BSRM Standards for Rehabilitation Services Mapped on to the National Service Framework for Long-Term Conditions

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BSRM Standards for Rehabilitation Services, Mapped on to the National Service Framework for Long-Term Conditions

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Background

The NSF for Long Term Conditions (NSF for LTC) was launched in April 2005 with a 10-year implementation phase. However, this is a new-style NSF without defined targets, and this has raised concern among commissioners and service providers over how to determine whether the Quality Requirements (QRs) have been met. On the other hand, many of the specialist societies had already developed written standards in areas of practice covered by the NSF.

In 2006, the NSF Advisory Group recommended that the relevant societies undertook a mapping exercise to relate their existing standards to the NSF 'recommendations for best practice' to produce a more clearly defined set of national benchmark standards, that would assist in evaluating implementation of the NSF.

The objectives of this document are:

- To map the published BSRM standards/other guidelines documents onto the NSF QRs
- To produce a more defined set of national guidance, with clear recommended targets where appropriate, concerning the planning and delivery of rehabilitation services in the UK, and the necessary resources (eg workforce) to support this.

The NSF is focused on long term neurological conditions (LTNC). Therefore the principal focus of this document is on standards for neurological rehabilitation services, even though many of the base principles can and should be extended to other areas of rehabilitation.

NSF QRs addressed:

The key NSF quality requirements which relate directly to rehabilitation services are:

- Quality Requirement 4: Early and specialist rehabilitation
- Quality Requirement 5: Community rehabilitation and support
- Quality Requirement 6: Vocational rehabilitation
- Quality Requirement 7: Providing equipment and accommodation

Service Mapping undertaken for the NSF revealed a shortage of rehabilitation service provision across all sectors, especially to support more heavily dependent patients with complex rehabilitation needs, who often stay for significant periods (often several months) in acute hospital wards whilst waiting for a rehabilitation bed. The inefficiency of such long waiting times when the patient is already in the health service system and blocking an acute bed is recognised. Similarly a lack of community rehabilitation services and equipment can lead to unnecessary admissions and delay hospital discharge. Community rehabilitation services can also play a key role in integrated care planning (Quality Requirement 1) which forms the backbone to the NSF.

Guidelines for implementation of the NSF recommend that service providers and commissioners should work together to increase capacity in rehabilitation services, both in hospital and the community which will help to relieve pressure on acute beds.

Key BSRM documents that provide the basis for these standards are:

1. The BSRM Standards for specialist in-patient and community rehabilitation services
2. The RCP/BSRM guidelines for rehabilitation following acquired brain injury, 2003
3. The Rehabilitation Medicine section of Consultant Physicians Working With Patients. Fourth Edition. July 2008.

The views of the BSRM membership were sought in a consensus meeting held at the BSRM/SRR meeting in London on 7 July 2006.

Early and specialist rehabilitation services: Quality Requirement 4

1. Provision of rehabilitation services for people with neurological conditions

Rationale:

The NSF emphasises the need for *local rehabilitation services*, as close as possible to the individual's home, and recognises that peoples' need for rehabilitation changes over time so that a range of different services need to be provided.

It also recognises the need for *specialist services for people with more complex needs* and therefore recommends that rehabilitation services are 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.

The NSF recognises the need for *'complex specialised services'* to support people with profound and complex disability, and the recently published Warner Report on specialised commissioning recommends that these should be planned over a suitable geographical area (approximately 1-3 million population in this case), and therefore require *collaborative commissioning arrangements.*

Standards:

S1 **Disabled people should have access to all appropriate rehabilitation services including:**

- Specialist in-patient neuro-rehabilitation services led by a consultant trained and accredited in Rehabilitation Medicine (RM) (Level 3 competencies in neurological rehabilitation - as will be defined in the 2010 version of the RM curriculum)
- Out-patient and day rehabilitation services, supported by adequate transport systems
- Home-based /domiciliary rehabilitation services for people who require them

S2 **Co-ordinated service planning and delivery should ensure that**:

- Suitable services are available within a reasonable traveling distance
- Rehabilitation services work together through planned network arrangements, where specialist neuro-rehabilitation services support local teams in the management of more complex patients, for example through the establishment of in-reach/out-reach, satellite services or peripatetic teams

S3 **Defined networks and systems for referral and funding should be in place** to ensure that individuals can gain timely access to appropriate neuro-rehabilitation services outside their locality, where gaps exist in local service provision

S4 **Collaborative commissioning arrangements should be in place** to provide 'complex specialised' rehabilitation services for people with profound and complex disabilities whose needs are beyond the scope of their local rehabilitation services

S5 **Current BSRM recommendations for specialist rehabilitation service provision are:**

- A minimum of 60 beds per million population for specialist in-patient rehabilitation medicine. (This figure assumes other services are locally available for stroke rehabilitation and for rehabilitation of older people)
  - The minimum size of an inpatient specialist rehabilitation unit should normally be around 20 beds to achieve critical mass
  - The beds must be co-located, together with therapy facilities (see S10), to provide a rehabilitative environment and to support co-ordinated inter-disciplinary team-working between nursing therapy and medical teams
- In addition, complex specialised rehabilitation (tertiary) services should be provided for patients with complex rehabilitation needs eg severe brain or spinal cord injury, low awareness states, challenging behaviour or concurrent complex medical needs. These should:
  - be provided in co-ordinated service networks over a population of 1-3 million
  - be expected to have special facilities and to take a demonstrably more complex case-load, for which higher staffing levels will be required
  - be subject to specialised commissioning arrangements (see Warner Report)

2. Staffing establishment and facilities in in-patient specialist rehabilitation services

Rationale:

The NSF recognises that *early and intensive rehabilitation is cost-effective*, and that *adequately staffed and resourced specialist rehabilitation services* are required to deliver this.

Staffing must be adequate both in terms of *staff numbers* and *experience*. Unqualified rehabilitation assistants can provide useful extra pairs of hands, providing they are supported and supervised by appropriately trained and skilled staff.

It is necessary to lay out recommendations for <u>minimum</u> staffing in a district specialist rehabilitation setting, as well as to propose mechanisms for adjusting staffing levels to case mix for services which take at least a proportion of more complex cases.

Standards:

S6 **All specialist rehabilitation services should be supported by dedicated sessions from a consultant specialist in rehabilitation medicine**

- A minimum of 6 WTE consultant specialists in rehabilitation medicine (RM) per million population including
  - 3.6 WTE for district specialist inpatient rehabilitation services and their associated out-reach activities
  - 2.4 WTE for specialist community rehabilitation services

  (These figures assume additional contributions from other specialties to support local rehabilitation in the context of Stroke Medicine and Care of the Elderly settings)
- No RM consultant should work single-handedly

S7 **Rehabilitation should be carried out by a co-ordinated inter-disciplinary team(s),** including:

- All the relevant clinical disciplines: doctors and nurses trained in rehabilitation, skilled paramedical professionals, psychologists, social worker etc
- Sufficiently qualified and experienced staff to meet the demands of the case-load
- Staff numbers to provide rehabilitation at an intensity that matches the needs of the patients

S8 **All inter-disciplinary team staff should be readily able to seek specialist advice** or intervention from other colleagues when required
In addition to the core clinical team, input from specialists in assistive technology should be locally available including rehabilitation engineering, orthotics, specialist seating/wheelchairs

S9* **Staffing establishment should be provided <u>at least</u> according to the <u>minimum standards</u>** for a specialist in-patient neurological rehabilitation service, given in Table 1
Complex specialised services require adjustment of these staffing levels in accordance with the nature and complexity of their caseload

S10 **In-patient specialist rehabilitation services should provide an appropriately adapted environment**, which facilitates rehabilitation and includes the relevant special facilities to suit the needs of the patient group. These may include:

- Exercise equipment, such as hydrotherapy, harness-treadmill
- Wheelchairs, special seating and other postural support equipment
- Electronic assistive technology, including communication aids
- Facilities to support vocational training and use of leisure time, such as computers
- Facilities to assess activities of daily living, including extended activities such as meal preparation, out-door mobility, driving assessment etc

Table 1: Minimum staffing provision for a district specialist in-patient rehabilitation service†		
	For every 20 beds:	
Medical staff	1.2 WTE Consultant accredited in rehabilitation medicine 2-3 WTE training grades (above FY) and/or 1.5 WTE Trust Grade doctors	
Nurses	24-30 WTE *(varies with dependency, but at least 1/3 should have specific rehab training)*	**Plus** Trained therapy assistants, technicians, engineers and other professions as appropriate to caseload
Physiotherapists	4 WTE	
Occupational therapists	4 WTE	
Speech and language therapists	2-2.5 WTE *(depending on whether patients with trach-eostomy are accepted)*	
Clinical psychologist/counsellor	1.5-2 WTE *(depending on whether patients with severe behavioural problems are accepted)*	
Social Worker/discharge co-ordinator	1.5 WTE	
Dietitian	0.75-1.0 WTE *(depending on the proportion of patients on enteral feeding)*	
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 service also offers community rehabilitation services *(see Table 2).*

Complex specialised services taking patients with more complex needs **are likely to require higher staffing levels** and an adjusted skill mix 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

A range of dependency tools to evaluate caseload complexity and staffing needs are currently in place and undergoing further development (eg the Northwick Park Nursing and Therapy Dependency Assessments).

3. Referral assessment and transfer to specialist rehabilitation - response times

Rationale:

The NSF recognises the importance of early assessment by a specialist rehabilitation team to advise on management to prevent secondary complications. It also emphasises that provision of rehabilitation services can reduce prolonged stay on acute wards. It is therefore incumbent on rehabilitation services to minimise response times to provide an efficient service.

The BSRM recognises that, at present, the majority of rehabilitation services are not adequately staffed and resourced to meet the proposed response times, and that the standards given are *aspirational*.

† These recommendations are adapted from the Royal College of Physicians and British Society of Rehabilitation Medicine, Rehabilitation following acquired brain injury: national clinical guidelines: 2003.

Standards:

S11	**Patients who are in hospital for >48 hours** with impaired consciousness or immobility following sudden onset of neurological illness or injury **should be assessed by a specialist neuro-rehabilitation team** (or at least a member of the team) to provide advice on interim management to prevent secondary complications. The patient should be assessed by that team within 5 working days of referral. Specific advice and information should be given to the person and/or their family relating to sources of support and further information.
S12	**Patients who are unable to go home directly** and require a period of post-acute in-patient rehabilitation **should be transferred to a specialist neurological rehabilitation unit** as soon as they are medically stable and fit to participate in rehabilitation. The patient should be assessed by that unit within 5 working days of referral. If accepted, the patient should be transferred within 2 weeks of being fit for transfer.
S13	**Patients with highly complex needs requiring referral to a complex specialised rehabilitation service**, (CSRS)***** should be identified and referred as early as possible in the acute phase to allow time for any additional arrangements, eg negotiation of funding to be put in place The CSRS should assess within 10 working days of referral *(target 7 days)* If accepted, the patient should be transferred within 6 weeks of being fit for transfer *(target 1-3 weeks)*
S14	**Following assessment, a written summary should be provided to the referrer within 3 working days** which includes: • A summary of the case and the individual's rehabilitation needs • Specific recommendations for management and the intervention plan • Recommendations for alternative placement if specialist rehabilitation is not considered to be the most appropriate solution for the individual's needs • Specific information for the person and/or their family on sources of further support The assessment summary should be copied to the GP and other relevant agencies, including the individual and/or their family, if appropriate
S15	**All response times should be recorded, audited and reported** back to service planners/ commissioners together with regular assessment of unmet need

4. The rehabilitation process in specialist rehabilitation services

Rationale:

The NSF emphasises the need for:

- Well-coordinated rehabilitation programmes
- Involvement of the person and their family and/or carers in defining goals for rehabilitation and decisions regarding their care
- Joined-up multi-agency working across all boundaries
- On-going support and rehabilitation in the community following discharge
- Re-access to in-patient rehabilitation as required

*****CSRS services are provided on a regional/national basis and currently have markedly limited capacity. It is accepted that response times will be slower for these services until capacity can be expanded to meet demand.

Standards:

S16 **Rehabilitation must be a 24-hour process**, with agreed goals and activities, which are followed through out-of hours by the nursing rehabilitation team

S17 **All major decision-making meetings** eg assessment, goal planning, case conferences, discharge planning **should be undertaken by the inter-disciplinary team**, in conjunction with the individual, and their family and carers where appropriate

S18 **The individual and/or their family should:**

- Be provided with appropriate, accessible and timely information to allow them to make/participate in decisions regarding their treatment and care
- Participate as actively as possible in agreeing and reviewing their rehabilitation goals, which should include both long and short term goals

S19 **There should be clearly defined systems for ensuring co-ordination of effort** between the various different disciplines which include:

- An agreed common set of goals which are reviewed at frequent intervals – and the programme adjusted accordingly
- Multi-disciplinary patient record system which includes recording of agreed outcome measures
- A designated member of the team (eg a key-worker, case manager)***** responsible for
  - overseeing and co-ordinating the individual's programme
  - supporting the individual and communicating information to them and their family
  - acting as their 'advocate' in team discussions from which the individual is absent

****** *It is recognized that this role is time-consuming, and this is currently possible only in teams of sufficient critical mass to support this practice*

S20 **Discharge planning should begin as soon as possible** during the rehabilitation programme
At an early designated stage in admission, a prediction should be made of the expected outcome of the programme and time scale, even though this may subsequently be reviewed.
Programme planning should include an action plan to prepare for discharge, which should involve all relevant agencies including:

- Community healthcare and social service providers and purchasers
- Community nursing and care teams
- Housing, education, employment, insurers, voluntary services as appropriate

S21 **People discharged from specialist in-patient services should have:**

- A written report summarising their further requirements, and recommendations for on-going care to accompany the patient at discharge or follow within 24 hours
- Access to continued therapy on an out-patient, day-case or domiciliary basis, and/or future re-access to inpatient services as appropriate to their clinical problem and circumstances
- Clear information about who to contact should further needs arise, eg for equipment review

S22 **Follow-up and longer term outcome evaluation.** Contact should be made with the patient 12-18 months following discharge from a rehabilitation service, either by visit or phone:

- at least one standardised outcome measure should be applied at discharge and at 12-18 months
- An assessment should be made as to:
  - Whether gains made during rehabilitation have been maintained
  - Whether recommendations made at discharge were implemented, and whether there are other unmet needs
- People who have complex needs and are subject to annual integrated care planning review, should have this assessment as part of their annual review
- A brief summary of this contact, including any recommendation, should be communicated to the GP or other appropriate agency

Note:
It is recognised that there are logistical challenges to this principle which include:

- Constraints on staff time – current caseload may consume all availability
- Large geographic area constrains travel, especially for regionally based services
- Itinerant population (especially brain injury) which can be difficult to trace

Person centred care and integrated care planning: Quality Requirement 1 & Community rehabilitation and support: Quality Requirement 5

Rationale:

The NSF emphasises the need for:

- Integrated service provision from healthcare and social services
- A single point of contact and excellent communication between services
- Rehabilitation centred as closely as possible on the individual's home, providing information and education to support and empower the individual and their family/carers to manage their neurological condition
- Co-ordinated service networks in which local generic community rehabilitation teams, are supported in the management of people with more complex needs. This support may come from:
  - more specialist community-based neuro-rehabilitation teams or
  - out-reach or peripatetic teams from complex specialised rehabilitation services
  - intensive holistic day rehabilitation programmes
- Providing appropriate care and support which takes account of cognitive and behavioural needs, provided by carers with appropriate knowledge and skills in the management of neurological disability

Standards:

1. Joined-up working between healthcare and social services

S23 ***Community health and social services managers should work in close partnership*** to ensure that an adequate range of services exists to meet the specific needs of those with LTNC and their carers. These should include:

- Maintaining a register of people with LTNC who require on-going support
- Provision of information and education to assist the person, their family and carers to access support services and to make informed decisions regarding their on-going treatment and care and to manage their own condition

S24 ***Explicit arrangements should be in place regarding the responsibilities of health and social services*** in the timely provision of:

- Assistance with care, including respite, supported living arrangements, care home facilities, day centres etc
- Provision and maintenance of any special equipment
- On-going rehabilitation, which should be focused on improving participation and societal integration, including support for purposeful activities such as leisure and voluntary work

S25 ***Funding arrangements should be clearly established*** for all people with a LTNC who require long-term care packages which include nursing or therapy input in addition to basic care, including:

- Explicit arrangements for joint funding
- Clear and consistently applied eligibility criteria for NHS Continuing Care

The expertise of a **Consultant in Rehabilitation Medicine** should be utilised where appropriate to establish the case for funding specialised health needs

2. Provision of specialist community rehabilitation services for people with LTNC

S26 **Specialist community rehabilitation services should be supported by dedicated sessions from a consultant specialist in Rehabilitation Medicine (RM).**
Explicit networking arrangements should be in place to ensure that community teams are fully integrated with in-patient services, and have access to in-patient facilities for those patients who require them

S27 **Community rehabilitation should be carried out by a co-ordinated inter-disciplinary team(s),** including:

- All the relevant clinical disciplines: doctors and nurses trained in rehabilitation, skilled paramedical professionals, psychologists, social worker etc
- Sufficiently qualified and experienced staff to meet the demands of the case-load
- Staff numbers to provide rehabilitation at an intensity that matches the needs of the patients

S28 **All inter-disciplinary team staff should be readily able to seek specialist advice** or intervention from other colleagues when required
In addition to the core clinical team, there should be access to input from other disciplines as required (eg rehabilitation engineers, orthotists)

S29 **Staffing establishment should be provided <u>at least</u> according to the <u>minimum standards</u>** for a specialist community neurological rehabilitation service given in Table 2

Table 2: Minimum staffing provision for community specialist rehabilitation services to support people with LTNC (population 1million) †

Team leader/co-ordinator*	2
Nurse specialists**	8
Physiotherapists	6
Occupational therapists	10
Speech and language therapists	4
Clinical psychologists	4
Specialist Social Workers	8
Dietitian	2
Technical instructors	8
Generic assistants	8
Consultant iaccredited in Rehabilitation Medicine	2.4

** The team leader/co-ordinator may be from any clinical background, but should have at least half of their time designated for co-ordination and team management, including staff appraisal, audit etc*

*** Nurse specialists to cover the common neurological conditions eg acquired brain injury, multiple sclerosis, motor neurone disease, Parkinson's and related conditions*

† These recommendations are adapted from the Royal College of Physicians and British Society of Rehabilitation Medicine, Rehabilitation following acquired brain injury: national clinical guidelines: 2003.

3. The community rehabilitation and support process

S30 ***People living in the community with LTNCs should have timely and on-going access to an named individual or team*** with experience in management of their condition who:

- takes responsibility for their rehabilitation and for their continuing care and support
- has knowledge of the various specialist and local services available
- co-ordinates appropriate referrals, assessments and reviews as require
- works across the range of statutory, voluntary and independent services to meet the needs of the patient and their family

S31 ***Care services should be provided by skilled workers,*** trained in the needs of people with LTNC, to ensure that:

- the support is relevant and appropriate to meet needs
- care provision takes into account the needs of those with cognitive and communication problems

S32 ***Family and carers*** should be:

- involved in assessment and subsequent decisions about help that is required
- offered assessment to establish their own needs and to increase the sustainability of the caring role

S33 ***For patients with complex needs, there should be joint assessment by health and social services***, at least once a year, followed by continued communication, and review and re-assessment. This should include:

- a care-plan detailing specific arrangements should be communicated to the patient and their family/carers, with clear agreement of who will provide which services, and preferably joint funding arrangements
- continued support from specialist rehabilitation services where local services are unable to meet the needs of the patient and/or their families, which may include input from a specialist community neuro-rehabilitation team, or intermittent on-going access to residential/in-patient rehabilitation services

Note:
This annual review does not replace the need for more frequent and proactive review for people with rapidly changing needs

Vocational rehabilitation: Quality Requirement 6

1. Provision of vocational rehabilitation services for people with LTNC

Rationale:

The NSF emphasises the need for local vocational rehabilitation services, to provide basic support for people to remain in or return to work, or to withdraw from work – including employment, education, training or voluntary work.

The NSF also recognises the need for specialist vocational services for people with more complex vocational needs and therefore recommends that rehabilitation services are planned and delivered through co-ordinated networks in which specialist services support local teams.

Standards:

S34 **All adults of working age with a LTNC should have their vocational needs considered** as a routine part of their rehabilitation and support programme
Clinicians should:
- put patients in touch with the relevant agencies as part of routine planning
- refer, where appropriate, to a specialist vocational rehabilitation programme

S35 **All adults of working age with a LTNC** who are **considered to have potential to work** in any capacity should have **access to local or specialist vocational rehabilitation services**, in accordance with the complexity of their needs

2. The vocational rehabilitation process

S36 People with LTNC seeking a return to employment, education or training should be assessed by a professional or team trained in vocational needs for LTNC. **Assessment should take place within 4-6 weeks of referral** and should include:
- evaluation of their medical condition to address any effects which may impact on their ability to work or study, and also to anticipate possible future effects
- evaluation of their individual vocational and/or educational needs
- identification of difficulties which are likely to limit the prospects of a successful return to work/education and appropriate intervention (including environmental adaptation, provision of assistive technology etc) to minimise them
- direct liaison with employers (including occupational health services when available), or education providers to discuss needs and the appropriate action in advance of any return
- verbal and written advice about their return, including arrangements for review and follow-up

S37 **Rehabilitation teams should work directly with the person's local Disability Employment Advisor (DEA) and/or employer to support arrangements** to
- return to or remain in their existing employment
- identify alternative employment, including any training requirements or need for vocational rehabilitation, supported employment etc

S38 **Patients who are unable to return to employment** or training should be
- provided with alternative occupational provision or adult education appropriate to their needs, or
- given advice and support with regard to taking medical retirement and take up of alternative financial support, and other purposeful activities such as leisure activities, voluntary work

Note: The majority of these standards have been drawn from the guidelines for vocational rehabilitation following acquired brain injury. More specific inter-agency guidance in relation to specialist vocational rehabilitation services to support people with progressive and other LTNC is in the process of preparation

Equipment and accommodation: Quality Requirement 7

Rationale:

The provision and maintenance of adaptive equipment is often central to the rehabilitation process, and delays in provision or breakdown of equipment can be a significant factor in causing unnecessary hospital admissions or prolonged stay in hospital.

The NSF emphasises the need for flexible and responsible equipment services planned in co-ordination with other rehabilitation/care services and systems for tracking, re-cycling and changing equipment in accordance with changing need. The NSF also recognises the need for specific arrangements between healthcare and social services for joint funding of complex equipment,(eg standing aids, special seating) especially where this impacts on independence and reduced needs for personal care and support.

Standards:

1. Provision of equipment and accommodation for people with LTNC

S39 **People with LTNC should have timely provision of the equipment they need** to maintain their health, assist with their care, and support independence
Equipment should be provided and maintained in safe working order, in accordance with the relevant nationally agreed standards

S40 **Services supplying specialist equipment, eg special seating, orthotics, and assistive technology should have**
- Sufficient equipment resources to support temporary loans or trials of equipment
- Arrangements in place for tracking and monitoring the use of equipment to support re-cycling to increase cost-efficiency and temporary provision; also to ensure that equipment is meeting the need for which it was prescribed and to replace it if not

2. The process of specialist equipment provision

S41 **People with LTNC should have their needs for special equipment reviewed** and documented at least annually as part of their integrated care programme, or more frequently in the light of rapidly changing need

S42 **Equipment services should work closely with neurology and rehabilitation services** to ensure that the most appropriate equipment is selected to meet their needs and lifestyle

S43 **Explicit arrangements between healthcare and social services should be in place for the joint funding** and purchase of certain items of equipment which impact on both services. These include:
- Special seating
- Standing frames and hoisting equipment
- Communication aids
- Computers and Environmental control systems

S44 Any person who is provided with a piece of equipment/technology should have **clear information about who to contact for maintenance and repair,** and equipment providers/repairers should ensure that their services are accessible ie that telephones are staffed by people trained to communicate with people who have disabilities

S45 **Social services should work in direct liaison with housing/accommodation services** to ensure timely provision of suitable adapted or purpose-built accommodation

3. Training, education and research

Rationale:

The NSF recognises the need for:
- A well qualified workforce of highly skilled professional staff who have specialist knowledge and experience of the needs of people with LTNC
- The provision of education and information for carers, both formal and informal, to understand the needs of people with LTC for whom they care
- Research to understand the needs of people with LTNC and those who care for them, to determine how those needs may best be met

All specialist rehabilitation services should have a recognised role in education, training and published research for development of knowledge and experience in specialist rehabilitation. It is recognised that not every service will have the skills or resources to initiate and execute funded research programmes. However, the BSRM recommends a research network where specialist and local services contribute to collaborative research projects led by the academic and specialist centres.

Standards:

S46 **All staff should have regular appraisals** which include:
- 360°feedback *(This is recognised to be a time-consuming process - see Appendix 1)*
- clearly stated objectives for continued professional development (CPD) with review

S47 All professional staff have responsibility for **keeping themselves up to date**, but their employing services should provide:
- access to up-to-date rehabilitation textbooks and the major rehabilitation journals relevant to their service
- Regular training both within and between disciplines, with time allocated for training on a regular basis
- Financial support and study leave arrangements to allow staff to meet their training needs at external meetings, at least some of which should be multi-professional
- Active encouragement to attend national conferences, which will afford the opportunity to network with other colleagues both within and outside their own discipline

S48 **All specialist and complex specialised neurological rehabilitation services** should collect the national BSRM minimum dataset for all in-patient case-episodes (which includes both inputs and outcome data) and should contribute anonymised data for central analysis, which will be used to establish benchmarks for different categories of inpatient services

S49 **Audit should be undertaken as a routine part of clinical practice.** Audit should be:
- undertaken as a multi-disciplinary activity, to encourage dialogue between professions, and preferably in collaboration with other services and centres
- documented, with proper evaluation of process and outcome, and clear recommendations for change and implementation plans which are reviewed to complete the audit cycle

S50 **Research should be an integral part of rehabilitation practice** with routine data gathered through systematic application and reporting of agreed outcome measures

Service networks should identify local research leads with specific responsibility for co-ordinating research efforts

S51 **Staff in research-active rehabilitation centres** should have
- defined academic links to support high quality research and funding applications
- designated time for research under the new R&D funding arrangements
- systems in place to support research training for trainees and other professional staff
- active involvement of users and carers in defining research priorities

Appendix 1: Draft BSRM pragmatic advice

1. Recommendations for long term follow-up

AS1 The BSRM recommends that at least some attempt is made to assess the both the short term and the longer-term results of rehabilitation

- For the purpose of this standard, long-term outcome is defined as 12-18 months post discharge from a rehabilitation service
- If possible, at least one standardised outcome measure should be applied at discharge and at 12-18 months

However, it is recognised that there are logistical challenges to this principle which include:

- Lack of staff time – this may not always be the best use of time in under-staffed services
- Large geographic distances, particularly for services covering a regional catchment
- An itinerant population which can be difficult to trace

The following advice is offered towards a pragmatic solution.

AS2 Wherever possible, contact should be made 12-18 months post discharge from a rehabilitation programme to determine:

- Whether gains made during rehabilitation have been maintained
- Whether recommendations made at discharge were implemented, and whether there are other unmet needs.

AS3 People who have complex needs and are subject to annual integrated care planning review, should have this assessment as part of their annual review.

AS4 For those without a routinely planned review, the information may be solicited by telephonic interview or by postal questionnaire, if appropriate. For example, self completion versions of the Barthel Index and the Northwick Park Care Needs Assessment are available.

AS5 A brief summary of this contact, including any recommendation, should be communicated to the GP or other appropriate agency.

2. 360° appraisal – a pragmatic approach

All NHS staff are required to undergo regular appraisal and review, and increasingly it is recommended that this includes 360° feedback from work colleagues at all levels.

The BSRM is in discussion about 360° appraisal and at present is making no firm recommendations as a society.

However, in the interim period, the following are noted:

- A subgroup of BSRM members is currently working with the RCP to develop valid and feasible methods for appraisal and re-validation of doctors – rehabilitation has been chosen as a specialty which best exemplifies the situation where a doctor works as an integral part of a multidisciplinary team
- In the meantime, many rehabilitation consultants already undergo routine 360° appraisal and the majority report that they find this a useful process
- When put to a vote with the members attending the workshop in July 2006, an overwhelming majority supported 360° appraisal as part of the general appraisal process for consultants
- However, it was noted that it can be extremely time-consuming and, unless conducted in a consistent and constructive manner, it has the potential to be open to abuse and could therefore be counter-productive if not managed appropriately

It is accepted that this process will probably become compulsory and will have to follow a standard format to be determined at the centre, but in the meantime the following pragmatic advice is informally offered to BSRM members wishing to explore it.

- If 360^{o} appraisal is to be used within a service, it should be applied for all staff
- Annual appraisal should include 360^{o} feedback at least every 2-3 years, but more frequent 360^{o} feedback is of doubtful value
- The feedback should be confidential but not anonymous, so that if serious concerns are raised, they can be appropriately followed up by further enquiry
- Feedback is obtained from:
  - 7-12 colleagues, identified by the appraisee, which includes people who are both senior and junior to the appraisee
  - A simple standard feedback form (one side A4) is recommended with open questions allowing free text answers, as opposed to a long and repetitive list of closed questions. One example is the form* *(see over)* that has been in used at Northwick Park for 15 years which asks 3 questions only:
    - What things the person does well?
    - What things they do not do so well?
    - What changes could be made to improve his/her performance? *(These may include either changes on the part of the individual or on the part of management)*

- Feedback is passed to a named individual who then collates and summarises the feedback so that the source of each comment is concealed from the appraisee. If comments conflict, as they often do, the collator will give thought to how these conflicts may have arisen and how they might be resolved, which can be discussed further at appraisal.

*360° appraisal feedback form

Name of appraisee:

Name of person providing feedback:

Dear Colleague

My appraisal is coming up on < date >. I would be very grateful if you could provide some feedback for my 360 degree appraisal. Your comments will be kept confidential.

All comments will be collated by …….. to pass me at my appraisal.

Thank you for your help

What does this person do well?

What does s/he do not so well?

What changes could be made to improve his/her performance in the department?

Signed: Date: