# PAS 150:2010

# Providing Rehabilitation Services Code of Practice



Rehabilitation Council
The voice for rehabilitation

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## Publishing and copyright information



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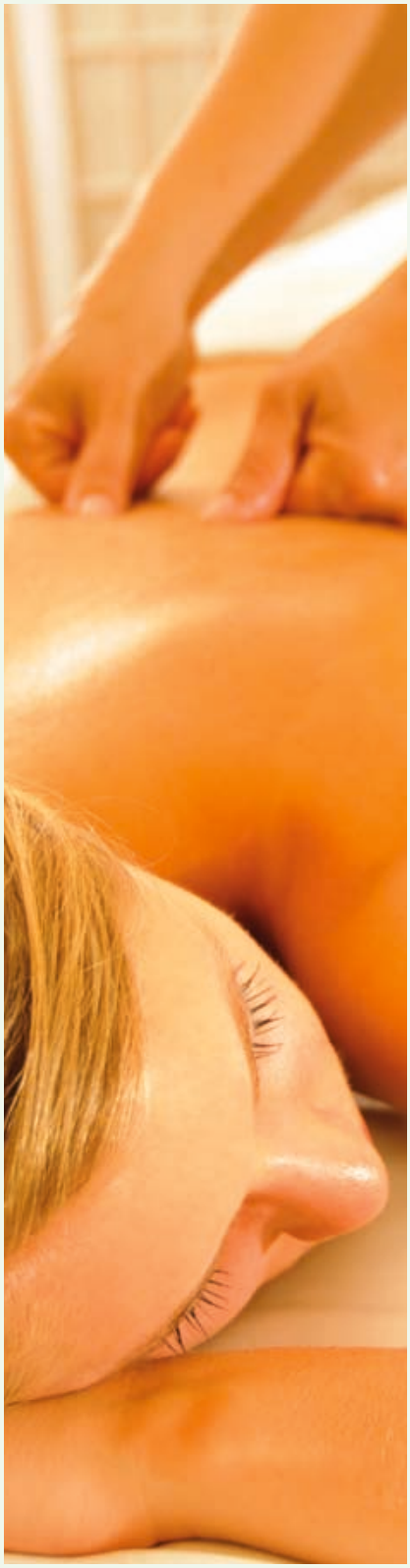


# Foreword

PAS 150 was sponsored by the United Kingdom Rehabilitation Council[1)] (UKRC) and enabled by the Department for Business, Innovation and Skills as part of its ongoing commitment to supporting innovation in the UK. Its development was facilitated by the British Standards Institution (BSI) and it came into effect on 9 April 2010.

This Publicly Available Specification has been developed in consultation with a large number of providers, service user representatives, organizations, government departments, and professional bodies and associations.

Acknowledgement is given to the following organizations that were involved in the development of this PAS as members of the Steering Group:

- British Association of Rehabilitation Companies (BARC)
- British Society of Rehabilitation Medicine (BSRM)
- Department for Work and Pensions (DWP)
- IUA/ABI Rehabilitation Working Party
- Jobcentre Plus
- Kingston University/St George's University of London
- NHS Employers
- Skills for Health
- Trades Union Congress represented by the trade union Community
- Vocational Rehabilitation Association

Acknowledgement is also given to those organizations who participated in the PAS 150 workshop (see Annex A) and those who reviewed the draft PAS 150 and submitted comments for consideration.

This PAS is published by BSI which retains its ownership and copyright. BSI reserves the right to withdraw or amend this PAS on receipt of authoritative advice that it is appropriate to do so. This PAS will be reviewed at intervals not exceeding two years, and any amendments arising from the review will be published as an amended PAS and publicized in *Update Standards*.

This PAS is not to be regarded as a British Standard. It will be withdrawn upon publication of its content in, or as, a British Standard.

1) www.rehabcouncil.org.uk

The PAS process enables a specification to be rapidly developed in order to fulfil an immediate need in industry. A PAS may be considered for further development as a British Standard, or constitute part of the UK input into the development of a European or International Standard.

## Relationship with other publications

The provider's attention is drawn to all existing legislation, professional standards and codes of practice covering rehabilitation, some of which are listed in the bibliography.

## Use of this document

As a code of practice, this PAS takes the form of guidance and recommendations. It should not be quoted as if it were a specification and particular care should be taken to ensure that claims of compliance are not misleading.

Any service provider claiming compliance with this PAS is expected to be able to justify any course of action that deviates from its recommendations.

It has been assumed in the preparation of this PAS that the execution of its provisions will be entrusted to appropriately qualified and experienced people, for whose use it has been produced.

## Presentational conventions

The provisions in this standard are presented in roman (i.e. upright) type. Its recommendations are expressed in sentences in which the principal auxiliary verb is "should".

Commentary, explanation and general informative material is presented in smaller italic type, and does not constitute a normative element.

The word "should" is used to express recommendations of this standard. The word "may" is used in the text to express permissibility, e.g. as an alternative to the primary recommendation of the clause. The word "can" is used to express possibility, e.g. a consequence of an action or an event.

Notes and commentaries are provided throughout the text of this standard. Notes give references and additional information that are important but do not form part of the recommendations. Commentaries give background information.

## Contractual and legal considerations

This publication does not purport to include all the necessary provisions of a contract. Service users are responsible for its correct application.

**Compliance with a PAS cannot confer immunity from legal obligations.**

# Introduction

The aim of PAS 150 is to improve the quality, efficiency, value and outcomes of rehabilitation services (see a) to p) below and **2.12**) through setting out recommendations for providers working in all sectors, including statutory and non-statutory services. The recommendations are also intended for individuals working in residential facilities, specialist centres and other local community based services. As a Code of Practice, PAS 150 supports the service user's journey through early and specialist rehabilitation, community rehabilitation and vocational rehabilitation.

PAS 150 covers the provision of rehabilitation services for all disabilities and health conditions by all rehabilitation practitioners including those providing:

a) management of symptoms and disorders that alter the function and performance of the service user;
b) provision of health advice and promotion to individuals;
c) individual and group psychological interventions focused on facilitating adjustments to the medical and psychosocial impact of disability;
d) support for self management of health conditions and the rehabilitation process;
e) services to maximize meaningful activity and participation in life situations;
f) the rehabilitative elements of health and social care interventions;
g) assessment and appraisal of specific barriers to goal attainment;
h) goal setting and action planning designed to mitigate identified barriers and to help goal attainment;
i) rehabilitation referral, and services coordination;
j) interventions to remove environmental, employment, and attitudinal barriers within organizations and systems;
k) interventions for job retention and support;
l) career (vocational) counselling;
m) job analysis, job development, and placement services, including assistance with employment and adjustments;
n) provision of consultation about and access to rehabilitation technology;
o) advice and consultation on the delivery of rehabilitation;
p) rehabilitation programme evaluation and research.

As the full list of services suggests, the rehabilitation sector in the UK is vast and takes into consideration a variety of potential service user outcomes including:

- improved function and performance;
- improved health and wellbeing;
- recovery;
- independence;
- quality of life;
- education;
- employment.

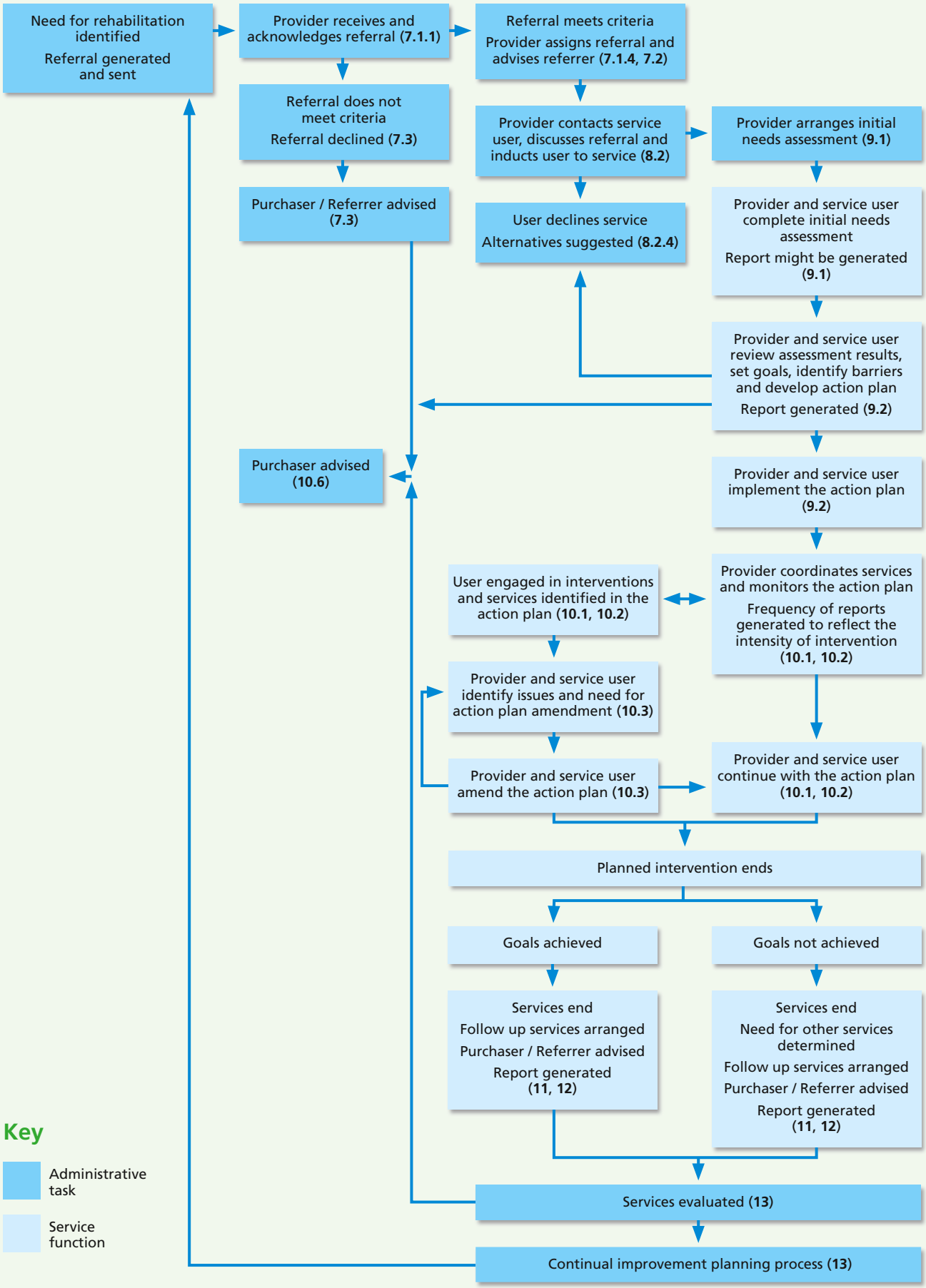
Figure 1 illustrates the process of service delivery that is applied across many of the services noted in the list items a) to p). It is intended to capture the basic rehabilitation principles of:

- early initial assessment;
- goal setting;
- case coordination;
- service evaluation;
- service user involvement;
- purchaser / referrer, service user and provider "partnering";
- clear and purposeful communication.

Specific interventions have been cross referenced to chapters in the body of the PAS.

PAS 150 has, at its foundation, service user centred principles and practices. It encourages service user independence and autonomy affording them the opportunity to live as they wish. The service user's rights and responsibilities especially related to choice and control are at the core of service delivery and their personal goals inform decision-making throughout. The service user should also be involved in a real and meaningful way to influence rehabilitation service delivery in general. PAS 150 recognises service users' experience and expertise and seeks to strengthen service user contribution.

**Figure 1** – Example of a process of service from referral to delivery



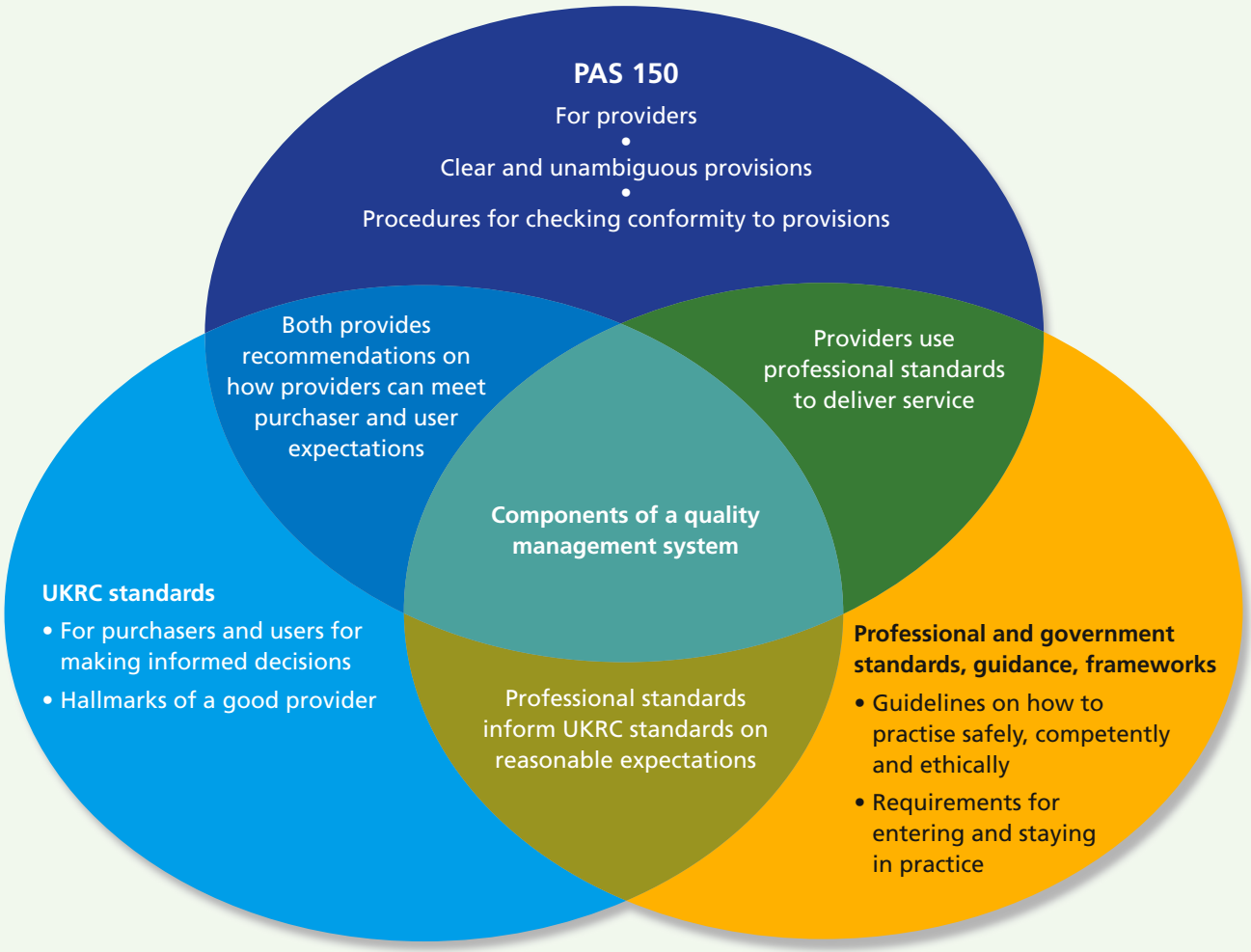
PAS 150 provides a general approach to delivering rehabilitation services in parallel with professional standards, frameworks and commissioning documents that have been developed by statutory regulated, voluntarily regulated and non regulated professions. PAS 150 supports and reinforces work completed by the Department of Health, British Society of Rehabilitation Medicine, the Vocational Rehabilitation Association, the Case Management Society of the UK, UKRC, and other organizations dedicated to the delivery of quality rehabilitation services. The relationship between PAS 150 and other developed products is illustrated in Figure 2. The overlaps between the different products indicate how they relate to and validate each other.

PAS 150 supports and further encourages evidence-based practice. It promotes clarity, transparency, consistency and fairness in application and offers a level playing field for small and large providers.

PAS 150 can be used as a tool for service planning and development, for staff and service user induction and development and programme evaluation. It can be used by purchasers as a benchmarking tool. As a reference, it may be used to help providers, purchasers and service users reduce risk and defend decisions and actions.

PAS 150 aims to stimulate innovation and commitment to excellence.

**Figure 2** – PAS 150 relationship with other products



# 1 Scope

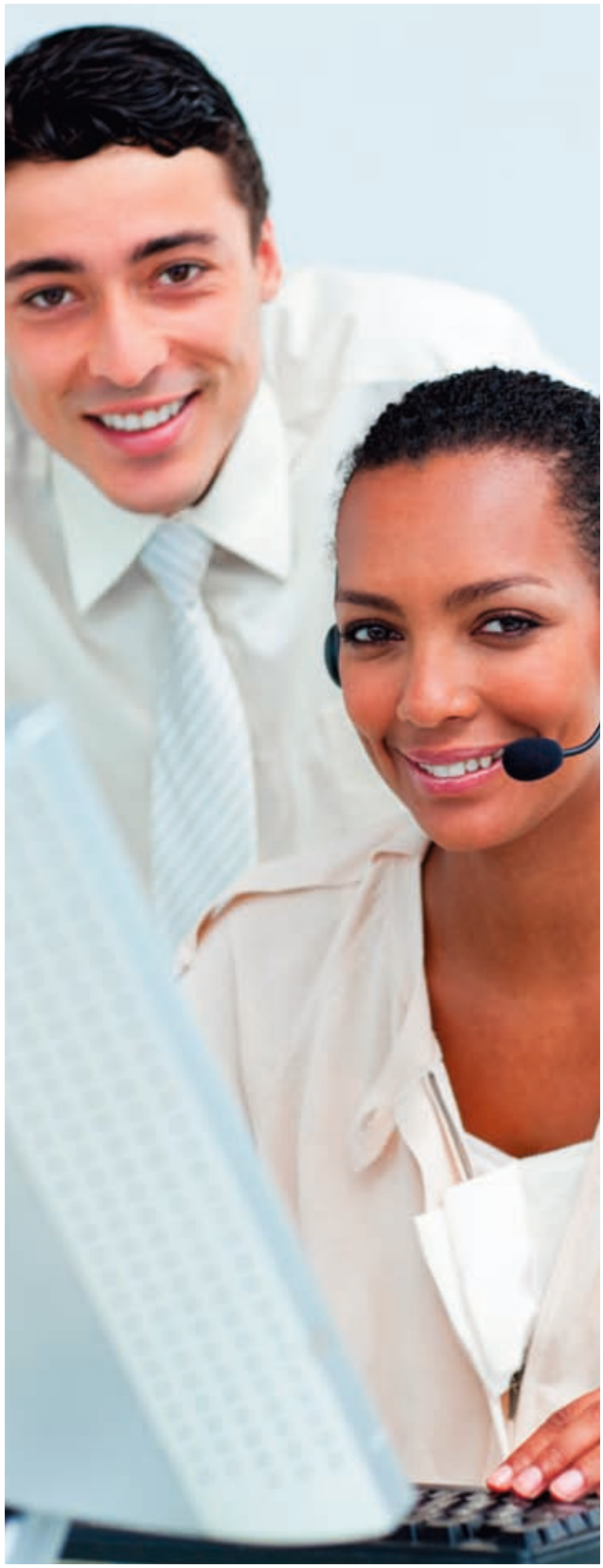
This PAS gives recommendations for the delivery of rehabilitation services for all disabilities and health conditions, with both short- and long-term needs. It covers providers in health, social care and employment and focuses on the interdependence between work, health and wellbeing.

***NOTE*** *Service users range from those with less complex situations to profound communication and cognitive impairments where often they are unable to advocate for themselves. These service users may present with long-term needs to access rehabilitation services.*

It covers:

a) the services;
b) the organization;
c) the rehabilitation workforce;
d) service user involvement;
e) referral;
f) induction;
g) assessment and planning;
h) intervention;
i) case coordination;
j) discharge/closure;
k) follow-up services;
l) programme evaluation;

It is for use by providers of rehabilitation services regardless of their employment environment, target population or area of specific expertise. It is also of interest and benefit to purchasers and users of these services.



# 2 Terms and definitions

For the purpose of this PAS the following terms and definitions apply:

***NOTE** Professional roles and rehabilitation processes have not been defined here as these are clearly defined elsewhere in the professional arena.*

## 2.1 action plan

plan drawn up following a needs assessment covering the service user's goals, interventions needed to achieve the goals, specific tasks, task assignments, timeframes and milestones

## 2.2 assistive technology

any item, piece of equipment or product system, whether acquired off the shelf, modified or customized, that is used to increase, maintain and improve an individual's functional abilities

***NOTE** Examples of assistive technology include but are not limited to wheelchairs, prostheses, mobility aides, hearing aids, visual aids and specialized computer software and hardware.*

## 2.3 carer

person who provides help and support to an individual who would have difficulty managing without their help

***NOTE** This could be due to age, physical or mental illness, addiction or disability.*

## 2.4 case coordination

collaborative process which assesses, plans, implements, co-ordinates, monitors and evaluates the services required to meet a service user's health, care, educational or employment needs, using communication and available resources to promote continuity of services and quality cost effective outcomes

***NOTE 1** Case coordination ensures that the needs and values of the service user are met by collaborating with providers. It links service users with appropriate providers and resources throughout the continuum of health and human services and care and community settings, while ensuring that the service provided is safe, effective, service user centred, equitable and efficient.*

***NOTE 2** There are various titles for an individual functioning in the coordination role, often dependent upon the goal and stage of rehabilitation and the environment within which the coordinator works. Titles include but are not limited to: general practitioner, key worker, case manager, care manager, community matron, specialist commissioner, disability manager, rehabilitation consultant and employment advisor.*

***NOTE 3** It should be noted that not all service users have access to or require case coordination services. Many service users are able to self manage throughout their rehabilitation.*

## 2.5 evidence-based practice

provision of services where the choice of what service to deliver or how to deliver it is based on the recognized best available evidence/research as to the efficacy of such services and their relevance/applicability to the user's needs

## 2.6 goal setting

service user-focused process of discussion and negotiation in which the service user works with the provider to determine the key priorities for rehabilitation for that service user, and agree the performance level to be attained by the service user for defined activities within a specified time frame

## 2.7 intervention

specific action incorporated into the service user's overall action plan aimed at achieving a goal in the process of rehabilitation

## 2.8 professional

statutorily regulated or voluntarily regulated individual practising within a rehabilitation scope of practice or employed or contracted worker in rehabilitation required to adhere to standards of practice and a code of ethics

## 2.9 provider

organization or sole practitioner whose business is to supply rehabilitation services

## 2.10 purchaser

individual or organization that purchases rehabilitation services

***NOTE*** *A purchaser may be, for example, an employer, insurer or a commissioning body, such as the DWP.*

## 2.11 referral source

organization, professional or individual requesting rehabilitation services either for themselves or on behalf of a potential service user

***NOTE*** *A referral source may be but does not have to be a purchaser.*

## 2.12 rehabilitation

process of active change of an individual or their environment by which a service user seeks to achieve optimal physical, sensory, intellectual, psychological and social function

[adapted from UK Rehabilitation Council]

***NOTE 1*** *Any health condition that causes mental or physical impairment resulting in disability may need rehabilitation.*

***NOTE 2*** *Rehabilitation services are referred to in this PAS as "services".*

***NOTE 3*** *Rehabilitation services can help with psychological adjustment, improve physical functioning and provide help with work and recreational activities.*

## 2.13 rehabilitation equipment

objects or devices based on rehabilitation knowledge, engineering methodologies, or scientific principles to meet the needs of, and address the barriers confronted by, service users in areas that include education, rehabilitation, employment, transportation, environmental adaptation

## 2.14 scope of practice

procedures, actions and processes that the rehabilitation provider is permitted to carry out, relative to the provider's specific education, experience and current evidenced competence

***NOTE*** *Competence can be demonstrated by qualifications and licensing – see **2.8**.*

## 2.15 service user

individual that participates in rehabilitation services

***NOTE 1*** *A service user may purchase the services themselves or may have the services purchased on their behalf by another party, for example, a purchaser or given access through a government sponsored programme. A service user may therefore also be a purchaser, see **2.10**.*

***NOTE 2*** *Examples of government sponsored programmes include Pathways to Work, Flexible New Deal, Work Choice and Fit for Work.*

## 2.16 stakeholder

individual or organization with a vested interest in the service user's rehabilitation and identified by the service user and provider based on the circumstances

## 2.17 user involvement

active participation of service users as far as reasonably possible in their own rehabilitation programme or in the development, planning and delivery of the provider's overall services

***NOTE*** *The aim of user involvement is to ensure service user needs, views and suggestions can inform decision-making about services.*

# 3 Services

## 3.1 Defining the services

3.1.1 The provider should have a written statement of values.

3.1.2 The provider should produce a clear written definition of the services offered.

3.1.3 The service definition should cover the following at a minimum:

- the services and specialism(s) offered by the provider;

  ***NOTE 1*** *It is important the services are defined clearly to ensure that service users and purchasers understand the service being offered. Generic phrases such as "rehabilitation services" do not provide sufficient detail and so ought to be avoided. Phrases like "whiplash management programme", "functional restoration programme" or "condition management programme" need to be further defined so that the exact nature of the service is clear.*

- the targeted service user of services offered, including any provision for their employers, carers and families;
- the geographical area(s) where the services are provided;

  ***NOTE 2*** *Describing the geographical area(s) using commonly recognized geographical city, county or national areas will provide clarity for the service user and the purchaser.*

- how the services can be accessed;

  ***NOTE 3*** *Services may be accessed through various means, such as directly by service users or by referral.*

- the type and the setting of the services;

  ***NOTE 4*** *Type of services could be telephone-based, web-based, email, desk-top assessment, face-to-face individual or face-to-face group sessions. Setting could be residential, domiciliary, community or workplace.*

- what constitutes a successful outcome;
- office hours and service hours.

  ***NOTE 5*** *An example of a service definition document is given in Annex B.*

3.1.4 When the service receives a referral the provider should be able to explain to service users:

- why they have been referred to the services;
- who has referred them to the services;
- the service's procedures;
- the service's limitations;
- the expected outcomes, costs, travel and attendance requirements;
- who will work with them; and
- the purchaser's, provider's and service user's roles and responsibilities.

***NOTE*** *The provider may be asked to explain these points to the purchaser and / or carer with due regard for confidentiality.*

3.1.5 All marketing materials, including literature and website, should describe the services in a way which accurately represents the organization's service definition.

## 3.2 Designing the services

3.2.1 Services should be designed taking into account the need to protect the user.

***NOTE*** *This duty of care involves informing and educating the user and carer about their rights and protecting these rights at all times.*

3.2.2 The provider should operate on the basis of documented core values and principles in line with service user-focused or needs-focused services (see **3.1.1**). The provider should demonstrate how they deliver programmes and processes in accordance with evidence-based practice.

3.2.3 The provider should ensure that all the biological, functional, social, psychological, vocational and financial factors affecting any service user are taken into account during assessment, planning and service delivery.

3.2.4 Services should be designed such that they encourage service user empowerment and independence.

***NOTE*** *Working "with" a service user instead of "for" or "to" and providing rationale supports service user learning and builds a foundation upon which the service user can make future decisions and choices. The focus is on enabling the service user to do things for themselves as much as possible so they can regain / maintain independence and dignity.*

3.2.5 The provider should communicate effectively with the service user during service provision. Where English is not the preferred language of the service user, the provider should make interpretation services available.

Assistance (in communication) should be provided for service users with communication disabilities.

***NOTE*** *Where the service user is unable to express their needs, an advocate, often the carer, may assist with communication.*

**3.2.6** Services should be designed with a focus on creating positive and effective relationships between the purchaser, provider and service user and in meeting service user and purchaser expectations. Relationships should be maintained on a professional level at all times. The provider should:

a) act with integrity;

b) commit to providing the best possible outcomes of the services for service users and purchasers;

c) where there are apparent differences between the preferred outcome for the purchaser and the user, to address these openly and fairly, to work towards positive outcomes for both parties wherever possible;

d) encourage the sharing of good practice;

e) promote equality and diversity in their own staff and in their service supply chain;

f) ensure transparency, non-discrimination, equal treatment and accountability in all relationships;

g) respect actual and potential working partners, including contracting and funding arrangements;

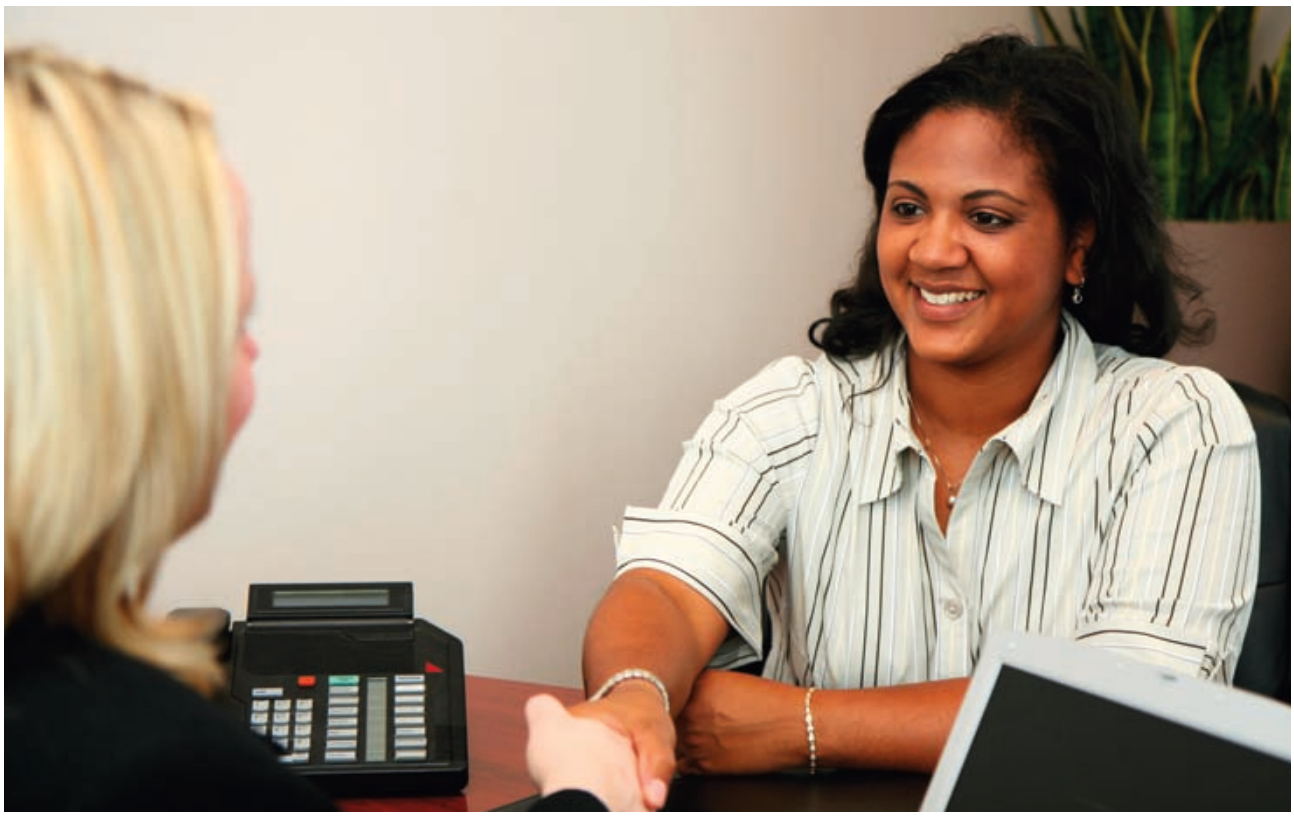
h) ensure that their workforce demonstrate evidence of continuous professional development, based on personal performance data (e.g. CPD record, annual appraisals).

**3.2.7** The provider should have available for reference the professional and other relevant standards, frameworks and commissioning documents to which staff work and comply.

**3.2.8** Service level arrangements should be adhered to and communicated to staff and others as needed. The service level arrangements should:

a) be clear and concise and cover all aspects of service delivery from referral to discharge/closure;

b) demonstrate that the service delivery philosophy reflects requirements of legislation, policy, guidelines and procedures issued by the monitoring authority responsible for that service;



c) provide rationale for service user and purchaser expectations;
d) be measurable so the provider can compare the services provided against the service user's and purchaser's expectations;
e) identify who is responsible for each specific intervention;
f) indicate timeframes for completion;
g) be signed off by all those falling under their guidance;
h) be part of the staff's performance review process;
i) be imbedded in operational activity, to ensure they are up to date and aligned with overall professional practices.

**3.2.9** Services should be designed to take into consideration the following:

a) obtaining valid and informed consent to interventions and for research purposes;
b) obtaining consent and sharing/disclosure of information;

*__NOTE__ Attention is drawn to the following legislation:*

*1) The Health Records Act 1990 [1];*
*2) The Mental Capacity Act 2005 [2];*
*3) The Data Protection Act 1998 [3].*
*4) Access to Medical Records Act 1988 [4].*

c) human rights, equality and discrimination;

*__NOTE__ Attention is drawn to the Human Rights Act 2000 [5].*

d) health and safety in relation to facilities, equipment, home/workplace visits, etc.;

*__NOTE__ Attention is drawn to the Health and Safety at Work etc Act 1974 [6];*

e) disability;

*__NOTE__ Attention is drawn to the Disability Discrimination Act 2005 [7].*

f) other aspects including adherence to confidentiality requirements, reporting requirements, contractual agreements, licensing requirements, corporate status reporting, commissioning guidelines, employment practices, and all other requirements identified within the field.

*__NOTE 1__ Attention is drawn to Employment and Labour Relations Act 2004 [8].*

*__NOTE 2__ For up-to-date information on legislation see www.direct.gov.uk.*

**3.2.10** Services should be designed to be outcome driven. Performance should be demonstrated against key performance indicators (outcomes, duration, average cost, etc.) and a track record of success. However, neither commissioning processes nor providers' performance management processes should unreasonably exclude users with higher levels of needs.

Service users should be involved in agreeing and developing various aspects of the service including key performance indicators.

**3.2.11** Services should be designed to be proactive. Programme targets should be identified and built into the delivery mechanisms.

**3.2.12** Services should be designed to be of high quality and efficiency with consideration for speed, timeliness and cohesive connections to the local community resources.

*__NOTE__ This would involve:*

*a) pro-active involvement;*
*b) quickly identifying actions;*
*c) communicating at an early stage;*
*d) considering early independent assessment.*

**3.2.13** Service delivery should be designed to be cost effective having regard to all available resources. The provider should estimate and agree any costs with purchasers prior to the commencement of services.

**3.2.14** The provider should create and maintain service user records that are in accordance with purchaser and provider policies, procedures and other requirements such as confidentiality, storage and destruction of files and service users' rights to access their own data.

*__NOTE__ Records need to be professionally presented and maintained, logically organized, well managed, clear and concise, so that those referring to them find them accessible.*

## 3.3 Managing the services

**3.3.1** Services should be managed taking into account evidence-based practice.

*__NOTE__ Attention is drawn to current national guidelines, frameworks, standards, codes of conduct and legislation.*

**3.3.2** All services should be managed by competent staff who are appropriately experienced and qualified. Administrative structures should support the service delivery, including staffing and staff reporting arrangements, delegations and approvals.

**3.3.3** Case/caseload management systems and procedures should be in place.

***NOTE*** *See **5.5** and **5.6** for details regarding supervision.*

**3.3.4** Financial and human resources should be available to ensure for continuous service delivery and sustainability. There should be a defined number of staff available to:

- deliver the services;
- ensure the safety of service users;
- deal with unplanned absences of staff;
- meet the provider's performance expectations.

**3.3.5** Documented procedures should be in place to verify the credentials and backgrounds of all staff and to support job retention.

***NOTE*** *Attention is drawn to Criminal Records Bureau and Vetting and Barring Scheme.*

**3.3.6** Management should be responsible and accountable for:

a) establishment of the mission and direction of the operation;

b) promotion of value in the programmes and services offered;

c) meeting service user and purchaser expectations and also those of other stakeholders;

d) financial solvency;

e) clinical governance;

***NOTE*** *Clinical governance is the system through which NHS organizations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish. For reference to this definition and guidance on its application go to the Department of Health's website at www.dh.gov.uk/en/Publichealth/Patientsafety/Clinicalgovernance/index.htm*

f) management of incidents and complaints;

g) compliance with insurance and risk management requirements;

h) regular performance appraisal;

i) development and implementation of corporate responsibilities including health and safety;

j) compliance with all legal and regulatory requirements;

k) ensuring prompt and receptive responses to market place issues and challenges.

# 4 The organization

*NOTE The organization may be a sole practitioner or a larger entity.*

## 4.1 Policies

**4.1.1** The provider should have policies ensuring the protection of service users and staff.

*NOTE This is both about preserving the personal safety and rights of each service user (regarding for example their rights to privacy and confidentiality) and about protecting the rights and interests of other service users and of purchasers. It is also about staff safety and rights.*

**4.1.2** The provider should have written policies that are publicly available, applied consistently and which can be referred to as needed. Policies should be drawn up in consultation with staff, and service users; and all staff, including managers, should receive training to enable effective implementation of policies. They should include as a minimum:

a) equal opportunity and diversity policy including equality of access, discrimination and investigation, monitoring and reporting, recruitment and retention;

b) service user involvement policy including details related to involvement in their own services but also opportunities to be involved in overall programme design and evaluation;

c) service user care and protection policy incorporating statements on working with children, adolescents, working with vulnerable adults and escorting unaccompanied females and children;

*NOTE Attention is drawn to the following:*

*i) the Protection of Vulnerable Adults under the Care Standards Act 2000 [9];*

*ii) the Protection of Children Act 1999 [10];.*

*iii) Criminal Records Bureau and Vetting and Barring Scheme.*

d) data protection and confidentiality policy inclusive of automation sharing agreements, storage of confidential information, data recovery and loss, destruction of data;

e) health and safety policy nominating a senior manager or company director to be responsible for health and safety, detailing the arrangements for consultation with staff on health and safety matters, and taking into consideration both service user and staff welfare and wellbeing including lone workers, emergencies and crisis management;

*NOTE Attention is drawn to:*

*i) Health and Safety at Work etc, Act 1974 [6], Section 37.*

*ii) HSE/IOD guidance Leading health and safety at work [11].*

f) bullying and harassment policy with due consideration for violent acts;

g) drug and alcohol policy;

h) customer service policy;

i) gift policy;

j) communications policy both for internal and external use when working with other providers;

k) corporate social responsibility policy;

l) recruitment and selection policy;

*NOTE Attention is drawn to the Criminal Records Bureau (CRB) checks, the Protection of Vulnerable Adults under the Care Standards Act 2000 (POVA) [9] and the Protection of Children Act 1999 (POCA) [10].*

m) continual professional development policy;

n) quality assurance and feedback policy;

o) contracting/subcontracting policy outlining items such as disclosure of health and safety enforcement data prior to being commissioned and management of the supply chain;

p) business continuity policy;

q) whistle blowing policy;

r) environmental policy.

*NOTE Guidance on drawing up and implementing policies, including sample policies and templates, can be found on government and academic websites. For example, a search on the internet for "model consent policy" will include in its results list a reference to the Department of Health's Good practice in consent implementation guide: Consent to examination or treatment [12]. Other model consent policies can also be located and reviewed for appropriateness to the provider's operation.*

**4.1.3** Policies should be clear and concise and should specify which issues are covered by individual and corporate accountability.

**4.1.4** Providers should demonstrate that policies are embedded in practice and that their implementation is checked through regular audits.

**4.1.5** Policies should be reviewed, at least annually, to ensure they are up-to-date and aligned with overall service and business practices, and reflect current guidance and legislation.

## 4.2 Corporate governance

**4.2.1** The provider should have business governance and practices in place ensuring that they support the services offered and demonstrate:

a) service user involvement;

b) effective delivery of outcomes;

c) efficient use of resources;

d) business viability.

**4.2.2** A provider, whether an organization or a sole practitioner, should have the financial and human resources to facilitate the following:

a) designated accountability;

b) appropriate business registration, e.g. limited liability partnership, plc, self-employed;

*__NOTE__ Attention is drawn to the Companies Act 1985 [13] and the updating legislation contained in the Companies Act 1989 [14] and Companies House (www.companieshouse.gov.uk).*

c) financial management with appropriate solvency, asset management, cash/credit management, accounting procedures and pricing structures.

d) objective capacity management and planning that demonstrates stability and scalability;

e) reliable information management systems with security, retention and back-up procedures;

f) performance management with quality assurance, complaint management and continuous data review and performance improvement programmes;

g) risk management procedures, accompanied by robust contingency/business interruption/disaster recovery plans.

**4.2.3** A small business may need to combine all functions in one or two staff members but should demonstrate a sound operating policy including financial management with evidence of annually independently audited or examined accounts.

**4.2.4** The provider should have in place the level of liability and professional indemnity insurances relevant to their services.

**4.2.5** The criteria for contracting out should be documented and adhered to on a consistent basis. The provider should ensure for accurate audit trails when establishing partnerships or associations.

**4.2.6** Pricing structures should be included in all contracts and service level agreements providing transparency in what is or is not included.

**4.2.7** The provider should promote and advertise their services in an honest and factually correct manner. They should not make any unsubstantiated claims or libel competitors.

## 4.3 Duty of care

**4.3.1** The provider has a duty to the service user and should act in the service user's best interests and ensure and protect the service user's safety, dignity and privacy.

**4.3.2** Where the provider suspects the service user is being abused or harmed in any environment, the provider should take immediate action in accordance with current best practice.

*__NOTE 1__ In dealing with such situations, best practice courses of action may be determined through reference to legislation, professional standards and codes of ethics.*

*__NOTE 2__ See __4.1.1__ and __4.1.2__ for recommended protection policies.*

**4.3.3** The provider should take into account the interests of the purchaser.

**4.3.4** The assessment and delivery of rehabilitation should be a collaborative process. All assessment, planning and delivery by the provider should occur with the service user's consent in liaison with the key stakeholders concerned with the user's care.

*__NOTE__ Attention is drawn to legislation on issues of consent. See __3.2.9__ b).*

**4.3.5** The provider should acknowledge that the service user may choose to have others advocate on their behalf. The provider should:

a) encourage the service user to recognize the scope of others' participation within the process;

b) encourage participation of others at key points in the process;

c) protect the rights and confidentiality of the service

user during stakeholder participation.

***NOTE** Attention is drawn to the Mental Capacity Act 2005 [2].*

**4.3.6** The provider should ensure that all stakeholders understand their role in the rehabilitation process recognizing that the service user is at the centre of the process.

***NOTE** The rehabilitation process could include stakeholders like other medical/clinical practitioners, non-regulated rehabilitation professionals, carers, family, friends, employer, colleagues, union representatives or other advocates.*

**4.3.7** The provider should ensure service user and staff safety through the proper and professional use of equipment needed during service delivery including as a minimum:

a) matching the equipment to the intervention;

b) using equipment only for the purpose for which it was developed and following the manufacturer's guidelines and procedures;

c) maintaining the equipment in accordance with the manufacturer's guidelines and procedures;

d) following procedures in adherence to infection control and decontamination;

e) providing service users with adequate information and training to ensure they use loan rehabilitation equipment in a safe and effective manner;

f) storing all equipment in a safe and secure manner;

g) ensuring staff adhere to safe working procedures relating to work equipment and manual handling operations;

***NOTE** Attention is drawn to Medical Devices Alert and the, Medical and Healthcare Products Regulatory Agency*

h) ensuring equipment is safely placed and restrained for transportation purposes.

**4.3.8** The provider should support the service user and staff in urgent, serious or emergency situations within a defined timeframe and in accordance with the provider's policy. In urgent, serious or emergency situations, the provider should:

a) have a procedure in place for triggering and coordinating critical incident or emergency services;

b) have procedures and guidelines for dealing with crisis situations such as suicide risk or potentially violent behaviour, potential threat to life and safety of others and critical incident management;

c) participate in training related to abuse, harassment and violence at work in order to build knowledge and awareness and to develop strategies that can be put into play;

d) demonstrate that they follow legal requirements regarding the reporting of accidents or injuries occurring during service delivery and/or within specific facilities to the proper authorities;

***NOTE** Attention is drawn to Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR)*

e) have clear and current programmes, systems and policies in place to identify, manage, eliminate, avoid or reduce real and potential risk;

f) introduce contingency plans for risks that cannot be avoided;

g) have critical incident processes in place, which includes as a minimum determining what constitutes a critical incident, how investigations are to be conducted, how documentation is to be completed, who is responsible for completing documentation, who is notified, and where written documentation of incidents is to be kept;

h) change process and procedures where review suggests this is prudent;

i) complete a critical incident form as needed that includes as a minimum date, time, location, who was involved, what led to the incident, a description of what happened, the consequences of the incident, witnesses, who was notified and follow up recommendations;

***NOTE** Information provided in the critical incident form needs to be descriptive and factual.*

j) review critical incidents immediately to determine causes, trends, actions for improvement, results of performance improvement plans, necessary education and training of staff, prevention of recurrence, internal and external reporting requirements;

k) implement a contingency plan where emergencies occur out of normal working hours;

l) where positive risk taking is an important part of services, assess the likelihood of risk and ensure safe practice is applied;

m) involve staff and service users as appropriate in risk assessments and record the results of all risk assessments.

**4.3.9** The provider should have a documented and published complaints procedure with an aim of protecting the service user where service level arrangements are not met. Procedures should incorporate the reporting, recording and handling of complaints and be used to develop and improve the service.

## 4.4 Working practices

**4.4.1** The provider should have a working practices document.

**4.4.2** The working practices document should cover all operations and administration, including the work processes and procedures for:

a) involving the service user in service design, delivery and evaluation (see Clause **6**);
b) reviewing and accepting/declining a referral (see Clause **7**);
c) inducting the service user to services (see Clause **8**);
d) carrying out a needs assessment (see **9.1**);
e) developing, implementing and monitoring an action plan (see **9.2**);
f) providing the interventions (see **9.2.3**);

***NOTE*** *Where, for example, services are delivered according to an accredited rehabilitation programme, the relevant programme documentation will need to be annexed to the working practices document.*

g) case coordination (see Clause **10**);
h) delegating activities (see **10.4**);
i) referring on to other providers (see **10.5**);
j) informing and updating the purchaser on progress (see Figure 1) ;
k) discharge/closure (see Clause **11**);
l) follow-up services (see Clause **12**);
m) costing and billing (see **9.2.8**).

**4.4.3** The working practices document should record for the components in **4.4.2**:

a) decision criteria;

***NOTE*** *For example, decision criteria for accepting/declining a referral, referring on, discharge/closure and follow-up services. Decision criteria may be broadly stated or specific and should note that exceptions may occur.*

b) assessment and evaluation tools;

***NOTE*** *For example, for an initial needs assessment, the working practices document will need to identify how the needs assessment is conducted, what the final product looks like and the templates for rehabilitation assessment and planning.*

c) service levels and timeframes for all services delivered;
d) rationale and references to the best practice

evidence for each working practice (where an evidence base exists);

e) consent procedures relating to interventions and sharing of information;

f) communication procedures including reporting and advising formats and frequency;

g) the maintenance of service user records and databases; including collecting, reporting, backing up and recovering data;

h) price information and payment terms including value added tax (VAT) status (see **9.2.8**).

***NOTE*** *Confidential commercial arrangements can be made although any credit or third party referral arrangements that exist will need to be declared to any legitimate interest.*

**4.4.4** The working practices document should be reviewed when there is any change in the service specification and reviewed annually to ensure:

a) it reflects the actual working practice;

b) that the working practice reflects the evidence-based practice and is maintained on an up-to-date basis.

**4.4.5** Where a change to the working practices document affects the continuous delivery of services, changes to the delivery of services should be agreed with the service user(s) and the purchaser(s).

**4.4.6** The provider should ensure that staff receive initial and ongoing skill focused competence-based training to ensure consistent delivery of the services covered by the working practices document.

## 4.5 Facilities and equipment

***NOTE*** *Attention is drawn to the Disability Discrimination Act 2005 [7].*

**4.5.1** The provider should promote and demonstrate accessibility to facilities and equipment and the removal of barriers to the service user's participation.

**4.5.2** The facilities should be accessible to meet the needs of the disabilities served.

***NOTE*** *This is required in order to:*

*a) provide access to rehabilitation services through access to facilities;*

*b) implement non-discriminatory practices;*

*c) meet legal and regulatory requirements.*

**4.5.3** Accessibility planning for staff and service users should be subject to consultation with those affected and should address:

a) architecture;
b) environment;
c) signage;
d) tools and equipment;
e) finances;
f) employment;
g) communication;
h) transportation;
i) home working;
j) timelines and actions for removal of barriers to service user participation.

**4.5.4** Providers should educate and inform service users, staff and purchasers of services in areas related to accessibility to convince them of the benefits of accessible facilities and equipment and to encourage positive attitudes around adoption and funding.

**4.5.5** The physical appearance and condition of the facilities should be designed and maintained to ensure the comfort and safety of the service user and staff. Accessibility of facilities and equipment should be reviewed and reported on annually.

***NOTE*** *For recommendations on the safe usage of equipment see* ***4.3.7****.*

**4.5.6** Facilities and equipment should be monitored on a defined regular basis (for equipment, in accordance with the manufacturer's instructions and the provider's guidelines) and evaluated to ensure maximum efficiency and effectiveness to allow for service delivery, confidential communications, privacy and dignity.

**4.5.7** There should be an adequate allocation of facilities space to allow for service delivery and confidential communications.

**4.5.8** The equipment necessary to meet the requirements of delivering the services should be available. The equipment should be up-to-date, fit for purpose and maintained. The equipment should be monitored and maintained in accordance with the manufacturer's instructions and maintenance schedules and the provider's guidelines. The provider should ensure that staff are trained on the use of all equipment specific to their tasks.

**4.5.9** The provider should be able to provide advice about a range of technologies and signpost for access to:

a) the provision of sufficient rehabilitation technology resources to support temporary loans or trials of rehabilitation technology;
b) arrangements for tracking and monitoring the use of rehabilitation technology to support re-cycling to increase cost-efficiency and temporary provision;
c) arrangements for tracking and monitoring to ensure that rehabilitation technology is meeting the need for which it was prescribed and to replace it if not;
d) proper assessment to ensure the best match of rehabilitation technology is made to meet the service user's needs and lifestyle.

**4.5.10** The provider should have a computer technology and system plan that demonstrates knowledge and applications of computers and addresses potential issues around:

a) hardware and software;
b) security;
c) confidentiality;
d) service user friendly interfaces;
e) data backup policies;
f) alternative access formats;
g) disaster recovery;
h) virus protection;
i) staff training/instruction.

# 5 The rehabilitation workforce

## 5.1 Staffing levels

**5.1.1** There should be a human resource plan and succession plan. The human resource plan and succession plan should address service sustainability.

**5.1.2** The views and involvement of service users should be sought in designing and implementing the human resource plan.

***NOTE*** *See* ***6.2****.*

**5.1.3** The provider should have access to the number of staff needed to deliver the defined services with a view to referral volumes, fluctuations and service user needs.

**5.1.4** The provider should ensure that staff, whether employed, subcontracted or volunteer, have the necessary mix of skills to deliver the services.

***NOTE*** *See* ***2.8****.*

**5.1.5** If at any time the skill-base of the rehabilitation workforce cannot be ensured, the provider should stop offering the affected services and not accept any new referrals. In respect of any service users actively receiving the services, the provider should take action to safely complete delivery by transferring those service users to other equably competent providers (or by other steps) as soon as reasonably possible.

## 5.2 Subcontracting

**5.2.1** Where services are subcontracted, the provider should:

a) manage the service supply chain and ensure that the subcontracted services are delivered at a minimum to the agreed service level;

b) be satisfied that the subcontractor can demonstrate rigorous governance structures.

**5.2.2** The provider should agree with the subcontracted provider before the services are provided:

a) the terms of delivery;

b) termination notice;

***NOTE*** *The provider and subcontracted provider need to agree a sufficient contract termination period to ensure for continuity of services with the service user.*

c) terms of payment;

d) how any risk is to be allocated.

## 5.3 Scope of practice

**5.3.1** The provider should be able to demonstrate awareness of the scopes of practice needed for delivery of their services.

**5.3.2** The provider should have review processes in place ensuring that the services offered can be delivered through the rehabilitation workforce's scopes of practice and competence, which are supported by their qualifications, training, skills and experience.

**5.3.3** The provider should ensure that staff deliver services only within their own scope of practice and competence, training, skills and experience.

**5.3.4** The provider should have a job description for each role that defines the role and responsibilities needed to deliver the services. For each job description there should be an associated person specification.

**5.3.5** Where the delivery of services requires staff to have a particular qualification, the provider should use only such staff to deliver these services.

**5.3.6** All qualifications and professional titles or designations accepted should be recognized in the UK. Where there is no equivalent UK accrediting body, the provider should check the status of the professional qualification.

**5.3.7** The provider should ensure that staff maintain professional registrations and memberships for their individual scope of practice.

***NOTE*** *Examples of professional registrations and memberships include General Medical Council (GMC), Nursing and Midwifery Council (NMC), Health Professions Council (HPC), Vocational Rehabilitation Association (VRA), Case Management Society of the UK (CMSUK), British Association for Brain Injury Case Managers (BABICM), UK Public Health Register (UKPHR), and General Social Care Council (GSCC).*

**5.3.8** Where staff are members of a professional body or association, the provider should ensure that staff act in accordance with the standards of practice and code of ethics of their professional body/association and hold evidence of current registration.

## 5.4 Staff competence

**5.4.1** The provider should have up-to-date records for all staff and this should include qualifications, training and experience with evidence to support:

a) their competence;

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

b) registration with their professional association and/or college;

c) CRB/Protection of Vulnerable Adults (POVA)/ Protection of Children Act (POCA) checks, as needed; and

d) validation of continuous professional development.

**5.4.2** Staff should have relevant experience, knowledge and skills, specific to the services, which depending on the services offered, may include:

a) awareness of the evidence-based practice (where this exists) that supports the services and experience in interpreting and delivering them;

b) ability to interpret legal and policy areas relevant to the services;

***NOTE*** *This will apply where interaction with legal or policy frameworks is necessary, for example in the context of nursing, housing, care and benefit entitlements.*

c) interpersonal skills that enable communication and negotiation with service users and others as needed;

***NOTE*** *This may extend to advocacy on behalf of service users.*

d) "know-how" or "local knowledge" specific to the scope of practice;

***NOTE*** *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.*

e) financial acumen for:

1) the assessment, planning and interventions balance the needs of service users with proportionality to their health condition and cost;

2) the management of funding, particularly where funds are delegated by the purchaser.

5.4.3 The provider should maintain a record that defines the competences required to deliver the service. The document should record the competences required to deliver each service and the identity of the staff, whether employed, sub-contracted or volunteer, who can deliver the services.

***NOTE 1*** *A sample format for a service competence document is provided in Annex C.*

***NOTE 2*** *Staff need to be able to define their core competencies.*

5.4.4 The provider should ensure staff competence through use of screening, recruitment and selection procedures.

5.4.5 The provider should ensure for the maintenance of competence through continuous assessment and appraisal programmes and through continuing development.

5.4.6 The provider should ensure staff practise in a safe, effective, ethical, equitable and non-discriminatory manner.

***NOTE*** *This includes maintaining high standards of personal conduct and maintaining their own health and care to ensure they are fit to practice.*

## 5.5 Staff training

5.5.1 The provider should induct new staff into the services. Induction should introduce staff to values, objectives, policies, procedures, processes, professional standards, disability awareness, expected outcomes, and service user and purchaser involvement and expectations.

5.5.2 The provider should ensure that staff are familiar with documented statements including the following documents:

a) the statement of values (see **3.1.1**);
b) the service definition document (see **3.1.2**);
c) their job description and employment contract (see **5.3.4**);
d) the policies (see **4.1**);
e) the working practices document (see **4.4**).

5.5.3 The provider should support continuing development of all staff. The support may comprise development funding, time for development activities, knowledge sharing and networking. Staff development activities should be interdisciplinary where appropriate.

5.5.4 There should be a training and development needs analysis supporting a training and development plan to ensure staff are, and remain, competent.

5.5.5 The provider should ensure supervision and mentorship is available to new staff and trainees to ensure learning is integrated into daily practice.

## 5.6 Staff supervision

5.6.1 The provider should ensure adequate time for supervision or mentorship activity aimed at periodical review of service delivery and professional skills enhancement. This activity should be documented to capture meeting dates, frequency, duration, location (including accessibility items), content, process and confidentiality matters. The document should be agreed and signed and available for use in performance reviews and other professional activity.

5.6.2 The provider should not utilise staff in areas for which they are not fully trained or experienced. The provider should insist that staff seek the necessary training, supervision and/or mentorship before using them in this way.

***NOTE*** *This may take the form of peer support.*

**5.6.3** The provider should ensure that trainees are fully supervised by qualified staff, do not carry their own case-loads and are not responsible for service delivery.

**5.6.4** The provider should conduct staff performance reviews. The provider should allow staff time to prepare for the performance review, to discuss findings, to agree and record personal objectives and development needs and to follow up on agreed actions.

**5.6.5** The provider should complete investigative and disciplinary processes that are fit for purpose relating to poor performance or complaint. Where poor performance or complaint is deemed serious, it should be reported where warranted to the appropriate authorities.

## 5.7 Professional responsibility

**5.7.1** The provider should encourage staff to contribute to the field of rehabilitation and to society's understanding of the field as part of their professional requirements.

***NOTE*** *Contribution may include research, articles, sharing of best practices, providing learning opportunities, colleague support and mentoring, committee participation and information sharing.*

**5.7.2** Professionals who undertake research should do so in a professional and responsible manner in accordance with research best practices published by recognized authorities.

***NOTE*** *See the following websites for further information:*

*National Health Services: www.nhs.uk/Conditions/Clinical-trials/Pages/Howtrialsareregulated.aspx*

*NHS National Patient Safety Agency, National Research Ethics Service: www.nres.npsa.nhs.uk/*

**5.7.3** The provider and the rehabilitation workforce should adhere to their respective code of ethics taking into consideration purchasers, service users, stakeholders and professional colleagues.

# 6 Service user involvement

## 6.1 Service user involvement in their own rehabilitation

**6.1.1** The provider's services should be service user centred.

**6.1.2** The service user should be an active partner in the rehabilitation process and the provider should ensure as far as possible that the service user understands the commitment to the process which is required from them.

**6.1.3** The service user should be offered the opportunity to actively contribute to all stages of their rehabilitation programme.

**6.1.4** The service user should have information available about their services and rights, including complaints, service boundaries and professional ethics, health and safety etc.

**6.1.5** The service user should have the opportunity to define what they want and expect from the services they receive.

**6.1.6** The service user should be involved in regular reviews of their rehabilitation plan.

**6.1.7** The service user should be able to talk to someone other than their primary worker if they have a difficulty that cannot be resolved with the person concerned.

## 6.2 Service user involvement with services in general

**6.2.1** The provider should listen and respond to the views and priorities of service users and make service user involvement and empowerment an integral part of their business.

**6.2.2** The provider should demonstrate their commitment to diversity and equality of opportunity and should ensure that all involvement opportunities are fair, inclusive and accessible to all service users.

**6.2.3** The provider should involve the service user at a level that the service user feels is appropriate to them and their circumstances at the time. The service user may choose not to be involved. They may change their mind when their circumstances change.

**6.2.4** The provider should ensure service user interests are reflected in their strategies and improvement plans by keeping service users well informed so they can communicate their needs and views.

**6.2.5** The service user should have a say in and be able to influence the organization's service development, planning, delivery, monitoring, evaluation, training and recruitment of staff.

**6.2.6** Service users should be encouraged to take part in strategic planning events, policy-making and activities that determine the vision and direction of the organization's development. The provider should have an effective communication strategy that informs the service user when these events are occurring.

**6.2.7** Service users who wish to become involved in the organization's governance should be informed what this involves and, when required, receive training and support to enable them to achieve this.

**6.2.8** The provider should give the service user timely feedback concerning the impact of their involvement. The service user should expect respect for their contributions.

**6.2.9** The provider should assist service users to engage with the wider community to enhance individual outcomes and to improve community cohesion. The provider should empower the service user to develop and maintain social networks and to contribute to their community.

# 7 Referral

***NOTE*** *The quality of the rehabilitation process and the outcome will depend in large measure on levels of trust generated by the inter-personal skills of the service user and provider (listening, empathy, optimism, reassurance of competence).*

## 7.1 Reviewing the referral

**7.1.1** The referral should be reviewed within a defined timeframe and in a confidential and accurate manner. The provider should acknowledge receipt of the referral.

**7.1.2** The referrer should obtain the user's prior, explicit, informed consent to the handling and sharing of personal data. The provider should specify that referrals will be accepted only where this condition is met. The provider should ensure that they have sufficient consent for further handling and sharing of personal data.

***NOTE 1*** *For further information regarding consent see* ***3.2.9****.*

The provider should retain service user records in accordance with the Department of Health's Health Records Retention Schedule.

***NOTE 2*** *For specific details related to the Department of Health's Records Retention Schedule refer to Department of Health, Records Management, NHS Code of Practice, Part 2, Second Edition, Annex D2, www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_093024.pdf*

**7.1.3** The provider should have a system in place to deal with urgent referrals and to minimize waiting times.

***NOTE 1*** *Where national targets for waiting times apply these should be reflected.*

***NOTE 2*** *See* ***4.2.2*** *d).*

**7.1.4** The referral should be reviewed for eligibility through the collection of information and evaluation against the defined referral criteria. The provider should have a protocol to gather information to determine whether it is able to meet the service user's and purchaser's needs.

***NOTE*** *Details needed to make informed decisions around accepting a referral, completing a needs assessment and developing an action plan are presented in checklist format in Annex D.*

## 7.2 Accepting the referral

**7.2.1** The provider should at all times consider whether there is any conflict of interest in accepting a referral and/or delivering services. Any perceived conflict of interest, whether general or in an individual case, should be declared to service users and purchasers. 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.

***NOTE*** *Those with a legitimate interest will usually consist of the service user and the purchaser.*

**7.2.2** The provider should allocate the referral in accordance with the service user's needs and the resources available. A member of staff should be identified to assume responsibility for the service user for the duration of their services.

**7.2.3** The provider should inform the service user, the purchaser, the referral source, if different from the purchaser, and stakeholders if there is a wait for service delivery. The potential waiting time should be indicated.

***NOTE*** *This gives the service user and purchaser/referral source the opportunity to consider alternative providers if the delay is lengthy.*

**7.2.4** The provider should ensure that funding for the services is in place prior to initiating delivery.

## 7.3 Declining the referral

**7.3.1** The provider should decline the referral if it does not meet the defined referral criteria for their services. The provider should give the purchaser/referral source a reason, in writing, for declining the referral.

**7.3.2** The provider should offer suggestions and alternatives to the purchaser/referral source or, if authorized, should signpost to other services.

# 8 Induction

## 8.1 Preparing for the service user

The provider should review all pertinent information, together with any special needs, and any necessary action or provision should be implemented prior to the start of services.

## 8.2 Preparing the service user

**8.2.1** Following acceptance of referral, the provider should establish contact with the service user within the pre-defined timeframe. The provider should advise the service user of their service start date during that contact.

**8.2.2** If there is a waiting list, the provider should inform the service user, the purchaser/referral source, and family or carers of the service starting date with sufficient notice to allow adequate preparation or for alternative arrangements to be made. If the start date is delayed, the provider should keep the service user and the purchaser/referral source informed and keep in contact in order to maintain engagement and commitment of the service user. The provider should be able to demonstrate timely contacts with the service user and the purchaser/referral source.

**8.2.3** Once the referral has been accepted the provider should give the following information:

a) an introductory letter;

b) agreed contact details and best methods for communicating;

c) information about the issues the referral has asked the service to help with;

d) information about the services being offered with enough detail for decision-making around participation;

e) roles and responsibilities of all parties;

f) expected outcomes;

g) information about other sources of help or support.

***NOTE*** *Information might be provided verbally, through the Internet or in the form of handbooks/handouts. A list of suggested topics to cover during this discussion is provided in Annex E.*

**8.2.4** The provider should gain service user and stakeholder commitment. The provider should advise the service user on expected outcomes of the services and the rehabilitation process.

***NOTE*** *It is important to align service user expectations with the expected outcomes.*

**8.2.5** Any associated costs for the service user should be explained prior to requesting consent.

**8.2.6** The provider should obtain documented informed consent before providing the services.

# 9 Assessment and planning

## 9.1 Needs assessment

**9.1.1** A needs assessment should be carried out to form the basis of an action plan. The assessment should be targeted to the presenting problem, and may cover:

a) physical functioning;
b) mental capacity / functioning;
c) cognitive functioning;
d) communication skills;
e) psychosocial functioning;
f) personal characteristics;
g) family / social circumstances;
h) environmental factors impacting on the disability;
i) personal mobility and accommodation needs;
j) training and employment needs;
k) reasonable adjustments necessary for implementing the action plan and for achieving the goals.

***NOTE*** *In some cases, admission to services may include an initial assessment period to establish suitability for participation in the services.*

**9.1.2** Where a specialized assessment is needed to support the needs assessment or to confirm and validate the outcomes, the provider should be able to differentiate between various specialized assessments and recommend the assessment of choice that will meet the service user's and purchaser's/referral source's needs.

**9.1.3** The provider should understand what level of assessment is needed based on the referral information.

**9.1.4** The provider should have an in-depth understanding of their own specific assessment area, specific skills and competencies and experience in providing the assessment.

**9.1.5** The provider should be aware of the consequences of over assessing and should avoid service user exposure to too many repetitive assessment activities.

**9.1.6** The provider should have specific knowledge, skill and experience in completing a needs assessment or any other form of diagnostic assessment they are providing including:

a) the purpose of the assessment;
b) the protocols for the assessment;
c) the skills required of the provider;
d) pre-assessment, assessment and post-assessment activity;
e) the selection of assessment tools to match the needs of the service user;
f) specific tool administration, timing, scoring and interpretation;
g) analysis and synthesis of the information;
h) the confidential assessment environment;
i) the potential outcome of the assessment;
j) how to share findings and conclusions;
k) making recommendations;
l) securing test material, scores and written feedback.

**9.1.7** Service users seeking a return to employment, education or training should be assessed by staff with specific knowledge, skills and experience in vocational assessment. When agreed with the user the needs assessment should include if applicable:

a) evaluation of the service user's medical condition and functioning levels to address any effects which may impact on their ability to work or study, and also to anticipate possible future effects;
b) evaluation of the service user's vocational and/or educational needs;
c) risk assessment within the workplace;
d) identification of barriers which are likely to limit the prospects of a successful return to work/education and interventions (including environmental adaptation, provision of rehabilitation technology, adjustments etc.) to minimize them;
e) direct liaison with employers (including occupational health services and health and safety personnel when available), or education providers to discuss needs and suggested actions in advance of any return;
f) verbal and written advice about their return, including arrangements for review and follow-up.

**9.1.8** Needs assessments should be service user centred, respecting the service user's needs, interests, occupation, societal role, environment and lifestyle. The provider should also consider the background and culture of the service user and the respective values to be applied during the needs assessment.

**9.1.9** The provider should ensure language is not a barrier by arranging for interpretation services

and / or carer support before, during and after the needs assessment and by checking that the service user understands their communication. Assistance should be provided for service users who have other communication requirements.

**9.1.10** The provider should prepare the service user ahead of time for the needs assessment to ensure they know what to expect, location details, transportation routes, timeframes and what to bring.

**9.1.11** The provider should evaluate and record the service user's physical, emotional and personal safety before and during the needs assessment. The provider should offer a clean, safe and accessible assessment environment. If the needs assessment is telephonic, the provider should ensure that the service user is in a quiet space void of distraction and disruption before starting the needs assessment. The provider should reinforce with the service user the need to report any key issues developing during the course of the needs assessment.

**9.1.12** The provider should complete a needs assessment of the service user's needs using the protocols and best practice for the specific condition. The provider should assist the service user with specific clarification of their needs.

***NOTE*** *This assessment may include interviews with the service user and other stakeholders, observation and measurement, diagnostic testing, file review or other activities required to investigate the service user's needs.*

**9.1.13** The provider should work with standardized assessment procedures and/or assessment tools adopting recognized models of best practice.

**9.1.14** The provider should debrief the service user so the needs assessment outcomes are clear and understandable. The provider should offer rationale for all recommendations made and should explain the role of the needs assessment in developing the action plan.

**9.1.15** The provider should give the service user the opportunity to comment on the needs assessment process and outcomes.

**9.1.16** The provider should document the needs assessment, its outcomes and recommendations, which may include:

a) the nature and extent of the injury or health condition;
b) any relevant medical background;
c) family and social circumstances;
d) employment circumstances;
e) immediate home adaptation needs;
f) steps needed to improve the service user's quality of life and support for family carers;
g) suggestions for other assessments;
h) how, and at what cost, recommendations can be implemented.

**9.1.17** The provider should document any decision and rationale for not assessing or for terminating the needs assessment and should inform the service user and the purchaser/referral source.

**9.1.18** In response to the outcomes of the needs assessment, the provider should provide information and options to the user about next steps such as exploring alternative solutions, goal setting and selecting interventions.

## 9.2 Action plan

### 9.2.1 General

**9.2.1.1** The action plan should be realistic, achievable, measurable, time limited and aligned with best practices to have a reasonable probability of success.

**9.2.1.2** Based on the needs assessment, the provider should develop an action plan with the service user. The action plan should include if applicable:

a) the goals, expected progress and solutions (see **9.2.2**);
b) the interventions and the expected outcomes (see **9.2.3**);
c) vocational needs (see **9.2.4**);
d) rehabilitation equipment needs (see **9.2.5**);
e) needs related to activities of daily living which may include parenting, housework, volunteering, hobbies, civic and religious activities;
f) specialist services needs (see **9.2.6**);
g) discharge/closure criteria (see **9.2.7**);
h) costs (see **9.2.8**)
i) list of stakeholders to be kept informed (see **9.2.9**).

**9.2.1.3** The action plan should identify the priority and timeframe for each component given in **9.2.1.1**. The priority and timeframe should be reviewed by the provider and service user and updated during the implementation and monitoring of the action plan, as needed.

**9.2.1.4** The action plan should reflect the service user's abilities, limitations, interests, skills, experience and training.

**9.2.1.5** The provider should be able to demonstrate that current medical, psychological, physical, social and vocational details have been considered in the development and evaluation of the action plan.

***NOTE*** *There are numerous potential barriers to successfully implementing and monitoring an action plan and to attaining the goals. Consequently the rehabilitation programme can consist of one or a number of interventions.*

**9.2.1.6** The action plan should be agreed with the user and should include details on coordinating the interventions, resourcing, timeframes, milestones, discharge/closure and costs. The provider should identify next steps or immediate actions.

**9.2.1.7** The provider should implement the action plan within the defined timeframe.

**9.2.1.8** The provider should ensure that the service user and other providers understand their roles and responsibilities and the provider's roles and responsibilities within the action plan.

### 9.2.2 Goal setting

**9.2.2.1** The provider should ensure the service user is involved (as actively as possible) in goal setting. The provider should in collaboration with the service user agree goals that are realistic and long- and short-term in nature. The goals should then be agreed between the service user, their family/carers, the rehabilitation workforce and the purchaser. The provider should establish and communicate a process for review of the goals and action plan.

***NOTE*** *These goals are based on the service user's priorities and needs as indicated by the needs assessment. The provider needs to consider the impact of the service user's continuing and changing needs on the plan.*

**9.2.2.2** The provider should, in collaboration with the service user, consider solutions and select interventions that will facilitate goal attainment.

***NOTE*** *Interventions may focus on the service user, on their family or on the workplace and workplace colleagues.*

**9.2.2.3** Tasks within the action plan should be allocated to the service user to keep the service user focused on their goals.

**9.2.2.4** The provider should share the goals and barriers identified in the action plan with other providers responsible for providing the specific intervention.

### 9.2.3 Interventions

**9.2.3.1** The provider should determine the intervention in accordance with best practice and clinical governance and operate independently of the influence of any party.

**9.2.3.2** The provider should avoid duplication of interventions unless it is in the best interest of the service user.

**9.2.3.3** The provider should ensure that interventions are carried out in effective and safe environments.

**9.2.3.4** The provider should ensure that only interventions agreed within the action plan are provided.

### 9.2.4 Vocational needs

**9.2.4.1** All providers should take into account the vocational needs of all adults of working age as a part of their rehabilitation programme.

**9.2.4.2** All providers should refer a service user or recommend a referral to a specialist vocational rehabilitation programme, where needed.

**9.2.4.3** The provider should put all adults of working age with the potential to work in any capacity in touch with the relevant vocational/employment services as part of routine planning.

**9.2.4.4** The provider should work directly with the service user's local disability employment advisor (DEA), employment service, healthcare provider, vocational rehabilitation provider and/or employer to support arrangements to:

a) return to or remain in their existing employment;

b) identify alternative employment, including any training requirements or need for vocational rehabilitation, supported employment etc.

**9.2.4.5** The provider should ensure that service users who are unable to return to employment or training are:

a) provided with alternative occupational provision or adult education to meet their needs;

b) given advice and support with regard to taking medical retirement and take up of alternative financial support;

c) given advice on other purposeful activities such as leisure activities and voluntary work.

### 9.2.5 Rehabilitation equipment needs

**9.2.5.1** The provider should identify any need for rehabilitation equipment, how it will be accessed and paid for, when it will be implemented, how it will be maintained and whose responsibility it will be once the plan is completed.

**9.2.5.2** The provider should liaise on behalf of the service user with statutory, voluntary, and charitable organizations to obtain rehabilitation equipment, where needed. There should be a defined procedure for prioritizing the provision of rehabilitation equipment that is funded and provided by a community rehabilitation service.

**9.2.5.3** The provider should liaise on behalf of the service user with both healthcare services and social services and with the employer and Access to Work for the joint funding and purchase of certain items of rehabilitation equipment including:

a) special seating;

b) standing frames and hoisting equipment;

c) communication aids;

d) computers and environmental control systems.

**9.2.5.4** The provider should ensure that the service user obtains access to rehabilitation equipment needed to maintain their health, assist with their care and support independence within a defined timeframe. The equipment should be provided in safe working order and should be used and maintained in accordance with the manufacturer's instructions and the provider's guidelines.

**9.2.5.5** The provider should ensure the service user is trained on the proper use of the equipment.

**9.2.5.6** The provider should arrange for the service user to have access to rehabilitation equipment prior to implementing the action plan.

### 9.2.6 Specialist services needs

The provider should identify any need for specialist services like specialized assessments or special disability services.

***NOTE*** *Specialized assessments may include for example transferable skills analysis, vocational evaluation, psycho-vocational assessment or neuro-psychological testing. Special disability services may include for example oncology related services, psychiatry or neuropsychiatry, substance misuse services, drug and alcohol treatment services, services provided by the Royal National Institute of the Blind (RNIB) or Royal National Institute for Deaf people (RNID), dyslexia assessments or general learning disability assessments.*

### 9.2.7 Discharge/closure criteria

The provider should identify the discharge/closure criteria and the expected date of discharge/closure and plans for follow up and evaluation. These details should be shared with the service user and purchaser.

### 9.2.8 Costs

**9.2.8.1** The provider should identify the costs of services to be provided.

**9.2.8.2** The provider with the referral source should ensure that financial resources are available to support the action plan for its duration including the costs of reasonable adjustments needed during and after the action plan.

**9.2.8.3** The provider should inform the service user that there may be potential financial consequences to benefits claimed from participating in the action plan.

**9.2.8.4** The provider should advise the service user to seek financial advice, e.g. from a Jobcentre Plus or Jobcentre Plus designated benefits adviser, from Citizens Advice Bureau or from Social Services, if applicable.

**9.2.8.5** The assessment, planning and interventions should balance the needs of service users with proportionality to their health condition and cost.

### 9.2.9 Stakeholders

**9.2.9.1** The provider, in collaboration with the service user, should identify the stakeholders, such as their employer, that should be kept informed of the implementation of the action plan and/or the delivery of specific services. The stakeholders' relationship to the service user, their contact details and the items they are to be informed about should be recorded in the action plan.

**9.2.9.2** With the consent of the service user, the action plan should be shared with stakeholders for their input unless otherwise specified in the contract between the purchaser and provider. Once finalized, it should be signed by the provider and the service user and, where referral is through a purchaser/referral source, agreed by the purchaser/referral source prior to implementation.

**9.2.9.3** The provider should establish procedures for exchanging information with other providers and should ensure that other providers are aware in advance of the service user's start and end dates within their specific intervention.

**9.2.9.4** The provider should share with other respective providers service user information after informed consent is received. This should include written direction on service delivery timeframes, required reasonable adjustments, specific service user needs, reporting and invoicing.

# 10 Case coordination

*NOTE Depending of the rehabilitation sector, the individual assigned to coordinating activities with the service user has different titles. For the purpose of this document, he / she is the coordinator. See **2.4** for definition of case coordination.*

## 10.1 Coordinating the rehabilitation process

**10.1.1** The provider should assign an individual to each service user to coordinate the rehabilitation process, to eliminate gaps in service and to navigate a range of health, social care and employment situations in accordance with the action plan (see **9.2**).

**10.1.2** Before accepting a new referral, the coordinator should:

a) conduct a review of workload to ensure there is sufficient resource to complete the service required;

b) not accept cases that they may not be in position to competently complete;

c) ensure the referral source has communicated direction and expected outcomes clearly and succinctly.

*NOTE It is important that the coordinator assess their position in taking on a new referral, to avoid having to transfer the case to another coordinator at a later date (see **10.4**).*

**10.1.3** All major decision-making meetings, e.g. needs assessment, goal setting, case conferences, closure/discharge planning, should be undertaken by the rehabilitation workforce, in liaison with the service user, and their family and carers where included and if applicable the purchaser/referral source.

**10.1.4** The coordinator should provide support to the service user and to other stakeholders during the development and implementation of the action plan. The coordinator should be responsible for:

a) overseeing and coordinating the service user's rehabilitation programme;

b) supporting the service user during their programme and when requested by the service user being prepared to explain rehabilitation issues at meetings and with employers.

**10.1.5** The coordinator should understand the roles and functions of multidisciplinary health care providers in diagnosing and treating injury or impairment. They should also understand the roles and functions of all other providers engaged in the action plan.

**10.1.6** To ensure that rehabilitation remains a continuous process, the service user, and their family and carers should be given guidelines for rehabilitation practice at home between formal rehabilitation activities. Where relevant, advice about home adaptation and self management strategies to facilitate both rehabilitation and independence should be offered to the service user and their family or carers.

**10.1.7** The coordinator should only provide counselling to the service user within their scope of practice. The coordinator should refer service users to counsellors or other providers trained in specific counselling areas (family, financial, mental health, alcohol and drugs), as needed.

**10.1.8** The coordinator should maintain a roster of other providers and community resources available to support the action plan.

*NOTE Coordinated service planning needs to ensure that services are available within a reasonable travelling distance. In rural areas, this may involve the establishment of satellite services or peripatetic teams to reach isolated locations.*

**10.1.9** The coordinator should use past experience and recognized sources to develop an information and evidence resource kit to support best practice. They should evaluate this evidence and compare findings with any action plan interventions.

**10.1.10** The coordinator should share issues and concerns about the progress of the action plan with other providers and ensure that issues are resolved within a defined timeframe.

## 10.2 Monitoring the case

**10.2.1** The coordinator and service user should systematically assess and evaluate the action plan (see **10.3**).

**10.2.2** The coordinator should monitor the case by:

a) evaluating the service user's adjustment to the health condition;

b) assessing the service user's needs including the need for rehabilitation equipment and for other reasonable adjustments needed for the action plan;

c) receiving and reviewing communications from other providers;

d) assessing the effectiveness of other services and resources involved in the action plan;

e) assessing other factors that impact on outcomes;

f) assessing factors that contribute to motivation and readiness to participate;

g) identifying incentives and disincentives to service user/stakeholder engagement;

h) evaluating other barriers impacting on achieving goals;

i) determining the need to amend the action plan.

**10.2.3** The coordinator should prepare the service user for each and every intervention through informing them of the process. They should review the service user's progress and achievements and celebrate their successes.

**10.2.4** The coordinator should maintain contact with the service user and other stakeholders as recorded in and necessitated by the action plan (see **9.2.9**). Documented case-conferences should be held for each service user at agreed intervals, involving service users, carers, relevant agencies, the rehabilitation workforce and the purchaser/referral source. The coordinator should respond to all communications and address concerns as they surface.

10.2.5 The coordinator should record decisions or actions taken that potentially put the plan at risk and could negatively impact on the service user's or purchaser's/referral source's choices. The coordinator should also identify and record any needs that have not been met through the action plan.

10.2.6 The coordinator should evaluate each intervention by:

a) recognizing a base measure as a comparison for change in the service user's status;
b) evaluating the intervention through this comparison;
c) accessing evaluation tools that work with outcome measures;
d) soliciting and collating the service user's feedback;
e) accurately and correctly interpreting evaluations;
f) verifying that progress is being made towards the agreed goals and objectives through the use of documents and outcome measures.

10.2.7 All service delivery in practice should be the subject of systematic continuous monitoring and evaluation, with particular regard to progress against action plan and timeframes.

*NOTE Primarily, staff delivering the interventions are responsible for this but, where relevant to the services and context, it needs to also take the form of:*

*a) inter-disciplinary or multi-disciplinary team review;*
*b) peer-review;*
*c) quality control and audit.*

10.2.8 The coordinator should ensure the service user and the purchaser/referral source are kept fully informed at all times of any material information and/or change in material information.

## 10.3 Amending the action plan

*NOTE 1 In some cases, the coordinator or the service user may identify the need for an action plan amendment. In other cases, a request for an action plan amendment may come from other sources. The coordinator needs to remain professional and ethical during any action plan negotiations.*

*NOTE 2 Amending the action plan might include:*

*a) adding, changing or deleting interventions as necessary;*
*b) adjusting timeframes and identifying new milestones;*
*c) identifying new resources;*
*d) re-costing the action plan;*
*e) obtaining buy-in from all stakeholders;*
*f) re-signing the action plan.*

10.3.1 The coordinator and service user should identify issues and problems arising or other reasons for lack of progress in the action plan.

10.3.2 The coordinator and service user should identify the necessary changes to the action plan and initiate the amendments.

10.3.3 The coordinator should evaluate any request for amendment to ensure that:

a) it is a logical request based on fact;
b) the new action plan is still in the service user's best interest;
c) it falls within the parameters of professional standards;
d) it does not jeopardize the coordinator's professional and ethical responsibilities;
e) it does not jeopardize the viability of the coordinator's or provider's business/practice;
f) the action plan is still realistic and achievable.

10.3.4 The coordinator should obtain the service user's and their stakeholders' agreement to any amendments to the action plan.

10.3.5 Amendments should be treated in the same way and with the same due diligence as the initial action plan development. They should be documented in the service user's file.

## 10.4 Transferring to another coordinator

10.4.1 In the best interest of the service user and purchaser/referral source, the coordinator should avoid transferring the service user to another coordinator, where possible. The coordinator should continually review workload and identify the need for a transfer as early as possible to ensure a smooth transition.

10.4.2 Where case transfer is needed, the coordinator should:

a) ensure that all file notes are up to date and that the hard copy and electronic files meet professional standards;
b) ensure that the new coordinator receives the documentation in time to review prior to communicating with the service user;
c) communicate the transfer to the service user and introduce them to the new coordinator;
d) ensure that the purchaser/referral source is aware

of the change, preferably with time to provide full agreement;

e) ensure that confidentiality is maintained throughout.

**10.4.3** Where the coordinator is absent for short periods of illness or annual leave, they should identify a temporary replacement. The coordinator should advise the service user in advance, if possible.

## 10.5 Referring on

**10.5.1** The coordinator should have awareness of and access to an appropriate range of specialist services as identified in the action plan (see **9.2.6**).

**10.5.2** The provider should have details about and identified pathways to access and/or work with other services including:

a) social service teams;
b) housing;
c) care agencies (including training for care staff for service users with complex needs);
d) private sector agencies, e.g. nursing homes;
e) education and further education including special needs and out-of area provision;
f) employers and occupational health;
g) employment services;
h) unions;
i) disability employment advisory services and facilities for preparation for work;
j) driving ability assessment centre(s);
k) financial advice (e.g. Benefits Agency, Citizens Advice Bureau, Public Trust Office);
l) legal advice (for service users and their families and carers);
m) advocacy services representing the service user's interest:
   1) for those whose competence to participate in decisions about their care, living circumstances, financial situation, etc. is restricted;
   2) in community settings, e.g. decision making for those with special care needs or communication needs;
n) charities, self help groups and voluntary agencies;
o) general practitioners, primary care teams, other providers, and families;
p) specialist medical services;
q) community mental health teams;
r) self management programmes;
s) expert patient / service user programmes;
t) specialist rehabilitation for children and adolescents approaching adult life, if related to the provider's services;
u) care for older people and services for adults approaching later life;
v) other rehabilitation services.

**10.5.3** The provider should demonstrate robust procedures to support service users at points of transition from one rehabilitation provider to another. While a transition from one service provider to another may occur at any point during the time that a service user has rehabilitation needs, the transition from services with expertise in child and adolescent rehabilitation, to adult services and from adult to older adult service providers should be comprehensively supported by both providers to ensure continuity in meeting the service user's needs.

## 10.6 Communicating with the purchaser

**10.6.1** The provider should assist with partnership building between the service user, purchaser and provider through clear and consistent communications and expectations.

**10.6.2** The provider should inform and update the purchaser at significant points in the rehabilitation process including when the referral is received / accepted, the goals are set, the plan is developed, the plan is amended and the goals are achieved.

**10.6.3** The provider should determine at time of commissioning the points at which written reports are expected by the service user and purchaser.

# 11 Discharge/closure

**11.1** The provider should discharge/close a case in accordance with the discharge/closure criteria defined in the service user's action plan (see **9.2.7**).

**11.2** The provider should determine when the action plan or intervention has ended or is no longer being effective through close monitoring of the action plan. The provider should bring their services to a close accordingly.

**11.3** The provider should discontinue services when one of the following occur:

a) the service user has met their goals;

b) the service user's goals are deemed unrealistic and they refuse to alter their goals;

c) the service user no longer meets the criteria for their services;

d) the service user or referrer/purchaser withdraws their consent;

e) the action plan failed and further plan amendments are unreasonable or not feasible.

**11.4** Discharge/closure planning should involve:

a) the service user;

b) their carers and/or family;

c) current and future providers (e.g. health and social services, therapists, general practitioner) if applicable;

d) the provider's rehabilitation workforce;

e) the purchaser/referral source.

**11.5** Appropriate discharge/closure provision/planning should take account of:

a) primary care needs;

b) accommodation;

c) occupation of the service user and their carers;

d) continuing specialist involvement.

**11.6** On discharging the service user or closing the case, the provider should ensure the service user has:

a) access to generic community health care services through primary care teams;

b) information about who to contact if further rehabilitation needs arise;

c) information about the source of any rehabilitation technology provided and who to contact for maintenance and repair;

d) information about who to contact with regard to return to work and vocational issues, if applicable;

e) information about who to contact to discuss further benefits.

**11.7** The coordinator should allocate sufficient time for the coordination and effective delivery of the discharge/closure. This communication should be completed within agreed timeframes.

***NOTE*** *This includes communication with the service user, with members of the service user's rehabilitation workforce and with the purchaser/referral source about outcomes, achievements and follow-up services.*

**11.8** The coordinator should document the discharge/closure details.

# 12 Follow-up services

*NOTE Not all funders provide the facility for follow-up services*

**12.1** At point of discharge/closure, the coordinator should, if applicable:

a) determine the service user's ability to self manage;

b) record the amount of support the service user needs to reach further milestones or to achieve outstanding goals;

c) identify possible options for any continuous support or services that might maintain or improve upon the outcomes achieved, including self-management;

d) identify and suggest any reasonable adjustments, accommodations and/or environmental modifications required;

e) identify and suggest follow-up, other activities or re-assessments that might help to improve the service user's situation.

**12.2** The provider should have a register of all service users requiring long-term review.

**12.3** The provider should evaluate long-term outcomes of their services, where feasible.

# 13 Programme evaluation

**13.1** The providers should conduct an evaluation of the rehabilitation programme. The provider should undertake an audit as a routine part of practice.

**13.2** The provider should operate a continuous improvement programme and be able to demonstrate the effectiveness of their services by recorded quantitative and qualitative data.

***NOTE*** *Evaluation of the rehabilitation programme and the sharing of findings can be used to demonstrate professionalism, integrity and accountability.*

**13.3** The provider should define measurable key performance indicators that add value to the evaluation of the rehabilitation programme. The provider should collate, as a minimum, data on:

a) total number of cases they have managed, and the success ratio;
b) ratio of drop out/failure to complete cases and reasons for drop out/failure to complete;
c) average cost and duration of action plans;
d) number of service complaints.

**13.4** The provider should refer to service user records during audits, identification of evidence-based practice and research with care for confidentiality. Information analyzed should be used to improve services. The provider should assign a specific staff member to implement recommendations.

**13.5** The provider should maintain case studies, customer feedback, satisfaction survey data, references and testimonials. Input from service users should be solicited, collected, and analyzed in order to create services that meet or exceed the service user expectations or those of the community and other stakeholders.

**13.6** Monitoring requirements should be consistent, proportionate, specified and agreed at the start of a contract or specific rehabilitation programme. Input received from evaluation should be used in:

a) programme planning;
b) performance improvement;
c) strategic planning;
d) financial planning;
e) human resource planning.

The analysis should be used in determining if the provider is:

1) meeting the expected outcomes;
2) meeting the expectations of service users and purchasers/referral sources;
3) offering relevant services;
4) identifying new opportunities for growth, development and quality improvement of services.

***NOTE*** *Monitoring requirements and management information need not be overly bureaucratic.*

**13.7** The provider should demonstrate an ethos of continuous improvement by improving existing services and evolving innovative new ones.

**13.8** The provider should show evidence of participation in audits and evaluations where these are requirements of the delivery.

# Annex A (informative)
## Further acknowledgements

Acknowledgement is given to those organizations who contributed to the development of PAS 150 through the attendance of the PAS 150 workshop:

- Action for Employment
- Association of British Insurers
- Bodily Injury Claims Managers Association
- Brain Injury Rehabilitation Trust
- British Association for Supported Employment
- British Association of Brain Injury Case Managers
- British Association of Rehabilitation Companies
- British Society of Rehabilitation Medicine
- British Psychological Society
- British Standards Institution
- Centrica
- Chartered Society of Physiotherapy
- College of Occupational Therapists
- Confederation of British Industry
- Department of Health
- Disabilities Trust
- Faculty of Occupational Medicine
- IUA Rehabilitation Working Party
- National Voices
- NHS Coventry
- Remploy
- Shaw Trust
- Trades Union Congress represented by the trade union Community
- UK Rehabilitation Council
- Vocational Rehabilitation Association

# Annex B (informative)
## Example of a service definition document

**Table B.1** – Service definition document: What the service does

### Section A: Provider details

| Name of provider | Date of document DD MM YYYY |
|---|---|
| *(Trading name and registered trading address)* | **Provider contact details**<br>*(Contact name and telephone/email details and contact address if different to registered trading address)* |

### Section B: Service definition

| **1. Service(s) offered**<br>*Aim for understanding by service users. Where a generic phrase such as 'condition management programme' is used, give a breakdown of the component elements of the programme. Comment on expected outcomes.* | **2. Geographical area in which the service is offered**<br>*Use commonly-recognized city, county and national areas and briefly describe how this coverage is supplied.* | **3. How the service is offered**<br>*Type of service for example face-to-face, telephonic or web-based, hours of operation.*<br>*Setting for service, for example work-place, clinic, residential or domiciliary.* | **4. Access to service(s)**<br>*Can the service be accessed by individual service users or only on referral from another agency?* |
|---|---|---|---|
| **Example A**<br>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 and Case-management, plus face-to-face physiotherapy where needed.<br>9 AM to 7 PM.<br>Clinic-based where physiotherapy required | Service can be accessed by individuals and their representatives. Primarily operated for motor insurance claims programmes |
| **Example B**<br>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<br>8:30 AM to 4:30 PM<br>Clinic or domiciliary arranged according to need | Individual access and referrals accepted from primary care trusts and NHS bodies |

**Table B.1** – Service definition document: What the service does *(continued)*

**Example C**

| | | | |
|---|---|---|---|
| Condition Management Programme of Scotland – a multi-disciplinary programme for long-term musculo-skeletal conditions using exercise therapy, physiotherapy, CBT[A)] techniques, pain-management education to help restore function and help service users 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<br>7:00 AM to 10:00 PM<br>Clinic-based with workplace support as necessary; residential programmes available | Service can be accessed by individuals<br>Primarily operated for Jobcentre Plus providers |

***NOTE 1*** *Source: UKRC's Rehabilitation standards: Hallmarks of a good provider [15].*

A) Cognitive behavioural therapy (CBT) is the psychotherapeutic approach that aims to influence dysfunctional emotions, behaviours and cognitions through a goal-oriented, systematic procedure.

***NOTE 2*** *CBT can be seen as an umbrella term for a number of psychological techniques that share a theoretical basis in behaviouristic learning theory and cognitive psychology.*

# Annex C (informative)
## Example of a service competence document

**Table C.1** – Service competence document: service skills

### Section A: Provider details

| Name of provider | Date of document |
|---|---|
| *(Trading name and registered trading address)* | DD MM YYYY |

### Section B: Service skills

| Service offered: *(The service(s) defined should reflect those identified in the service definition document)* | Competences required to deliver the service(s) | Identity of staff competent to deliver service(s) including sub-contracted staff *(where a service is sub-contracted to a multi-personnel agency, record the identity of the agency)* | Qualifications, professional designations and memberships of staff-member |
|---|---|---|---|
| | | | |

***NOTE 1*** *Source: UKRC's Rehabilitation standards: Hallmarks of a good provider [15].*

# Annex D (informative)

## Referral data and its importance in decision making and planning

Table D.1 is a tool to assist providers in interpreting referral information and in planning for service delivery. Checking the box implies that the factor has been considered and / or explored and may or may not be applicable to the service user's circumstances.

A question not answered or unclear can be explored with the service user. The need for a response in each case is directly related to the expected outcome of the service delivered.

**Table D.1** – Example referral data checklist

| Factor | Specifics/notes | Impact on decision/plan | Yes | No |
|---|---|---|---|---|
| **Source of referral** | | Is service user entitled to services on offer? | ☐ | ☐ |
| | | Is service user entitled to financial support and at what level? | ☐ | ☐ |
| | | Are there policy issues, contracts and service level agreement requirements/commitments? | ☐ | ☐ |
| | | Does the referral source have specific expected outcomes? | ☐ | ☐ |
| | | What are the reporting requirements? | ☐ | ☐ |
| **Nature of disability or health condition** | | What is the future prognosis and what does it mean for long-term planning? | ☐ | ☐ |
| | | What is the potential for deterioration and what is the long-term plan for adaptation? | ☐ | ☐ |
| | | Is there potential for secondary issues like stress or depression? | ☐ | ☐ |
| | | Is there indication for further medical/clinical assessments? | ☐ | ☐ |
| | | What has to go into the plan to allow for treatment/interventions? Delayed return to work, scheduled time away from daily work activity? | ☐ | ☐ |
| | | What is the impact on overall wellbeing? | ☐ | ☐ |
| | | What support levels are required? | ☐ | ☐ |
| | | What assessments might be useful? | ☐ | ☐ |
| | | What assistive devices/rehabilitation equipment is needed? | ☐ | ☐ |
| | | What is the impact on functioning levels for quality of life and work? | ☐ | ☐ |
| | | What reasonable adjustments need to be in place? | ☐ | ☐ |

Table D.1 – Example referral data checklist *(continued)*

| Factor | Specifics/notes | Impact on decision/plan | Yes | No |
|---|---|---|---|---|
| | | What is the impact on the return to work hierarchy? Will the service user be able to return to their old job, old job modified or new job? | ☐ | ☐ |
| | | Is there a need for disability awareness training at some level? | ☐ | ☐ |
| **Date of accident or onset of illness** | | Could there be possible medical complications that have delayed recovery? | ☐ | ☐ |
| | | What is the potential level of support required? | ☐ | ☐ |
| | | Are there possible pain management issues? | ☐ | ☐ |
| | | Are skills outdated skills so training is needed? | ☐ | ☐ |
| | | Will work experience be required prior to competitive employment? | ☐ | ☐ |
| | | Is placement support likely? | ☐ | ☐ |
| **Age** | | Are degenerative factors possible? | ☐ | ☐ |
| | | Might there be general physical and cognitive issues related to ageing? | ☐ | ☐ |
| | | Will age have an impact on recuperation? | ☐ | ☐ |
| | | Is there a possibility for the service user to take full benefits to retirement? | ☐ | ☐ |
| | | Is retraining a consideration? | ☐ | ☐ |
| | | What are the extent and level of technical and transferable skills? Could the service user function as a supervisor or trainer? | ☐ | ☐ |
| **Address** (geographic region) | | Is there access to treatment/services? | ☐ | ☐ |
| | | Is there access to community resources? | ☐ | ☐ |
| | | Is there access to support networks? | ☐ | ☐ |
| | | Is there access to tools and equipment? | ☐ | ☐ |
| | | What are the placement and employment opportunities? | ☐ | ☐ |
| | | Are there specific training opportunities? | ☐ | ☐ |
| | | Will transportation be a challenge? | ☐ | ☐ |
| **First language/ challenges with communications** | | Will an interpreter be required? | ☐ | ☐ |
| | | Will there be a need for translated documents? | ☐ | ☐ |
| | | What special assessment needs/tools are needed? | ☐ | ☐ |
| | | Should there be consideration for special training needs (e.g. ESOL)? | ☐ | ☐ |

Table D.1 – Example referral data checklist *(continued)*

| Factor | Specifics/notes | Impact on decision/plan | Yes | No |
|---|---|---|---|---|
| | | Will the service user benefit from a culturally based job search? | ☐ | ☐ |
| | | What are the communication requirements for reasonable adjustments? | ☐ | ☐ |
| | | Will the employer/colleagues need disability and diversity awareness? | ☐ | ☐ |
| **Extent and role of stakeholders** | | Does the service user have family/friends that are supportive? | ☐ | ☐ |
| | | Does the service user have a dedicated carer? | ☐ | ☐ |
| | | What other stakeholders are involved? Do they have a specific role to play? | ☐ | ☐ |
| | | Is the service user aware that they are the decision maker? | ☐ | ☐ |
| **Pre-accident/ illness job** | | What is the impact on an "own occupation or any occupation" policy? | ☐ | ☐ |
| | | Will the service user be able to return to their own job or own job modified? | ☐ | ☐ |
| | | Is there enough information about the job to help with decision making? Would a job demands analysis[A)] be helpful? | ☐ | ☐ |
| | | What conclusions can be made about aptitudes, skills, abilities, temperaments, work behaviours and work attitudes? | ☐ | ☐ |
| | | What will the service user need in the way of salary and benefits? | ☐ | ☐ |
| | | What is the service user's transferability? | ☐ | ☐ |
| | | Is retraining an option? | ☐ | ☐ |
| | | Would vocational/career assessment and counselling be beneficial? | ☐ | ☐ |
| | | What are the vocational barriers? | ☐ | ☐ |
| **Wages to restore/consider** | | Is vocational assessment required to determine the service user's potential to mitigate loss? | ☐ | ☐ |
| | | Is training to better position the service user feasible? | ☐ | ☐ |
| | | Would training help to mitigate loss? | ☐ | ☐ |

Table D.1 – Example referral data checklist *(continued)*

| Factor | Specifics/notes | Impact on decision/plan | Yes | No |
|---|---|---|---|---|
| **Functioning level** | | Is there enough information about the service user's functioning level? | ☐ | ☐ |
| | | Would a functional capacities evaluation[B)] help to determine functioning level? | ☐ | ☐ |
| | | Is there enough information about the job to help match the service user to the job? Would a job demands analysis be useful? | ☐ | ☐ |
| **Possible psycho-social issues** | | Would a neuro-psychological[C)] screen or psychological assessment[D)] be in order? | ☐ | ☐ |
| | | Would a psycho-vocational assessment[E)] help to identify and remove vocational barriers? | ☐ | ☐ |
| | | Is close monitoring required? | ☐ | ☐ |
| | | Is additional research needed around the service user's behaviours and attitudes? | ☐ | ☐ |
| | | Are there potential issues related to the service user's and other's safety? | ☐ | ☐ |
| | | Should counselling or cognitive behaviour therapy be considered? | ☐ | ☐ |
| | | What is the value of a reality based approach to service delivery? | ☐ | ☐ |
| | | Would the service user pass a Criminal Records Bureau check for employment? | ☐ | ☐ |

## Table D.1 – Referral data checklist

A) Job demands analysis is an employer-based assessment that measures strength, mobility, endurance, postural requirements, repetition, demographics, work shift schedules, manual materials handling, repetitive tasks, equipment, machinery used and duration/frequency of the tasks associated with the job.

***NOTE 1*** *Also known as physical demands analysis.*

***NOTE 2*** *This type of assessment is also instrumental in providing information for functional capacities evaluation, graduated return to work, workplace accommodation, cross training of employees, prevention of injuries/repetitive disorders, and job site and ergonomic analysis.*

B) Functional capacities evaluation is a set of performance-based tests that measure physical strength, range of motion, stamina and tolerance to functional activities, including lifting and carrying of the service user.

***NOTE 1*** *These tests can be used to evaluate work tolerance, and the necessity for work restrictions.*

***NOTE 2*** *Also known as physical capacities evaluation.*

C) Neuropsychological testing comprises tests to examine a variety of cognitive abilities that are necessary for goal-directed behaviour.

***NOTE 1*** *Cognitive abilities that are assessed in neuropsychological testing include speed of information processing, attention, memory, language and executive functions.*

***NOTE 2*** *By testing a range of cognitive abilities and examining patterns of performance in different cognitive areas, neuropsychologists can make inferences about underlying brain function. Neuropsychological testing is an important component of the assessment and treatment of traumatic brain injury, dementia, neurological conditions, and psychiatric disorders. Neuropsychological testing is also an important tool for examining the effects of*

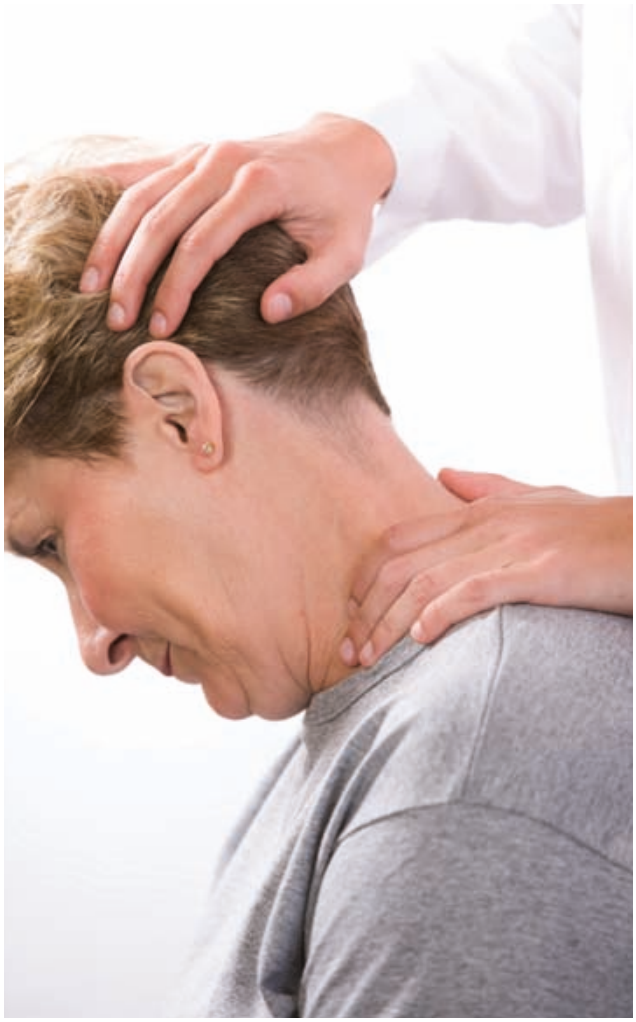
*toxic substances and medical conditions on brain functioning.*

D) Psychological assessment is the integration of information from multiple sources on a service user's psychological condition.

***NOTE 1*** *Sources of information for psychological assessment include tests of normal and abnormal personality, tests of ability or intelligence, tests of interests or attitudes and also information from personal interviews. Collateral information is also collected about personal, occupational, or medical history, such as from records or from interviews with parents, spouses, teachers, or previous therapists or physicians.*

***NOTE 2*** *Psychological assessment is a complex, detailed, in-depth process. Typical types of focus for psychological assessment are to provide a diagnosis for treatment settings; to assess a particular area of functioning or disability often for school settings; to help select type of treatment or to assess treatment outcomes; to help courts decide issues such as child custody or competence to stand trial; or to help assess job applicants or employees and provide career development counselling or training.*

E) Psycho-vocational assessment comprises a clinical review and psychometric investigation of the service user's innate intellectual capacity, core academic skills, vocational interests, aptitudes and transferable skills and a measure of the likelihood for learning disabilities, depression, as well as personality outcomes and their impact on present and future vocational outcomes.



# Annex E (informative)

## Sample checklist of points that may be covered during service user induction

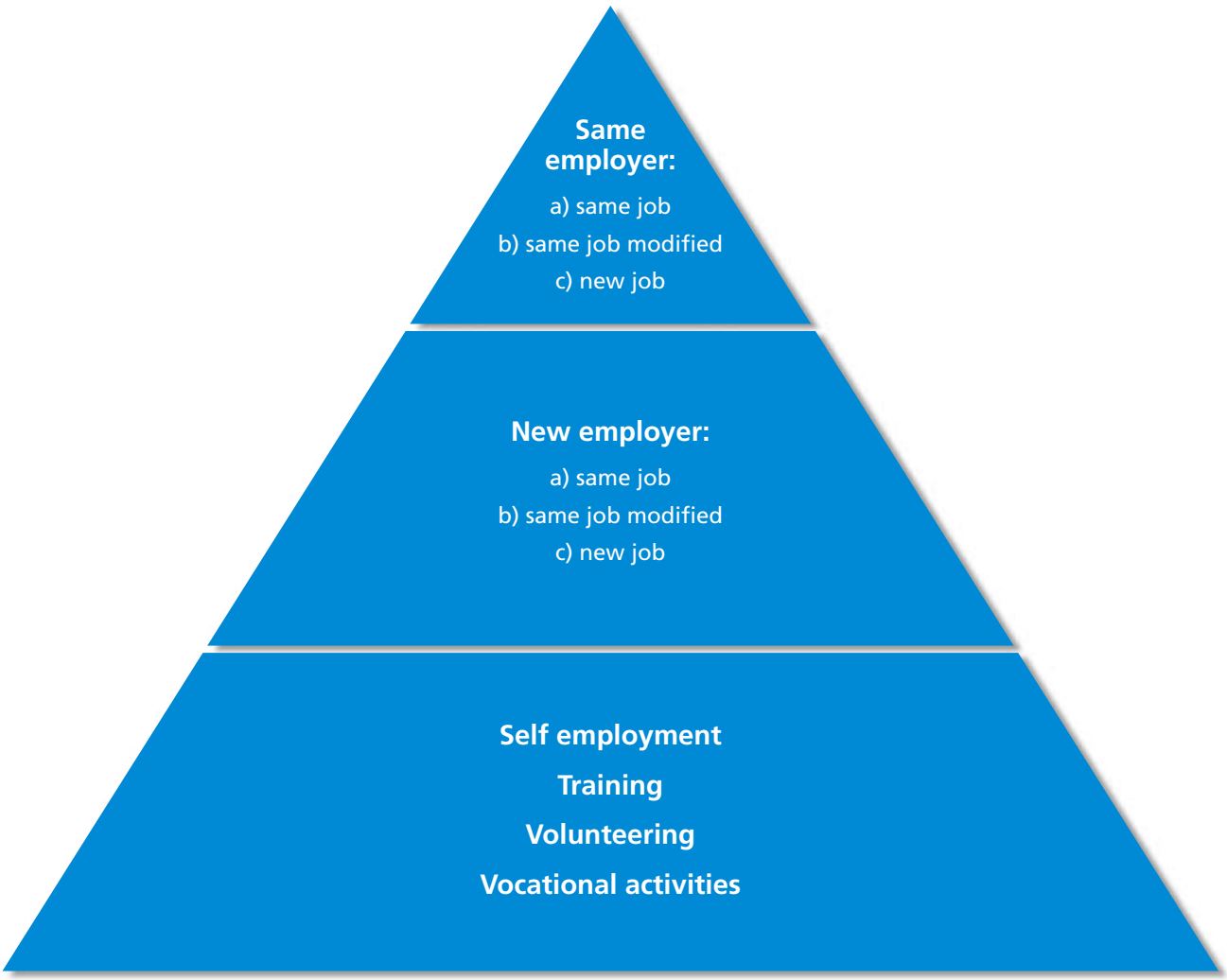
**Table E.1** – Service user induction checklist

| Information | Yes | No | Handout provided | Comments | Date |
|---|---|---|---|---|---|
| History of provider organization | ☐ | ☐ | Provider welcome form ☐ | | |
| Basic structure of provider's organization | ☐ | ☐ | Provider welcome form ☐ | | |
| Reason for referral | ☐ | ☐ | Provider information sheet ☐ | | |
| Review of details provided with the referral like service user's disability/ condition, treatment regime, current functioning level, education, employment details, personal/family details and contact information | ☐ | ☐ | | | |
| Provider's role, services provided and potential outcomes | ☐ | ☐ | | | |
| Provider's contact information (phone, fax, E-mail, meeting locations) | ☐ | ☐ | Business card ☐ | | |
| Service user's access rights (representation, reports) | ☐ | ☐ | | | |
| Service user's roles and responsibilities | ☐ | ☐ | Rights/responsibilities document ☐ | | |
| Referral source's role | ☐ | ☐ | | | |
| Other stakeholders (medical team, assessor, employer, representatives, carers, family, work colleagues, other providers) | ☐ | ☐ | | | |
| The service delivery process | ☐ | ☐ | | | |
| Timeframes for plan submission and monthly monitoring | ☐ | ☐ | | | |
| Information around reporting | ☐ | ☐ | | | |
| Payment information (service coverage, benefits, expenses, plan costs) | ☐ | ☐ | | | |
| Tasks the service user is or may be assigned | ☐ | ☐ | | | |

# Annex F (informative)
## The return to work hierarchy

This diagram reflects the preferred order of return to work for a service user re-entering the labour market. Providers should focus on "same employer" activity first for a variety of reasons; for example, it is usually the quickest and less costly route back into work. As one progresses down the triangle, timeframe and costs associated with success tend to increase.

**Figure 3** – The return to work hierarchy



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