of a collaborative venture between the British Society for Rehabilitative Medicine (BSRM) and the NHS Information Centre in a programme funded by the Department of Health to inform casemix development in rehabilitation services (see Annexe 3).

The UKROC database collates data on needs, inputs and outcomes for all patients admitted to inpatient specialist (Level 1 and 2) rehabilitation services in England. In addition, it provides quarterly benchmarking reports on quality and cost–efficiency, comparing the performance of each service with its peer group on key quality standards.

Since 2012, UKROC provides the commissioning dataset to NHS England. It is the vehicle by which specialist in-patient rehabilitation activity is counted and the complexity-weighted commissioning currency is implemented (described later in this document). To be designated and commissioned as a specialist rehabilitation service, all Level 1 and 2 services must therefore be registered with UKROC and routinely reporting the UKROC dataset for all admitted patient episodes.

Figure 1: Different levels of complexity in rehabilitation service provision



TERTIARY SPECIALISED REHABILITATION SERVICES- provided at regional / national level		
Level 1:	Specialised rehabilitation services Provided by specialised rehab teams led by consultants trained and accredited in the specialty of rehabilitation medicine (RM) (and/or neuropsychiatry):	
	Serving a regional or supra-regional population and taking patients with Category A needs – ie severe physical, cognitive communicative disabilities or challenging behaviours, with highly complex rehabilitation needs* that are beyond the scope of their local specialist rehabilitation services, and have higher level facilities and skilled staff to support these. Collect and report full National Specialist Rehabilitation Dataset	Catchment: 1-3 million Predominantly highly complex caseload: At least 85% pts have Category A needs on admission At least 70% pts with RCS-E score ≥11 cross-sectionally
LOCAL REHABILITATION SERVICES - provided at district level		
Level 2:	Local (district) specialist rehabilitation services Provided by inter-disciplinary teams led/supported by a consultant in RM, and meeting the BSRM standards for specialist rehabilitation services	
Level 2a	Led by consultant in RM. Serving an extended local population in areas which have poor access to level 1 services. Take patients with a range of complexity, including Category B and some Category A with highly complex rehabilitation needs* Collect and report full National Specialist Rehabilitation Dataset	Catchment: 600K-1 million Mixed caseload 50-80% Category A needs on admission 50-70% RCS-E score ≥11 cross-sectionally
Level 2b	Led/supported by a consultant in RM. Serving a local population, predominantly patients with Category B needs. Collect and report at least the minimum national dataset	Catchment: 250-500K Less complex caseload eg 30-50 % Category A needs on admission 30-50% RCS-E score ≥11 cross-sectionally
Level 3:	Local non-specialist services. Includes generic rehabilitation for a wide range of conditions, provided in the context acute, intermediate care and community facilities, or other specialist services (eg stroke units)	
Level 3a	Other specialist services led or supported by consultants in specialties other than RM - eg services catering for patient in specific diagnostic groups (eg stroke) with Category C needs. Therapy / nursing teams have specialist expertise in the target condition	
Level 3b	Generic rehabilitation for a wide range of conditions, often led by non-medical staff, provided in the context acute, intermediate care and community facilities, for patients with Category D needs	

*Defined by Rehabilitation Complexity / Northwick Park nursing and Therapy Dependency Scores – see below for more detail

What type of patients need specialist rehabilitation services?

The different categories of need for rehabilitation are detailed in Table 1.

The majority of patients have category C or D rehabilitation needs and travel satisfactorily down the path from injury/illness to independence with the help of their local rehabilitation and support services.

For example a patient admitted to hospital following a moderate - severe stroke may have acute treatment followed by 4-6 weeks rehabilitation in a specialist stroke unit or intermediate care setting, and may then transfer satisfactorily on to their local community rehabilitation services without the need for specialist rehabilitation.

However, a small minority of patients will have more complex needs requiring specialist rehabilitation, and a few will have very complex needs or profound disability, requiring a tertiary specialised rehabilitation service.

Local Specialist rehabilitation:

The type of patients who need a specialist rehabilitation service would typically be younger, previously fitter patients with more complex needs such as cognitive, communicative, perceptual, behavioural and social difficulties requiring the co-ordinated input of a specialist consultant-led team in order to manage difficult to treat symptoms and to coordinate multi-agency referral and on-going care.

These patients with category B needs would typically be those who require:

1. Co-ordinated interdisciplinary intervention from 2-4 or more therapy disciplines, in addition to specialist rehabilitation medicine/nursing care in a rehabilitative environment
2. Medium-Longer durations of stay, ie usually >6 weeks – occasionally up to 6 months
3. Rehabilitation/support to return to productive roles, such as work or parenting.
4. Special facilities/ equipment or interventions

They may also have medical problems requiring ongoing investigation / treatment during rehabilitation.

Tertiary Specialised rehabilitation

Some patients have very complex needs for rehabilitation which are beyond the resources of their local specialist services, and require a tertiary 'specialised (Level 1) service'.

These patients with category A needs would typically be those who require one or more of:

- Intensive, co-ordinated interdisciplinary intervention from 4 or more therapy disciplines, in addition to specialist rehabilitation medicine/nursing care in a rehabilitative environment
- Longer programmes - typically 2-4 months, but occasionally up to 6-12 months
- Very high intensity input – eg 1:1 nurse "specialling", or 2-3 trained therapists at one time
- Highly specialist clinical skills (see table 1 for details)
- Neuropsychiatric care, including risk management, treatment under the Mental Health Act
- Higher level facilities /equipment such as bespoke assistive technology
- Complex multi-agency vocational rehabilitation /support
- Ongoing management of complex / unstable medical problems in an acute hospital setting

A small number of patients have profound disability requiring specialised neuro-palliative rehabilitation services. Their needs are often substantial and ongoing and typically include support for family members as well as the patient him/herself. Specialised rehabilitation services often work closely with community rehabilitation teams, specialist nursing homes and palliative care services to support individuals during the later stages of their condition.

It is recognised that the complexity of patient needs changes over time. All specialist rehabilitation services will have a case mix that covers a range of complexity.

- Within a local specialist rehabilitation service it is expected that, a small number of patients (eg 30-50%) at any one time will be highly complex (RCS-E ≥ 11) – or 50-70% in the case of level 2a services
- In Level 1 services, >70% will be highly complex (RCS-E ≥ 11) at any one time, although all patients are expected to meet the admission criteria of needs beyond their local/specialist rehab services

It is therefore the proportion of complex patients that chiefly distinguishes these two levels of service.

Table 1: Four categories of patient need for rehabilitation services

<p>Patients with Category A rehabilitation needs</p> <ul style="list-style-type: none"> ● Patient goals for rehabilitation may include: <ul style="list-style-type: none"> ● Improved physical, cognitive, social and psychological function / independence in activities in and around the home; ● Participation in societal roles (eg work / parenting / relationships); ● Disability management eg to maintain existing function; manage unwanted behaviours / facilitate adjustment to change ● Improved quality of life and living including symptom management, complex care planning, support for family and carers, including neuropalliative rehabilitation ● Patients have complex or profound disabilities e.g. severe physical, cognitive communicative disabilities or challenging behaviours. ● Patients have highly complex rehabilitation needs and require specialised facilities and a higher level of input from more skilled staff than provided in the local specialist rehabilitation unit. In particular rehabilitation will usually include one or more of the following: <ul style="list-style-type: none"> ● intensive, co-ordinated interdisciplinary intervention from 4 or more therapy* disciplines, in addition to specialist rehabilitation medicine/nursing care in a rehabilitative environment ● medium length to long term rehabilitation programme required to achieve rehabilitation goals – typically 2-4 months, but up to 6 months or more, providing this can be justified by measurable outcomes ● very high intensity staffing ratios e.g. 24 hour 1:1 nurse “specialling”, or individual patient therapy sessions involving 2-3 trained therapists at any one time ● highest level facilities /equipment e.g. bespoke assistive technology / seating systems, orthotics, environmental control systems/computers or communication aids, ventilators. ● complex vocational rehabilitation including inter-disciplinary assessment / multi-agency intervention to support return to work , vocational retraining, or withdrawal from work / financial planning as appropriate ● Patients may also require: <ul style="list-style-type: none"> ● Highly specialist clinical input e.g. for tracheostomy weaning, cognitive and/or behavioural management, low awareness states, or dealing with families in extreme distress ● ongoing investigation / treatment of complex / unstable medical problems in the context of an acute hospital setting ● neuro-psychiatric care including: risk management, treatment under sections of the Mental Health Act, ● support for medicolegal matters including mental capacity and consent issues ● Patients are treated in a specialised rehabilitation unit (i.e. a Level 1 unit). ● Patients may on occasion be treated in a Level 2 unit depending on the availability of expert staff and specialist facilities as well as appropriate staffing ratios.
<p>Patients with Category B rehabilitation needs</p> <ul style="list-style-type: none"> ● Patient goals for rehabilitation may be as for category A patients ● Patients have moderate to severe physical, cognitive and/or communicative disabilities which may include mild-moderate behavioural problems ● Patients require rehabilitation from expert staff in a dedicated rehabilitation unit with appropriate specialist facilities. ● In particular rehabilitation will usually include one or more of the following: <ul style="list-style-type: none"> ● Intensive co-ordinated interdisciplinary intervention from 2-4 therapy disciplines in addition to specialist rehabilitation medicine/nursing care in a rehabilitative environment ● medium length rehabilitation programme required to achieve rehabilitation goals – typically 1-3 months, but up to a maximum of 6 months, providing this can be justified by measurable outcomes ● special facilities/ equipment (e.g. specialist mobility/ training aids, orthotics, assistive technology) or interventions (e.g. spasticity management with botulinum toxin or intrathecal baclofen) ● interventions to support goals such as return to work, or resumption of other extended activities of daily living, eg home-making, managing personal finances etc ● Patients may also have medical problems requiring ongoing investigation/treatment ● Patients are treated in a local specialist rehabilitation unit (i.e. a Level 2 unit).

Patients with Category C rehabilitation needs

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

Patients with Category D rehabilitation needs

- Patient goals are typically focused in restoration of function / independence and co-ordinated discharge planning with a view to continuing rehabilitation in the community if necessary
- Patients have a wide range of conditions but are usually medically stable
- Patients require less intensive rehabilitation intervention from 1-3 therapy disciplines in relatively short rehabilitation programmes (i.e. 6-12 weeks)
- Patients receive an in-patient local non-specialist rehabilitation service (i.e. Level 3b) which is led by non-medical staff.

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

[A patient categorisation tool \(PCAT\) has been developed to assist clinicians in identifying the patient category of needs \(see Annex 4\)](#)

Defining Complexity in Rehabilitation

In rehabilitation, diagnosis is a poor indicator of need for rehabilitation or the costs of providing it.

The key factors that determine complexity of **rehabilitation needs** are:

- Needs for basic care and safety
- Needs for skilled nursing care
- Needs for therapy input – no of disciplines involved and intensity of treatment
- Needs for medical care and intervention
- Needs for specialist equipment / facilities.

However, if a service is to take patients with complex needs, it must be able to demonstrate that it provides a **level of rehabilitation inputs** and facilities commensurate with those needs.

And if the commissioners are to fund these higher-level services, there must be measurable **outcomes** to demonstrate that useful gain has been made.

A hierarchical series of tools has been developed to capture needs, inputs and outcomes, with more detailed tools being used to define higher levels of complexity in low volume–high cost services. These form part of the National Dataset for Specialist Rehabilitation Services, and are collated through the UK Rehabilitation Outcomes Collaborative (UKROC) database.

Needs and inputs

- The **Rehabilitation Complexity Scale (RCS-E)** is designed as simple tool to measure the complexity of needs for rehabilitation resources in terms of nursing care, medical support therapies, and specialist equipment. It is easy and quick to apply and performs well as a casemix measure. It does not provide any information on how clinical teams spend their time with patients
- The **Northwick Park nursing and therapy dependency tools** have been developed to provide a more detailed evaluation of needs / inputs for use in the high cost/low volume services
 - The **NPDS** is an ordinal measure of needs for care and skilled nursing.
It translates by a computerised algorithm into an assessment of **care hours** (the **NPCNA** (Northwick Park care needs assessment))
 - The **NPTDA** is an equivalent tool for assessment needs for therapy intervention
It also translated by a computerised algorithm into **therapy hours** for each discipline

All of these tools may be applied either prospectively (to measure *needs for rehabilitation*) or retrospectively to measure *inputs actually provided*, and hence to confirm that needs have been adequately provided for – or alternatively to identify gaps in the level of service provision.

Within the UKROC dataset, each registered service is required to collect cross-sectional parallel data with a minimum of 100 sets of paired RCS-E, NPDS and NPTDA scores each year. They also submit a service profile listing their activity, staffing level and facilities, which is update annually.

Outcome

The dataset is not designed to be restrictive – units are still encouraged to collect any outcomes that they consider to be most relevant to their caseload. However for the purpose of comparative description all units are now required to collect a minimum of standardised outcome data,

- The UK Functional Assessment Measure (UK FIM+FAM) is now the standard outcome measure for all Level 1 and 2 services
- The Northwick Park nursing Dependency Scale (NPDS) and Care Needs Assessment (NPDS/NPCNA) are used to provide data on cost-efficiency of the services calculated as the 'mean time taken for the cost of each rehabilitation episode to be offset by savings in the cost of on-going care in the community'.

The FIM and the NPDS both translate to a Barthel score, so any of these tools can provide a common language at the level of the Barthel Index.

In patients with profound disabilities, where the focus of the programme is on neuropalliative rehabilitation, the goals for rehabilitation may be focussed more on symptom management and quality of life than gains in functional independence. Goal attainment scaling (GAS) is included in the UKROC software and offers a useful option for capturing individualized person centred outcomes or putting together the outcomes from a range of different measures, where the standardised measures of physical disability fail to capture the intended purpose of the programme.

Casemix and costing of specialist services

The UKROC project is registered as a PbR Improvement Project. Data from the UKROC database have been used to provide more accurate costing for specialist rehabilitation services than was available from reference costing alone. This information was used to develop indicative tariffs for rehabilitation services under the Payment by Results (PbR) programme.

A challenge for development of casemix and commissioning currencies for rehabilitation is the wide range of case complexity with variable time-course for change. Diagnostic and procedure codes which underpin the Department of Health's standard casemix system (HRG-v4) are poor indicators of cost in rehabilitation. After extensive exploration of other international payment models for rehabilitation⁽¹³⁾ the expert Reference Panel for casemix development in Rehabilitation developed a novel commissioning currency.

Because each level of service carries a range of patients at different levels of complexity at any one time, the best way to define costs is by a weighted tariff based on patient complexity, as opposed to fixed tariffs for different levels of service.

The panel has proposed a model where the cost is weighted proportionately to the period for which the patient is at a given complexity level, i.e. a multiple level tariff that can change over time according to the complexity of the patient's needs.

Units seeking to use this flexible tariff will need to record and report serial data and to demonstrate that they are able to provide inputs commensurate with patient needs.

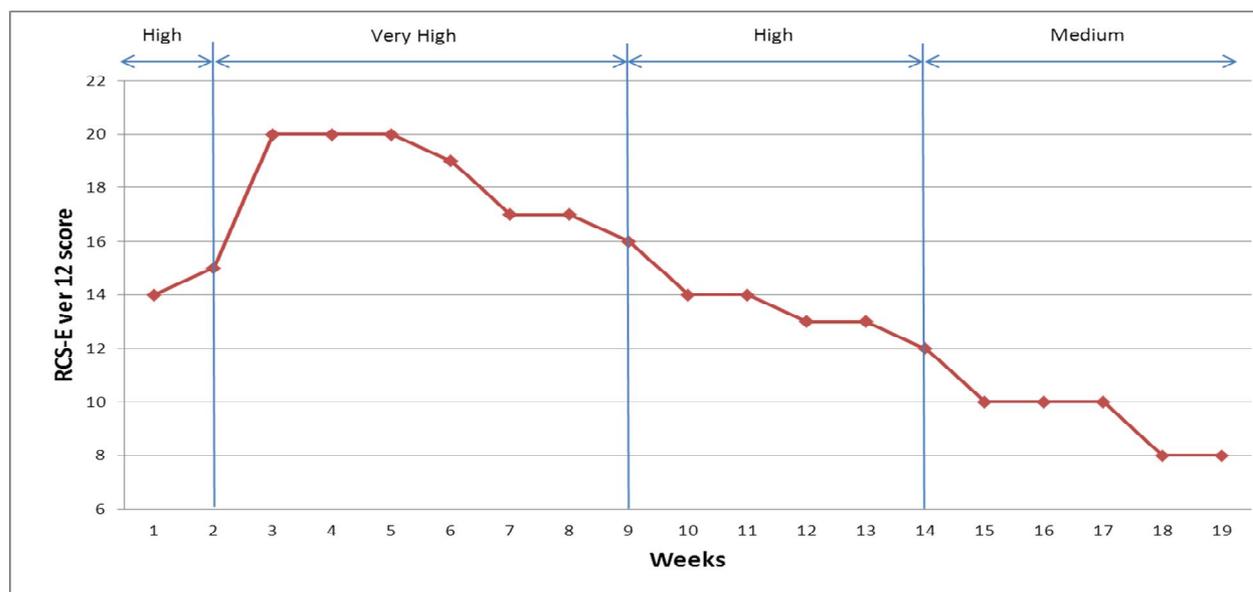
Weighted costing model

The costing methodology is described in more detail in a paper entitled "Determination of bed-day costs for specialist neurorehabilitation services". The model has been developed based on data from one service. It is now being extended to capture data from a wider range of services across the UK.

The multi-level weighted payment model is based on a per diem payment adjusted for complexity of rehabilitation needs.

- As the patient improves during rehabilitation, their needs may decrease over time.
- The daily tariff falls as complexity is reduced over time
- The model is designed to provide fair payment for higher cost patients but at the same time to provide an incentive to early discharge
- The model is based on serial assessment of complexity using the Rehabilitation Complexity Scale version 12 (RCS-E), which is applied at fortnightly intervals throughout the patients stay.

Figure 1 below shows an example of the multi level tariff in a patient who stayed 133 days



Mandated Commissioning Currency – 5-tier weighted per diem model

- The commissioning currency is operationalised through the UKROC dataset
- The currency is the weighted bed day – based on a 5-tier structure, in which a set of five weighting factors are applied to the standard per diem rate
- The weighting factors were derived from the relative proportion of nursing and therapy staff time used by patients within the different levels of complexity¹, so that higher complexity scores attract a higher weighting
- At the level of an individual episode: The total weighted bed days are derived from the number of days the patient spent at each of the five levels of complexity, multiplied by the weighting factors for each of the levels
- At service level, the total annual occupied bed days (OBDs) within each of the five levels are multiplied by their respective weighting factors and summed to calculate the total number of weighted bed days (WBD). The total annual cost is then divided by the total weighted bed days to calculate the weighted per diem cost
- **For simplicity, the multi-level WBD currency is expressed in terms of a single WBD figure for activity with a single WBD costs, although UKROC can provide more detailed breakdown on request.**

More information about the weighted payment model and how it is applied is available on the ‘Commissioning tools’ page of the UKROC website:

<http://www.kcl.ac.uk/lsm/research/divisions/cicelysaunders/research/studies/ukroc/Commissioning-Tools.aspx>

¹ Turner-Stokes L et al. Healthcare tariffs for specialist inpatient neurorehabilitation services: Rationale and development of a UK casemix and costing methodology. *Clin. Rehabil.* 2011;26(3):264-79

Annexe 1: Defining Criteria for 'Local Specialist' and 'Specialised' (Level 1) rehabilitation services

Criterion	Local specialist rehabilitation service (Level 2)	Tertiary specialised rehabilitation service (Level 1)
National standards	Meets the national standards for specialist rehabilitation laid down by the Royal College of Physicians and the British Society of Rehabilitation Medicine (BSRM).	
Specialist team	Rehabilitation is provided by a multi-professional team of nurses, allied health professionals (AHPs) and doctors who have undergone recognised specialist training in rehabilitation.	
Inter-disciplinary working practice	The team works in an inter-disciplinary, co-ordinated fashion towards an agreed set of goals to assist them to achieve their desired level of independence, autonomy and participation in society.	
RM Consultant leadership	Led or supported by a consultant, trained and accredited within the specialty of rehabilitation medicine with input from other specialists (eg neurology, psychiatry) as required.	Led by a consultant, trained and accredited within the specialty of rehabilitation medicine and/or neuropsychiatry.
Catchment	Catchment population typically 350-650 K (Level 2a: 600K-1m)	Catchment population typically <u>>1 million</u>
Complex caseload	Carries a more complex caseload than non-specialist services, as defined by agreed criteria (eg the Rehabilitation Complexity Scale (RCS) or equivalent)	Takes a selected group of patients with <u>complex rehabilitation needs beyond the scope of their local general and specialist rehabilitation services (category A)</u> . These include patients with severe physical, cognitive communicative disabilities or challenging behaviours – (or other highly complex needs defined by NPDS/NPTDA scores),
Facilities	Has specialist facilities as appropriate to the caseload – eg assistive technology, specialist orthotics, special seating, spasticity management programmes	In addition to facilities for specialist rehab services, has <u>higher level facilities</u> as appropriate to caseload eg bespoke assistive technology, ventilators, acute/ specialist medical facilities, rehab engineering, etc.
Staffing	Has appropriately skilled staff in numbers sufficient to provide rehabilitation at a level of intensity commensurate with the patients needs (see BSRM minimum standard staffing levels.)	Has <u>higher level skilled staff</u> and <u>increased staff numbers</u> to cope with complex case load.
Monitoring	It routinely monitors casemix and outcome data for the purpose of benchmarking and quality monitoring.	
	Systematically reports <u>minimum mandatory Dataset</u> for Specialist Rehabilitation Services through the national database (see Annexe 3)	Systematically reports <u>full Dataset</u> for Specialised (Level 1) Rehabilitation Services through the national database (see Annexe 3)
Networking	Acts as a resource for advice and support to other professional staff in local general and community rehabilitation services	Acts as a resource for advice and support to <u>local specialist</u> , as well as general and community rehabilitation teams in the management of patients with complex disabilities.
Education and training	Serves a recognised role in education, training for development of specialist rehabilitation in the field	Serves a recognised role in education, training and <u>publishes audit/research/development</u> in the field of specialist rehabilitation

Annexe 2: Minimum staffing provision for specialist in-patient rehabilitation service²

	Specialised rehabilitation service WTE Per 20 beds			Local specialist rehabilitation service WTE Per 20 beds	
	Hyper-acute	Level 1a	Level 1b	Level 2a	Level 2b
Medical Staff - Consultants accredited in rehabilitation medicine	3.0-3.5	2.5-3.0	2.0	2.0	1.5
Medical staff – Junior (Training grades above FY1 or Trust grades)	3.0-3.5	2.0-2.5	1.5-2.0	1.5-2.0	1.5-2.0
Nurses	45-60	40-50	35-40	35-40	35-40
% Qualified nursing staff (Band 5 or above) (Depending on acuity of caseload)	65-75%	50-60%	45-50%	45-55%	45-55%
% Nurses with specific rehab training		At least 45%	At least 40%	At least 40%	At least 30%
Therapy Staff					
Physiotherapists (Depending on proportion of patients with tracheostomy or requiring 2:1 therapy)	6.0-7.0	6.0-7.0	5.5-6.5	5.5- 6.0	4.5-5.5
Occupational therapists	5.5-6.5	6.0-7.0	5.5-6.5	5.5- 6.0	4.5-5.5
Speech and language therapists (Depending on proportion of patients with tracheostomy)	3.0-4.0	3.0-3.5	2.5-3.0	2.0-2.5	1.5-2.0
Clinical psychologist/counselling (Depending on whether patients with severe behavioural problems are accepted)	2.5-3.0	2.5-3.5	2.5-3.5	1.5-2.5	1.5-2.0
Social Worker / discharge co-ordinator	1.0-1.5	1.5-2.0	1.5-2.0	1.5-2.0	1.0-1.5
Dietitian (Depending on the proportion of patients on enteral feeding / complex nutrition needs)	1.0	1.0	0.5-1.0	0.75-1.0	0.5-0.75
Clerical staff	3.0 WTE, but dependent on caseload and throughput				

Note:

These staffing levels support both the inpatient activity and associated out-reach work including assessments home-visits, follow-up, case-conferences etc.

Additional resources are required if the services also offers community rehabilitation services.

Additional staff eg technicians, engineers, prosthetists etc may also be required depending on the caseload.

Tertiary specialised services taking patients with more complex needs the skill mix is adjusted to cater for the specific group of patients they serve – for example a cognitive behavioural rehabilitation services would require:

- A higher proportion of psychology/counselling staff
- Consultant neuropsychiatrist support
- A proportion of registered mental health nurses, and sufficient staffing levels to provide a safe environment for high risk patients, including 1:1 supervision when needed

² * These recommendations are adapted from the RCP/BSRM National Guidelines for rehabilitation following Acquired Brain Injury 2003.

Annexe 3: National Minimum dataset for Specialist Rehabilitation Services

CATEGORY	DATA FIELD	RESPONSE	
Unit details (Fixed for each unit)	Unit identifier	Unit Name / code	
	Designation	Level 1 (CSRS) / Level 2 (SRS) / Level 3 (Non specialist)	
Patient details	Person identifier (Mandatory)	NHS number	
	Date of Birth / Age at admission	Date: Birth	
	Gender	List: Male / Female	
	Race	List: Race/ethnicity	
	Postcode	Post code	
	PCT	PCT / code	
	Strategic Health Authority	SHA / code	
	Diagnosis at assessment	Text: primary diagnosis	
	Date of onset	Date: (set at first of month or year, if not precise)	
Referral and processing	Source of referral	List: Hospital / Community	
	Date of referral	Date: referred	
	Date of assessment	Date: assessed	
	Details of assessor / team	List: Uni-disciplinary / Multidisciplinary	
	Date of decision / waiting list	Date: on waiting list	
Admission details	Admission date	Date: Admitted	
	Admitted from	List: Hospital specialist / DGH / home / nursing home	
	Type of admission	List: Assessment only / Active rehab / disability management	
	Dependency category on admission	List: High / medium / low	
	Anticipated discharge date	Date:	
	If delayed discharge - reason	Text or List (eg waiting for housing/ care package)	
Interruption of rehab if any	Total interruption days	Number: Days transferred to other ward	
	Reason for interruption	Text or List (e.g. intercurrent illness/ procedure)	
Discharge	Discharge date	Date: Discharged	
	Length of stay (Mandatory)	Number: Days (calculated field)	
	Mode of episode end	List: discharge / death / transfer to other ward	
	Discharge destination	List: Home, nursing home/ residential care / other rehab	
Diagnosis / coding	HRG category (Mandatory)	HRG code	
	Primary ICD code (Mandatory)	primary ICD or diagnosis	
	Secondary ICD codes	Secondary codes	
Spinal cord injury Amputee rehab	ASIA impairment scale (SCI)	ASIA score	
	SIGAM grade (lower limb)		
Costing data	Unit cost per bed day	£---	
	Total cost of episode/spell (Mandatory)	£---	
Standardised costing and outcome data			
Complexity	Admission	Discharge	
	All services	RCS: C, N, T, M, Total (Mandatory)	RCS: C, N, T, M, Total (Mandatory)
	Level 1 services	NPDS	NPDS
Level 1 services	NPTDA	NPTDA	
Outcome	Admission	Discharge	
	All services	Barthel Index (Mandatory)	Barthel Index (Mandatory)
	Level 2 services	FIM Motor	FIM Motor
	Level 2 services	FIM Cognitive	FIM Cognitive
	Level 1 services	FIM+FAM Motor	FIM+FAM Motor
	Level 1 services	FIM+FAM Cognitive	FIM+FAM Cognitive
	Optional	GAS	GAS
Optional	(FIM+FAM Impairment Set)		

The National Database for Specialist Rehabilitation Services is held at Northwick Park Hospital and managed in collaboration with the BSRM.

All specialist rehabilitation services should submit de-identified data to the database:

- Level 2b services: at minimum report the five mandatory fields
- Level 1 and 2a (Specialised services) should report the full dataset

Annexe 4: Patient Categorisation Tool

Patient Name:.....

ID Number (e.g hospital/NHS number)

To be completed by the treating Consultant at time of admission.

Tick all boxes that apply. If Category A, B or C needs have not been identified (e.g no boxes ticked) a score of 1 will be assigned within the software

	Category A needs (Score 3)	Category B needs (Score 2)	Category C needs (Score 1)
Specialist medical / neuropsychiatric needs			
Medical/Surgical	<input type="checkbox"/> Complex specialist investigation/ intervention <input type="checkbox"/> Medically /surgically unstable <input type="checkbox"/> Complex on-going needs for coordinated trauma care	<input type="checkbox"/> Routine investigation/ intervention <input type="checkbox"/> Currently well but potentially unstable <input type="checkbox"/> Active on-going trauma care management	<input type="checkbox"/> No investigation/ intervention <input type="checkbox"/> Medically stable <input type="checkbox"/> Trauma care largely complete – review only
Neuropsychiatric	<input type="checkbox"/> Complex/unstable psychiatric needs <input type="checkbox"/> High Risk management <input type="checkbox"/> Treatment under section of the MHA	<input type="checkbox"/> Psychiatric condition stable but requires monitoring <input type="checkbox"/> Medium Risk management	<input type="checkbox"/> No psychiatric condition <input type="checkbox"/> Low or no risk
Intensity	<input type="checkbox"/> ≥5 therapy disciplines <input type="checkbox"/> >25 hours total therapy time per week <input type="checkbox"/> requires 1:1 supervision <input type="checkbox"/> ≥2 trained therapists to treat at one time	<input type="checkbox"/> 4 therapy disciplines <input type="checkbox"/> 20-25 hours total therapy time per week	<input type="checkbox"/> 1-3 therapy disciplines <input type="checkbox"/> <20 hours total therapy time per week
Clinical needs			
Physical	<input type="checkbox"/> Complex postural tone /contracture management <input type="checkbox"/> ≥ 2 to handle <input type="checkbox"/> Highly complex musculoskeletal/trauma/pain management issues <input type="checkbox"/> Complex amputee needs (Multi-limb, hi tech etc)	<input type="checkbox"/> Routine physical issues <input type="checkbox"/> 1 to handle <input type="checkbox"/> Moderately complex musculoskeletal/trauma/pain management issues <input type="checkbox"/> Standard specialist amputee needs	<input type="checkbox"/> Higher function problems only (e.g high level coordination/mild deconditioning) <input type="checkbox"/> Standard musculoskeletal/trauma/pain management/neurological issues <input type="checkbox"/> No physical issues
Tracheostomy/ventilatory	<input type="checkbox"/> Unstable tracheostomy requiring intensive suction <input type="checkbox"/> O ₂ sats monitoring programme <input type="checkbox"/> Active weaning programme <input type="checkbox"/> Assisted ventilation	<input type="checkbox"/> Tracheostomy in situ but stable	<input type="checkbox"/> No tracheostomy
Swallowing / nutrition	<input type="checkbox"/> Complex swallowing evaluation (eg FEES) <input type="checkbox"/> Complex nutritional requirements requiring intensive dietary support/intervention	<input type="checkbox"/> Enteral feeding programme <input type="checkbox"/> Moderate monitoring – eg progressive consistency, dietary content <input type="checkbox"/> Dietary education (eg healthy eating, weight reduction)	<input type="checkbox"/> Normal or stable modified diet <input type="checkbox"/> Able to eat independently or with supervision from care staff only <input type="checkbox"/> Standard dietary / Weight monitoring only
Communication	Complex communication needs requiring: <input type="checkbox"/> Specialist evaluation <input type="checkbox"/> Complex communication aid set/up provision	<input type="checkbox"/> Moderate communication issues with some listener burden, but able to communicate basic needs and ideas	<input type="checkbox"/> Higher function problems only <input type="checkbox"/> No problems with communication
Cognitive	Severe cognitive problems requiring <input type="checkbox"/> Intensive support for carryover / orientation etc <input type="checkbox"/> Complex cognitive / neuropsychological assessment	Moderate cognitive problems requiring <input type="checkbox"/> Structured environment, strategies <input type="checkbox"/> Routine cognitive assessment eg by O/T	<input type="checkbox"/> Higher function problems only <input type="checkbox"/> No cognitive problems
Behavioural	<input type="checkbox"/> Highly challenging behaviours (eg physical/verbal aggression) requiring interactive behavioural management programme	<input type="checkbox"/> Mild/moderate behavioural issues controlled in structured environment	<input type="checkbox"/> No significant behavioural problems
Mood/emotion	Severe anxiety / depression / emotional lability requiring: <input type="checkbox"/> Specialist evaluation <input type="checkbox"/> Active management and frequent crisis intervention	<input type="checkbox"/> Mood disorder/adjustment issues under active management with planned programme	<input type="checkbox"/> No significant mood / adjustment issues

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Complex disability management	Complex disability management eg <input type="checkbox"/> Evaluation of low awareness state <input type="checkbox"/> Neuro-palliative rehabilitation / end of life care	<input type="checkbox"/> Standard disability management eg set-up of care programme, care booklet, carer training etc	<input type="checkbox"/> None required
Social / discharge planning	<input type="checkbox"/> Complex placement / housing /funding issues requiring extensive multi-agency negotiation	<input type="checkbox"/> Active discharge planning requiring liaison with community SW/DN/OT eg to arrange care package	<input type="checkbox"/> No major discharge issues, taken care of by family / allocated social worker
Family support	<input type="checkbox"/> Major family distress issues require frequent support or crisis intervention	<input type="checkbox"/> Routine family support needs (met by planned meetings)	<input type="checkbox"/> No significant family problems
Emotional load on staff	<input type="checkbox"/> Demanding situation requiring highly experienced staff / extra support for staff	<input type="checkbox"/> Somewhat challenging situation but manageable	<input type="checkbox"/> Minimal or no emotional load on staff

Vocational rehabilitation	Specialist vocational rehabilitation needs eg <input type="checkbox"/> Multi-disciplinary vocational assessment <input type="checkbox"/> Multi-agency support for return to work, retraining or work withdrawal <input type="checkbox"/> Complex support in other roles (eg single-parenting)	Moderate vocational support, <input type="checkbox"/> Work visits or employer liaison <input type="checkbox"/> Support for other roles, eg home-maker / parenting	<input type="checkbox"/> Not of working age <input type="checkbox"/> No significant needs for vocational support
Medico-legal issues	Complex medico-legal issues eg requiring interaction with legal system: <input type="checkbox"/> Complex Best interests decisions <input type="checkbox"/> Court of protection applications <input type="checkbox"/> DoLs / PoVA applications <input type="checkbox"/> Litigation issues <input type="checkbox"/> Complex mental capacity / consent issues	Standard medico-legal issues eg <input type="checkbox"/> Mental capacity evaluation <input type="checkbox"/> Standard consent / best interests decisions <input type="checkbox"/> LPOA, advance care planning	<input type="checkbox"/> No significant medico-legal issues
Specialist equipment / facilities	Highly specialist equipment /facilities required eg <input type="checkbox"/> Bespoke Assistive technology <input type="checkbox"/> Highly specialist seating/wheelchair needs <input type="checkbox"/> Bespoke orthotics <input type="checkbox"/> Electronic assistive technology <input type="checkbox"/> Assisted ventilation	Moderate specialist equipment needs eg <input type="checkbox"/> Adapted Wheelchair / seating <input type="checkbox"/> Electric standing frame <input type="checkbox"/> Treadmill/harness training <input type="checkbox"/> Assisted cycling (eg motor-med) <input type="checkbox"/> Splinting / casting	<input type="checkbox"/> No equipment needs <input type="checkbox"/> Basic off the shelf equipment only <input type="checkbox"/> Standard exercise facilities, eg plinth, bike tilt-table, parallel bars

Service level required	Category <i>Clinical Impression</i>	Expected duration of admission	Funding Source (to be entered in Episode section – Commissioning & Referral of UKROC software)	Assessor (Print Name)
Clinical Impression <input type="checkbox"/> Level 1 <input type="checkbox"/> Level 2a <input type="checkbox"/> Level 2b <input type="checkbox"/> Level 3 <input type="checkbox"/> Slow stream / Specialist nursing home <input type="checkbox"/> Community rehab <input type="checkbox"/> Not for rehab Has onward referral been made? <input type="checkbox"/> No <input type="checkbox"/> Yes (where to)_____	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> Not applicable	<input type="checkbox"/> Long stay (5-6 months) <input type="checkbox"/> Medium (3-4 months) <input type="checkbox"/> Short (6-8 weeks) <input type="checkbox"/> Assessment / rapid intervention (2-4 wks) <input type="checkbox"/> Not applicable (slow stream or not for rehab)	<input type="checkbox"/> Clinical Commissioning Group (CCG) <input type="checkbox"/> NHS Commissioning Board (NHSCB) <input type="checkbox"/> NHS outside England <input type="checkbox"/> Social Services <input type="checkbox"/> Private	Signed by assessor _____
		Reasoning /Alternative recommendations:	Purchasing type <input type="checkbox"/> Contract <input type="checkbox"/> Other (e.g spot purchasing)	Date Completed _____

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