United Kingdom Rehabilitation Council

Selecting rehabilitation services

a purchaser's guide to the standards expected of a rehabilitation provider

UK Rehabilitation Council
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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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Purpose of this purchaser's guide

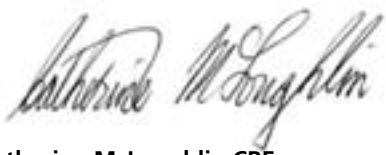
There is a growing demand for health and vocational rehabilitation in the UK, and with it a need for standards by which to assess potential providers. The NHS generally provides a high standard of rehabilitation especially in acute and secondary care, but its resources and capacity are limited and it is frequently necessary to look elsewhere, particularly for longer-term rehabilitation needs.

Much of the care used to help people who have had a disabling accident or illness comes from the private sector where firms are largely unregulated. It can be extremely difficult for purchasers / commissioners of services, not to mention individual consumers, to recognise good providers and to monitor the quality and value for money of the services received.

The Department for Work and Pensions has accordingly commissioned a set of guidelines ("Rehabilitation Standards: hallmarks of a good provider") and companion user guides for consumers and purchasers of rehabilitation.

This purchaser's guide, to be read in conjunction with the Standards, is designed to assist employers and insurers and other commissioning bodies in the selection and procurement of rehabilitation services. It may also be useful for purchasers to read the companion document which helps individual users know what to look for ("Choosing a Rehabilitation Provider: a consumer's guide").

The Rehabilitation Standards are not a regulatory tool but with their introduction we are creating a quality framework for rehabilitation services. At the heart of this framework are core principles underpinning the interests of both purchasers and consumers, with an engine-room of best practice driving the UK towards cost-effective and added-value outcomes.



Catherine McLoughlin CBE
Chair, UK Rehabilitation Council

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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.

Section 1:
decision factors

Prior to reviewing any particular sector of the rehabilitation market-place, you need to establish "what you are looking for" as a potential purchaser of services.

Organisational need

It is vital to understand both the factors driving your organisation's need to purchase rehabilitation, and the context of your need.

Employers, for example, will need to be mindful of their legal duties to consult employees and their representatives on all matters affecting their health and safety, including the procurement of appropriate rehabilitation services. Working together with employees when commissioning rehabilitation services is crucial to ensuring the services are in fact tailored to the end-user. The Health and Safety Executive provides guidance on this area at www.hse.gov.uk/sicknessabsence.

It may be helpful to spend some time examining the following questions:

- **Why are you purchasing rehabilitation services?**

  For most organisations the key driver is financial. Nearly every employer is nowadays alert to the direct and indirect impacts to their business's bottom line caused when employees are absent through injury or ill-health. For insurers and compensators the cost of injury claims continues to spiral.

- **Who is it that your organisation is intending to provide the service for? Who are the potential end-users?**

  You will wish to define both the population of the 'customer group' and the context.

  For example, you may be an employer seeking to improve a poor sickness-absence rate across your whole employee population where rehabilitation will be part of an employee-benefit or occupational health scheme. Or you may be an employer with one sector of your staff, for instance bench-workers, who all suffer with chronic low back pain. Or you may be an insurer or compensator obliged by law to consider rehabilitation for injured claimants.

- **What type of service(s) does your organisation require?**

  Optimum rehabilitation for individuals is always achieved by employing individually tailored, needs-focussed rehabilitation, rather than by focussing on the specific type of injury, ill-health or incapacity. However, depending on your organisation, your requirement for a rehabilitation service or services will generally fall into one broad category. For example, you may be:

  a) an employer with a work-force susceptible to musculo-skeletal or mental health conditions

  b) commissioning employment providers or other rehabilitation provision for DWP or Jobcentre Plus programmes

  c) a motor insurer wishing to implement a rehabilitation programme for whiplash

  d) a liability insurer who needs to organise rehabilitation for claimants with all types of injuries ranging from minor to catastrophic.

Organisational requirement

Having established the key drivers behind your organisational need, you also need to define the other factors which will influence your selection of providers. These are likely to include:

a) *potential referral volumes* – if you have a very large 'customer group', depending upon the service(s) required, you may need to consider a 'panel' of providers as few UK providers currently have the capacity to deal with very large volumes. Similarly, a panel of regional providers may be necessary if your 'customer group' is geographically spread: generally speaking, only the larger

rehabilitation / health organisations have nationwide capacity.

b) *available 'budget'* – this may be a specific allocation of funds ring-fenced in order to provide a service or perhaps a 'per capita' allowance enabling a pre-determined spend on rehabilitation services; alternatively, and particularly for motor and liability insurers, the 'spend' is unlikely to be predetermined (instead the price of services purchased is likely to be negotiated using cost-benefit analysis based on previous years 'claims experience'). N.B. It is important to point out here that 'budget' and 'price' should never be used as the sole determinants in selecting rehabilitation providers: **value** is the critical factor.

c) *setting required* – would the provider be required to work in-house or provide work-site visiting or clinics?

There are other factors which might affect your organisational requirement. For instance:

d) *brand* – it may be particularly important to your organisation to be affiliated with a particular provider brand (this may arise for instance where the provider is a large composite health / rehabilitation services provider with a house-hold name). There may be particular sensitivity attaching to your organisation's own brand. For instance, one insurer may not wish to be 'associated' with a competitor insurer's rehabilitation arm.

e) *brand values* – purchasers will normally expect that a provider asserts and operates values and organisational philosophies similar to their own, thus protecting the integrity of the purchaser's brand and fitting culturally.

f) whether *strategic partnering or exclusivity* or similar arrangements are required. Where this is desirable or required, the purchaser will look for compatible business models.

Section 2:

qualities to look for in a provider

> When individuals face challenges to their physical or mental well-being, they experience an impact on their quality of life. Rehabilitation is fundamentally about enabling and supporting individuals to recover or adjust during this time, achieve their full potential and – where possible – to live full and active lives.
>
> **Jacqui Lunday, Chief Health Professions Officer, Scotland**

Rehabilitation is about people

In one sense, purchasers of rehabilitation services are purchasing a "commodity" and will apply all the usual rules of "supplier-selection" and procurement to the process of finding and appointing the right providers. Of paramount importance however is the fact that a rehabilitation provider is dealing with people's lives and livelihoods. A purchaser will therefore want to know that the provider is absolutely trustworthy and reliable: a 'safe pair of hands' to which people can be entrusted. In appointing a provider, the purchaser will be seeking to form a strong collaborative relationship.

Briefly listed below are some of the types of quality that you might wish to look for in a potential rehabilitation provider. The qualities will not all be relevant or appropriate in all contexts.

- *'person' (or 'needs') focus* – the provider should demonstrate a rigorous approach to delivering evidence-based programmes and processes, whilst adapting and tailoring the interventions to individuals. A bio-psycho-social approach should be firmly rooted in the provider's ethos and practice, meaning that all the environmental, social and psychological factors affecting any given individual are taken into account.
- *professionalism, integrity and accountability* – the organisation should be well managed and well presented and able to demonstrate that they can service your organisation effectively. A purchaser will wish to be confident of a relationship with 'no surprises'.
- *clarity of vision* – can the provider see what it is that you as an organisation want?
- *results-driven* – a purchaser will require operational efficiency demonstrated by successful performance against key performance indicators (outcomes, lifecycles, average cost etc.) and a track-record of success.
- *responsiveness* – key attributes are speed, timeliness and pro-activity.
- *flexibility and dynamism* – a 'can do' attitude.
- *stability and scalability* – the ability to grow alongside your organisation if necessary and to handle a growing volume of referrals.
- *ethos of continuous improvement* – where the provider improves existing services and evolves innovative new ones.

Section 3:

rehabilitation standards guidance notes

What the Service Does	
1. What type of service is provided? The provider's **service definition document** should be readily available. This should include service descriptors that are clear and sufficiently specific. All service(s) and service-elements should be identified.	The aim of the **service definition document** is to give a snapshot overview of the service(s) provided and to support the provider to define their services and thus advertise them correctly. The document should give enough information for potential purchasers to decide quickly whether the provider is in the category of service provider required by them. Purchasers may then wish to seek much more detailed information from a provider.
2. Type and Setting of Service N.B. One important requirement in any setting is the ability to communicate with the user. Where English is not the user's preferred language, the provider should make interpretation services available. Similarly assistance should be provided for others who have any communication difficulties.	*Clinic-based / residential:* ● wherever practicable, the clinical setting should be vetted, particularly in the case of residential rehabilitation. ● ensure the clinic has an "escort" policy for unaccompanied females and children. *Domiciliary / Work-site:* ● establish charging rate for travel time etc. *Web-based:* ● is the service interactive? ● how is the individual programme and user kept under review? *Telephonic:* ● are the telephone staff appropriately trained (a particular consideration where clinical information is being delivered)? ● request detail of telephony systems, call-centre, capacity (number of calls answered, not answered, response times, etc.) and back-up systems. Is the service 24/7? Is a call-recording system in operation? ● a visit to the call-centre is a good idea to see it in action.
3. Geographical Coverage	If, for instance, liaison with statutory services, networking in local job-markets for job placements, or providing hands-on treatment is required, the provider should demonstrate that they can access local services and networks in an appropriate and timely way and that they understand the local conditions. Online research into local conditions and facilities is feasible but networking into local organisations can still be difficult unless a provider has existing connections and the ability to operate locally.

Competence and Skills

4. How does the provider ensure that staff have the necessary qualifications and skills to deliver the service?

The provider's **service competency document** should be readily available.

In completing the **service competency document**, the provider (a senior accountable staff-member) is required to identify the skills, qualification and experience needed by staff to deliver each and every service element. This requirement will be straightforward for many disciplines, including for instance health and vocational case-managers who subscribe to the requirements set out by CMSUK, BABICM and VRA.

The requirement may challenge some currently working in the field of rehabilitation who may find it difficult to define what they do and their competence. The aim of the requirement is to support providers in ensuring they have the right skills for the service they offer. If they are unable to define their competence requirement, this should raise a question in the mind of potential purchasers.

- ask to meet key professional staff. N.B. Where the provider sub-contracts any part of their service, you may wish to meet the sub-contractor's key professional staff as well.
- to ensure they offer the right skill-mix providers should operate appropriate screening, recruitment and selection procedures; ongoing assessment and appraisal programmes; and training and development programmes.

Screening:

- staff working with children or vulnerable adults must have CRB (Criminal Records Bureau) and POVA (Protection of Vulnerable Adults scheme) clearance.
- full professional CV's should be available for all practitioners.
- qualifications and designations: providers should check all original certificates and also professional registers. Practitioners should hold UK accredited qualifications: where the qualification or certification is not UK-accredited, the provider should investigate the provenance/ status of the professional designation/ qualification and the competence this implies.

Training:

- does the provider provide in-house training and/or time allowance for external training and continuing professional development? Does the provider monitor staff CPD (continuous professional development) accreditation records? How does the provider ensure that staff are kept up-to-date regarding best practice?
- trainees should be fully supervised by designated fully-qualified and competent practitioners.

N.B. Regarding completion of the **service competency document** in respect of sub-contracted services – where services are sub-contracted to an individual, that individual should be identified along with their competency. Where services are sub-contracted to an agency, it is sufficient for the provider to simply identify the agency. Purchasers may wish to review the agency.

How the service works in practice

5. What are the working practices?

There should be evidence that the provider systematically and vigorously reviews their practice with ongoing monitoring and evaluation. The **working practices document** should be reviewed by senior accountable personnel on an ongoing basis to ensure that

The provider should be able to provide a **working practices document** fully recording, for example:

- service coverage
- acceptance criteria, instruction and onward referral procedures
- service-levels / time-frames for each service delivery element

• it reflects the actual working practice • it is maintained on an up-to-date basis • that the working practice reflects the current evidence-base.	• the practices for each element. Where a service is delivered according to a national baseline, for instance within a National Service Framework or according to an accredited programme, relevant framework or programme documentation should be annexed to the working practices document. • assessment and evaluation tools and decision criteria used in delivery of the services • communication practices and policies – e.g. report and advice formats and frequency • baseline prices, VAT (value added tax) status and payment terms for each service delivery element. There should be quality assurance procedures in place which check that the service delivers what it promises.
6. Best practice / practising to the evidence base – is there good evidence for the provider's approach?	Some types of rehabilitation have quite a lot of good quality research evidence to support using a particular type of treatment or approach but in other areas there is not yet an established body of evidence. The provider should be fully knowledgeable about the current evidence-base supporting the service they provide. Designated senior personnel should be accountable for ensuring an evidence-based/best practice approach for each service element. The provider should be able to explain to you why they use a particular intervention, treatment or approach and refer you to the evidence or rationale for this. The provider should also be able to explain why in their professional judgement they are recommending a particular approach.
7. What evidence does the provider have that their particular service, programme or intervention works?	What does the provider regard as a successful outcome? Does this meet with your requirements? An efficient provider will provide supply data on: • total number of cases they have managed, and the success ratio (increasingly providers are keeping records which monitor whether people maintain their outcomes post-programme, e.g. how many people have managed to stay in work six or twelve months later) • ratio of 'drop out' / failure to complete cases and reasons for drop out / failure • average cost and duration of programmes • number of service complaints. High numbers of cases marked by a lack of success, by failure to complete, or by drop out, or high numbers of complaints about the service, could indicate something is inherently wrong. Request case-studies and customer feedback / satisfaction survey data; references and testimonials should also be sought.

Safeguarding Users	
8. Is the provider compliant with the legislative and regulatory requirements governing the type of service they deliver?	There is no excuse for any provider to be ignorant about the compliance requirements affecting the service they provide. Depending on the service(s) delivered, the following may apply: ● Access to Health Records legislation ● Data Protection legislation ● Equality and Discrimination legislation ● Health and Safety legislation ● Disability Discrimination Acts ● Financial Services legislation (FSA compliance – this is likely to be relevant to purchasers operating in the financial services arena). This list is not exhaustive. A provider should be able to detail to you the legislative and regulatory requirements governing their service delivery. Failure to be fully knowledgeable raises a very big question over their fitness to provide a service. Two areas of particular concern relate to: ● obtaining, use of, retention and disclosure of information. Providers must comply with **Data Protection Acts** (DPA) and additionally (where health records are concerned) **Access to Health Records** legislation ● obtaining informed consent to treatment vis-a-vis adults with a mental impairment and children under the age of 16.
Good Business Practice	
9. Can the provider show that their business is 'in good order'? Is the business robust and viable? Where there are any partnership / referral arrangements or where any element of the service is contracted out, the provider must be able to demonstrate that the relationship with the sub-contractor has been entered into with 'due diligence' with a view to ensuring that the partner or contracted party complies with the requirements of the Rehabilitation Standards. N.B. Current accounting rules require auditing for businesses with a turnover in excess of £5.6m and net assets of £2.8m. Smaller businesses need only have their accounts examined.	The provider should demonstrate an appropriate management structure for the business relative to the size of the business, operating to business practice standards which allow the business to: ● operate effectively in delivering outcomes in a timely way, and ● operate efficiently in using resources and thereby delivering overall customer satisfaction for both the end-user and the purchaser. Larger providers may be able to demonstrate compliance with relevant business standards such as ISO 9000. Again, bearing proportionality in mind, the following should be demonstrable: ● an appropriate management team with designated function management and accountability

	• strong financial management with appropriate financial and fiscal planning, solvency, cash and credit management procedures, and accounting and reporting procedures • capacity management and planning with robust service-level agreements which realistically and correctly reflect the capacity management • reliable information and data management systems with appropriate information security, retention and back-up procedures • performance management of identified 'key performance indicators' with processes for managing the performance of staff and resources against these, accompanied by quality audit and ongoing process improvement processes • ongoing risk assessment and risk management procedures, accompanied by validated contingency and business interruption or disaster recovery plans • customer satisfaction, issue-management and relationship management functions. It is a good idea to meet key operational staff and vet the administrative and IT systems. You should also ask about staff turnover and absence rates. High rates will affect continuity of service (and have a direct impact upon users of the sevice who require continuity of care).
10. Does the provider have the necessary capacity to take referrals?	What is the recommended caseload for the provider's individual practitioners? A well-organised provider should know this, and actual caseloads should not exceed the recommendation or service delivery may be affected negatively.
11. Insurance	The provider should be able to show their certificates of professional indemnity and liability insurances. They should be insured for at least £5m in each respect.
12. Vested Interests and Conflicts of Interest	This issue may arise in a compensation setting. Insurers and other compensators and injured parties and their representatives may wish to understand referral fee arrangements undertaken by the provider.

Definitions

Rehabilitation – 'A process of active change by which a disabled person achieves optimal physical, psychological and social function' (UK Rehabilitation Council)

Vocational rehabilitation – 'Whatever helps someone with a health problem to stay at, return to and remain in work' (Vocational Rehabilitation Task Group)

User – 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".

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.

"Rehabilitation Standards – hallmarks of a good provider", UK Rehabilitation Council www.rehabcouncil.org.uk

"**Choosing a rehabilitation provider – a consumer'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

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

Members of the standards advisory group

Fiona Barr	Spinal Injuries Association
David Bingham	British Association of Rehabilitation Companies (BARC)
David Booth	DWP Psychology Services
Roger Butterworth	Independent Consultant
Mike Clarke	Remploy
David Coggan and Paul Nicholson	Faculty of Occupational Medicine
Norman Cottington and Ian Walker	Bodily Injury Claims Managers Association (BICMA)
David Fisher	Association of British Insurers (ABI)
Kevin Fitzpatrick	Inclusion21
Andrew Frank	British Society of Rehabilitation Medicine (BSRM)
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)
Amanda Stevens	Association of Personal Injury Lawyers (APIL)
Marilyn Sycamore	Papworth Trust
Su Wang	Royal Mail

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Catherine McLoughlin, CBE Chair

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Helen Merfield	HCML	Health and Case Management Limited
Susan Murray	Unite	Unite the Union
Steve Pointer	EEF	The Manufacturers' Organisation
Joy Reymond	VRA	Vocational Rehabilitation Association
Julia Scott	COT	College of Occupational Therapists
Amanda Stevens	APIL	Association of Personal Injury Lawyers
Matthew Young	ABI	Association of British Insurers

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UK Rehabilitation Council

c/o
Sainsbury Centre for Mental Health

134-138 Borough High Street, London SE1 1LB

Tel 020 7827 8300

Fax 020 7827 8369

Email info@rehabcouncil.org.uk

Web www.rehabcouncil.org.uk

Copies can be download as a PDF from www.rehabcouncil.org.uk

Paper copies are available (at a small charge for postage and packing) by ordering through our website www.rehabcouncil.org.uk or email info@rehabcouncil.org.uk

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.