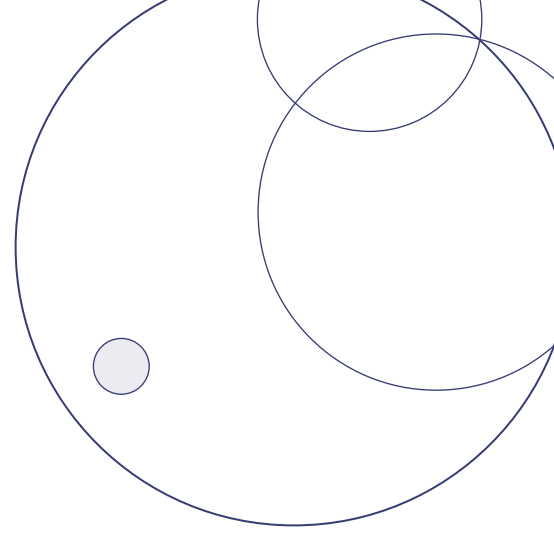


Rehabilitation Standards

hallmarks of a good provider





○ **Rehabilitation
Standards**
hallmarks of a good provider

○ Foreword

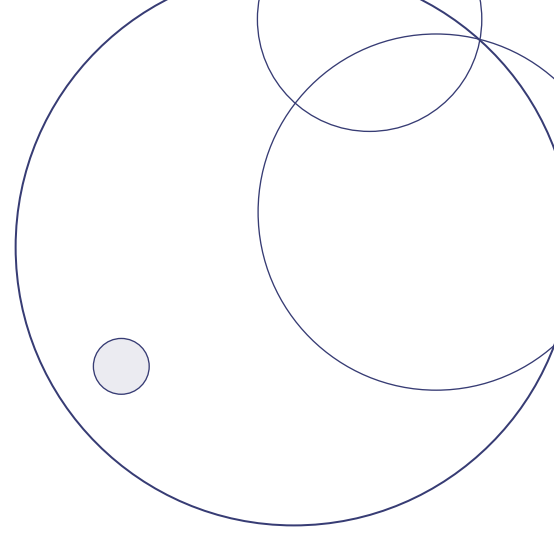
Good rehabilitation is an important element to enable people who have sustained injury, ill health or sickness to improve or regain their independence and return to work.

I am delighted that the UK Rehabilitation Council has taken the initiative to develop Rehabilitation Standards that are focused on the needs of purchasers and consumers of rehabilitation services. The Standards illustrate the hallmarks for quality provision of rehabilitation services whilst the accompanying guides, aimed at purchasers and consumers of rehabilitation services, offer assistance to seek out good providers.

I welcome the Standards as a key piece of work supporting the recommendations in my Review of the health of Britain's working age population, *Working for a healthier tomorrow*.



Dame Carol Black



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○ Introduction

The rehabilitation market-place in the UK is developing rapidly. With this growth comes a demand for users to be able to easily establish which of the services on offer will meet their need in terms of both outcome and price, and which of the many providers has the necessary quality hallmarks. Accordingly the Department for Work and Pensions has commissioned these rehabilitation Standards.

The Standards aim to help potential users make informed choices when selecting quality rehabilitation providers who can deliver the right solutions.

The Standards also aim to:

- create a framework which recognises best practice and safe delivery by skilled and experienced practitioners
- influence the creation of cost-effective services.

In some areas of rehabilitation, practice standards and professional codes of conduct already exist or are currently being created. This is the case in a few specific sectors (such as case-management), and also where certain clinical disciplines cover areas of rehabilitation (such as the clinical aspects of stroke recovery). But these practice standards and codes of conduct tend to govern the 'technical' delivery of services rather than the relationship between the provider and the user

and, even more importantly, there are large areas of rehabilitation practice which fall outside their scope. Accordingly, the rehabilitation Standards will bridge gaps and create an over-arching 'umbrella' mechanism to help users assess the quality of what is on offer.

Although this is a stand-alone document, you may also find it useful to read our companion user guides for consumers and purchasers of rehabilitation services.

Adherence to the Standards by providers will initially be on a voluntary basis. However, users will expect providers to meet the benchmarks set out and thus the Standards are a powerful first step in influencing market quality. Accreditation and regulation are questions for the future.

I would like to thank the many expert people who have given so generously of their time to help us produce these Standards. We hope you find them of value.



Catherine McLoughlin CBE
Chair, UK Rehabilitation Council



○ Acknowledgements

The UK Rehabilitation Council would like to thank all members of the Standards Advisory Group, who have been involved throughout the development process, for their constructive ideas and comments, which have been invaluable drawing together this document.

We would also like to thank the many contributors who offered their opinions and comments during the consultation phase and at the various events where the draft Standards were presented and discussed.

Thanks also to Andy Vickers and David Booth at the Department for Work and Pensions, for their support and constructive contributions.

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Our sincere thanks also to the Sainsbury Centre for Mental Health for the generous practical support provided to the Council throughout the development process.

The Department for Work and Pensions commissioned the UK Rehabilitation Council to develop Rehabilitation Standards. The UK Rehabilitation Council is solely responsible for the content and views expressed in this document which do not represent the official view of the Department for Work and Pensions.

○ Explanatory notes

This document is designed to support professional practice standards where these already exist. The combination of professional practice standards alongside the rehabilitation Standards for providers will be key to underpinning delivery of quality services.

The Standards cover all rehabilitation services, both health and vocational.

The Standards are general in application. They do not attempt to describe condition-specific practices or types of interventions or programmes. It is a fundamental concept underlying the Standards that providers follow best practice for their particular field of delivery. Also that condition-specific interventions and programmes will adhere to the relevant evidence-base (recognising that in some arenas there is still a very limited evidence / research base). Where the services are clinical in nature, they should be delivered within a framework of clinical governance.

The Standards apply in all sectors, whether in private, public or not-for-profit settings (including services provided on a gratuitous basis).

The Standards apply to any size of organisation, from sole practitioner to large corporation.

The principles of the Standards are appropriate to all services and can be applied consistently in each and every context. However, 'proportionality' has to be recognised across the range of organisational size and scope of services. Therefore, for certain Standards, such as the Standard relating to business governance ('the business'), there may be different ways of evidencing compliance depending upon the size and type of organisation.

The Standards are designed to be meaningful and pragmatic and relate to activities, practices and outcomes which can be:

- a) shown to be evidence-based (wherever this is possible, as per note above), and
- b) demonstrated by documentary evidence and / or by observation, and
- c) objectively measured, monitored and evaluated.

As a result, rehabilitation providers can collate consistent, valid and reliable information which can be used to demonstrate the quality of their services. In due course this information may provide evidence for accreditation purposes.

Standard 1: what the service does



- **Principle** – the provider should clearly define the service(s) offered in a **service definition document**.¹

1.1 Services should be defined by reference to the following four elements:

a) the service(s) and specialism(s) the provider is skilled to offer

The provider should aim for clear understanding by users. Generic phrases like ‘rehabilitation services’ should be avoided. Where phrases like ‘whiplash management programme’, ‘functional restoration programme’ or ‘condition management programme’ are used, these should be further defined so that the exact nature of the service is clear.

b) the ‘type’ and the ‘setting’ of the service, e.g.

(type) telephone-based interaction, web-based / email interaction, desk-top assessment, face-to-face individual or face-to-face group sessions

(setting) residential, domiciliary, clinic, community, workplace

c) the geographical area(s) where the service is provided

The provider should use commonly recognised geographical city, county or national areas. The provider should aim for clear understanding by users, and support this with information about offices, staff, and telephone coverage as appropriate.

d) whether the services can be accessed direct by individual users

1.2 All marketing materials, including literature and website, should clearly reflect the defined services.

1.3 The provider should have review processes in place ensuring that the service(s) offered reflect their ‘scope of practice’, i.e. are supported by their qualification, skills and experience.

1.4 The provider should ensure that every referral and all practices / interventions remain within their ‘scope of practice’, i.e. remain within their qualification, skills and experience. The provider should not act beyond the limit of their qualification, skills and experience.



¹ (See template at appendix 1)

Standard 2:

the skills used in delivering the system

- **Principle** – the provider should have staff with the appropriate skill, knowledge and ability to deliver each of the services offered. This standard relates to competency and is about the qualification, training, experience and ongoing learning of the staff delivering the services.

- 2.1 The provider should ensure that staff (whether directly employed, sub-contracted or volunteer) have the necessary mix of skills to deliver the defined service.

If at any time this skill-base cannot be ensured, the provider should stop offering the affected service and not accept any new instructions. In respect of any users actively receiving the service, the provider should take action to safely complete delivery by transferring those users to other suitably qualified providers (or by other appropriate steps) as soon as reasonably possible.

- 2.2 The provider should maintain a **service competency document** (see template at appendix 2) which records the skills and experience required to deliver each service and service-element, and the identity of the staff (employed, sub-contracted and volunteer) who can deliver each element.

- 2.3 The provider should ensure staff competency through use of recruitment and selection procedures and by ongoing assessment, appraisal, training and development.

The qualification, training and experience of practitioners should be evidenced by full individual CV's, evidence of qualification and registration, Criminal Records Bureau (CRB) / Protection of Vulnerable Adults (POVA) checks as appropriate and certification of current / ongoing relevant continuous professional development.

- 2.4 Where a particular qualification is necessary for staff to deliver a service or service element, the provider should ensure staff are appropriately qualified.

Where the service requires or allows activities different in nature from those permitted by a practitioner's underlying clinical, psychological, allied-health, social-work, vocational, or similar qualification, the provider should ensure that the practitioner has additional relevant qualification and / or training and experience to enable them to operate beyond the scope of practice allowed by the underlying professional qualification.

Not every service-element will require a qualification but appropriate competence with relevant training and experience should still be demonstrated.

All qualifications and professional titles or designations should be recognised in the UK. Where there is no appropriate UK accrediting body, the provider should check the status of the professional qualification.

Competence to deliver certain services may be demonstrated by evidence of compliance with the practice standards of organisations such as the Case Management Society of the United Kingdom (CMSUK), the Vocational Rehabilitation Society (VRA), and the British Association of Brain Injury Case Managers (BABICM).



- 2.5 The provider should ensure that staff maintain appropriate professional registrations and memberships relevant to their individual scope of practice, for instance: General Medical Council (GMC), Nursing and Midwifery Council (NMC), Health Professions Council (HPC), United Kingdom Public Health Register (UKPHR), VRA, CMSUK or BABICM.
- 2.6 Where a practitioner is a member of a professional body or association, the provider should ensure that s/he acts in accordance with the standards of practice and code of ethics and conduct of their professional body / association.
- 2.7 The provider should ensure that staff have, specific to the service, relevant experience, knowledge and skills. Depending on the service / service-element offered, this may include for instance:
- awareness of the current evidence-base (where this exists) that supports the service(s), and experience in interpreting and delivering this; where no sound evidence-base exists, staff should be aware of the rationale for adopting the intervention
 - ability to interpret legal and policy areas relevant to service. This will apply where interaction with legal or policy frameworks is necessary, for example in the context of nursing, housing, care and benefit entitlements.
 - interpersonal skills that enable communication and negotiation with users and others as required. This may extend to advocacy on behalf of users.
 - 'know-how' or 'local knowledge' specific to the scope of practice / service(s). This may, for example, be knowledge of the local employment market and networks / placement opportunities; or knowledge of how to access statutory services; or a working knowledge of the UK compensation system.
 - financial acumen – in order that all assessment, planning and interventions balance the needs of users with 'proportionality' and cost, and are delivered cost-effectively; staff should also be effective in the management of funding (particularly where funds are delegated).
- 2.8 The provider should ensure that staff are properly trained, supporting this by time-allowance and by internal knowledge-pooling etc.
- All staff should undertake relevant ongoing professional development and the provider should support this through time-allowance.
- 2.9 Trainees should be fully supervised by competent staff and not have their own allocation of users or be responsible for service-elements.

Standard 3:

how the service works in practice

- **Principle** – the provider should clearly define the service delivery elements of each service offered, including, for example, the work practices for referral, assessment and reporting, and, where appropriate, charges and rates. The provider should monitor the effectiveness of the working practices vis-à-vis outcomes.

In creating robust working processes based on best practice, the provider will be able to ensure that service(s) are:

- good, effective and safe
- needs-focused
- outcome-focused
- cost-effective.

Evidence of conformity with this standard may vary considerably in accordance with the scope and size of the organisation.

- 3.1 The provider should have a **working practices document** that outlines the working practices for each service delivery element. This document should include the rationale, with references to the ‘best practice’ evidence, for each working practice (where an evidence-base exists).

In an established business organisation the documentation available should be extensive, covering every process. As a bare minimum the working practices document should record an outline of:

- service definition (the **service definition document** – see appendix 1)
- acceptance criteria and instruction, onward referral and case closure procedures
- service-levels / time-frames for each service delivery element
- practices for each element. For example, for an initial needs assessment under the Rehabilitation

Code: how the assessment is conducted, what the final product looks like (clear concise assessment report with recommended action-plan indicating predicted costs, time-oriented goals agreed with users etc.) and the templates for assessment and planning. Similarly, where for example a service is delivered according to an accredited programme, the relevant programme documentation should be annexed to the working practice document.

- consent procedures (relating to interventions and treatments, and sharing of information)
- assessment and evaluation tools and decision criteria
- communication policy – e.g. report and advice formats and frequency
- where appropriate, price information and payment terms including VAT (value added tax) status. N.B. These should be the marketed price; confidential commercial arrangements can be made (although any credit or “third party referral” arrangements which exist should be declared to any legitimate interest).

- 3.2 The “working practices document” should be regularly reviewed to ensure:

- that it reflects the actual working practices
- that the working practice reflects the current evidence-base.



Any change to that recorded in the working practices document during the delivery of service(s) should be agreed with the users.

- 3.3 On receipt of instructions, providers should issue users with an initial 'client care' letter setting out, for example, the next steps for the user, contact points and the user's rights and responsibilities.
- 3.4 All assessment, planning and delivery by the provider should occur in liaison with a user's NHS health team and all other health, care, employment, and social-work professionals and agencies concerned with the user's care.
- 3.5 Following assessment, an individual rehabilitation plan should be objectively prepared and tailored for the user, reflecting the user's needs and outlining the likely outcome and goals. The plan, timescales and goals should be agreed with users.
- 3.6 The principle of 'proportionality' should be central to all service planning and delivery, balancing need with available funding.
- 3.7 All service delivery should be cost-effectively designed having regard to best practice and to all available resources. Any cost likely to attach should be estimated and agreed with users beforehand.

- 3.8 All service delivery in practice should be the subject of systematic ongoing monitoring and evaluation, with particular regard to progress against plan and timeframes. Primarily, staff delivering the service elements are responsible for this but, where relevant to the service and context, it should also take the form of:

- inter-disciplinary or multi-disciplinary team review
- peer-review
- quality control and audit.

Issues and problems arising, or other reasons for lack of progress in the rehabilitation plan, should be identified and recorded along with any appropriate adaptation to the plan. The user's agreement should be obtained and any other stakeholders involved as appropriate.

- 3.9 Providers should operate a continuous improvement programme by monitoring and evaluating programme and outcome data and user feedback and be able to demonstrate the effectiveness of their service by recorded data.

Standard 4:

how users of the service are safeguarded

- **Principle** – the provider should have clear policies ensuring the protection of users. This is both about preserving the personal safety and rights of the individual user (regarding for instance their rights to privacy and confidentiality) and about protecting the rights and interests of other purchaser-users.

- 4.1 The provider has a duty to the user who is receiving rehabilitation, and the provider should at all times act in his / her best interests and ensure and protect his / her safety, dignity and privacy.

The provider also owes a duty to any other purchaser-users such as employers and insurers, and at all times should be mindful of their interests.

- 4.2 The provider should, when determining the rehabilitation intervention in accordance with best practice and clinical governance, operate independently of the influence of any party, except to the extent that funding from a purchaser-user is legitimately restricted. In the case of restricted funding, the provider should ensure best use of all available resources.

- 4.3 The provider should at all times consider whether there is any conflict of interest in accepting an instruction and / or delivering services. Any perceived conflict of interest, whether generally or in an individual case, should be declared to users. The identity of proprietors, directors and other stakeholders with any financial or commercial interest in the provider's business, however arising, should be declared on request to those with a legitimate interest.

- 4.4 Users should be kept fully informed at all times of any material information and / or change in material information.

- 4.5 The provider should ensure that staff are fully familiar with the organisation's documented statements setting out the:

- ethical values of the organisation. This statement may follow the code of ethics of relevant professional organisations or designations.
- principles of user personal safety, confidentiality and privacy recognised by the provider
- statutory requirements governing obtaining valid and informed consent to intervention and treatment and for research purposes
- statutory requirements governing the obtaining of and sharing/disclosure of information in accordance with Health Records and Data Protection legislation
- statutory and legislative requirements governing equality and discrimination.

- 4.6 Any staff working with children and / or vulnerable adults should be checked in accordance with Criminal Records Bureau (CRB) and/or Protection Of Vulnerable Adults (POVA) procedures.

- 4.7 The provider should determine Health & Safety requirements in relation to premises, equipment, home / workplace visits etc. and ensure that these are met.

- 4.8 The provider should maintain an accessible and effective complaints procedure.

Standard 5: the business



- **Principle** – the provider should have in place business governance and practices ensuring that the business structure and processes support the service(s) offered.

The provider should have a demonstrable structure and processes which support:

- effective delivery of outcomes
- efficient use of resources
- business viability.

Evidence of conformity with this standard may vary considerably in accordance with the scope and size of the organisation.

5.1 In an established organisation the following features should be present:

- a management team with designated accountability
- appropriate business registration e.g. limited liability partnership (llp), public limited company (plc), self-employed
- financial management with appropriate solvency, cash / credit management and accounting procedures
- objective capacity management and planning
- reliable information management systems with security, retention and back-up procedures

- performance management with quality assurance, complaint management and ongoing data review and performance improvement programmes
- human resource management
- risk management procedures, accompanied by contingency / business interruption / disaster recovery plans.

A small business may need to combine all functions in one or two individuals but should still be able to demonstrate a sound operating policy including financial management with evidence of annually audited or examined accounts.

5.2 The provider should have in place appropriate liability and professional indemnity insurances.

5.3 Where there are any partnership / referral arrangements or where any element of the provider's service is contracted out, the provider should demonstrate that the relationship has been entered into with reasonable care to ensure that the partner or contracted party complies with the requirements of the Standards.

Appendix 1:

Service definition document: what the service does

Section A: Provider Details		Date of Document: DD / MM / YYYY		
Name of Rehabilitation Provider: (Trading Name and Registered Trading Address):		Provider Contact Details: (contact name and telephone / email details and contact address if different to registered trading address):		
Section B: Service Definition				
1. Service(s) Offered – aim for clear understanding by users. Where a generic phrase such as 'condition management programme' is used, give a breakdown of the component elements of the programme.	2. Geographical area in which the service is offered – use commonly-recognised city, county and national areas and briefly describe how this coverage is supplied.	3. How the Service is Offered:		4. Access to Service(s) – Can the service be accessed by individual users or only on referral from another agency?
		Type of Service for example face-to-face, telephonic or web-based.	Setting for service, for example work-place, clinic, residential or domiciliary.	
Example A: Whiplash management programme including initial telephone triage and / or face-to-face assessment, telephone case-management, exercise advice, pain-management advice, physiotherapy, psychological support.	UK coverage: 15 staff clinical call-centre with 20 UK direct-managed clinics with additional support provided by nationwide physiotherapy network.	Telephone triage & case-management, plus face-to-face physiotherapy where needed.	Clinic-based where physiotherapy required.	Service can be accessed by individuals and their representatives. Primarily operated for motor insurance claims programmes.
Example B: Specialist neurological physiotherapy services for stroke recovery patients.	Hampshire and Isle of Wight: 8-clinic network (Romsey, Southampton, Eastleigh, Basingstoke, Alton, Petersfield, Portsmouth, Newport IOW).	Face-to-Face.	Clinic or domiciliary arranged according to need.	Individual access and referrals accepted from primary care trusts and NHS bodies.
Example C: Condition Management Programme – a multi-disciplinary programme for long-term musculo-skeletal conditions using exercise therapy, physiotherapy, CBT techniques, pain-management education to help restore function and help clients manage their conditions and return to work.	Edinburgh, West Lothian, Midlothian, East Lothian, Greater Glasgow, Renfrewshire, Inverclyde, North Lanarkshire and Ayrshire (Centres in Edinburgh, Glasgow, Airdrie).	Face-to-Face Individual and Group Sessions, with telephone support.	Clinic-based with workplace support as necessary; residential programmes available.	Service can be accessed by individuals. Primarily operated for Jobcentre Plus providers.

Appendix 2:

Service competency document: service skills

Section A: Provider Details	Name of Rehabilitation Provider:	Date of Document: DD / MM / YYYY	
Section B: Service Skills			
Service offered: (the service(s) defined should reflect those identified in the service definition document).	Qualifications, skills and experience required to deliver the Service(s) competently.	Identity of staff competent to deliver service(s) (including sub-contracted staff. Where a service is sub-contracted to a multi-personnel agency, the identity of the agency should recorded).	Qualifications, professional designations and memberships of staff-member.

○ Definitions

Rehabilitation	<p>'A process of active change by which a disabled person achieves optimal physical, psychological and social function'</p> <p>(UK Rehabilitation Council)</p>
Vocational rehabilitation	<p>'Whatever helps someone with a health problem to stay at, return to and remain in work'</p> <p>(Vocational Rehabilitation Task Group)</p>
User	<p>This term includes both the consumer ("end user") of services and the purchaser where different. An individual may both consume and purchase services, or may have services purchased on his/her behalf by another party – usually an employer, insurer or commissioning body such as DWP. For the purposes of this document and the companion guides, the term "user" means both consumer and purchaser and should be taken to mean both/either. Where a Standard or guidance note relates only to a purchaser and not to a consumer, this is made clear by use of the term "purchaser-user".</p>



Glossary of abbreviations

This section lists the abbreviations used for organisations referenced within the Standards and companion user guides, and provides details of each organisation's website where more information can be found.

BABICM	British Association of Brain Injury Case Managers www.babicm.org
BACP	The British Association for Counselling and Psychotherapy www.bacp.co.uk
BAOT/COT	British Association/College of Occupational Therapists www.cot.co.uk
BASE	British Association for Supported Employment www.base-uk.org
BPS	The British Psychological Society www.bps.org.uk
CAB	Citizens Advice Bureau www.citizensadvice.org.uk
CMSUK	Case Management Society UK www.cmsuk.org
CRB	Criminal Records Bureau www.crb.gov.uk
CSP	The Chartered Society of Physiotherapy www.csp.org.uk
DWP	Department for Work and Pensions www.dwp.gov.uk
GMC	General Medical Council www.gmc-uk.org
HPC	Health Professions Council www.hpc-uk.org
NMC	Nursing & Midwifery Council www.nmc-uk.org
POVA	Protection of Vulnerable Adults scheme www.dh.gov.uk/en/socialcare/deliveringadultsocialcare/vulnerableadults/index.htm
UKPHR	UK Public Health Register www.publichealthregister.org.uk
UKRC	UK Rehabilitation Council www.rehabcouncil.org.uk
VRA	Vocational Rehabilitation Association www.vocationalrehabilitationassociation.org.uk

○ Sources of useful information

The list below is by no means exhaustive but indicates where more information may be found about the legislative, regulatory or governance matters referenced within the Standards and companion user guides.

“Choosing a rehabilitation provider – a consumer’s guide to the standards expected of a rehabilitation provider”, UK Rehabilitation Council
www.rehabcouncil.org.uk

“Selecting rehabilitation services – a purchaser’s guide to the standards expected of a rehabilitation provider”, UK Rehabilitation Council
www.rehabcouncil.org.uk

“Clinical Governance”, Department of Health
<http://www.dh.gov.uk/en/Publichealth/Patientsafety/Clinicalgovernance/index.htm>

“Rehabilitation: A Practitioner’s Guide”, Bodily Injury Claims Management Association (BICMA)
www.bicma.org.uk

“Think Rehab: Best Practice Guide on Rehabilitation”, Association of Personal Injury Lawyers (APIL)
www.apil.org.uk/campaigns.aspx

“Managing sickness absence & return to work”, Health and Safety Executive (HSE)
www.hse.gov.uk/sicknessabsence

“The Rehabilitation Code”, Rehabilitation Working Party
www.iua.co.uk/rehabilitation

“Guide to Best Practice at the Interface between Rehabilitation and the Medico Legal Process”, British Society of Rehabilitation Medicine (BSRM)
www.bsrm.co.uk/Publications/Publications.htm

“Good Practice in Consent”, Department of Health
www.dh.gov.uk/en/Publichealth/Scientificdevelopmentgeneticsandbioethics/Consent/index.htm

“Patient Confidentiality and Access to Health Records”, Department of Health
<http://www.dh.gov.uk/en/Managingyourorganisation/Informationpolicy/Patientconfidentialityandcaldicottguardians/index.htm>

Data Protection Act, Information Commissioner’s Office
www.ico.gov.uk



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David Fisher	Association of British Insurers (ABI)
Kevin Fitzpatrick	Inclusion21
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Jan Harrison	Case Management Society UK (CMSUK)
Gail Kovacs	Vocational Rehabilitation Association (VRA)
Cathy Johnson	British Association of Brain Injury Case Managers (BABICM)
Dave Joyce	Communication Workers Union (CWU)
Mike McPeake	The Disabilities Trust/Brain Injury Rehabilitation Trust (BIRT)
Andrew Pemberton	Argent Rehabilitation
Robert Sneddon	Trades Union Council (TUC)
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The UK Rehabilitation Council would welcome
comments on this and companion documents.

Comments can be made through our website:
www.rehabcouncil.org.uk or addressed to the
Council.