communication between the two is crucial. Setting up such a service may never have happened outside of a pandemic, but the rapid release of charitable funds to allow secondment of University academics into this new NHS service has been truly ground breaking. N-ROL provides a template for how different stakeholders can come together to provide the ideal conditions for rapid development of desperately needed innovative new services driven by patient need.

Conclusion

The COVID-19 pandemic has created an urgent need for rehabilitation services to take centre stage during the recovery process. Given the chronic under-resourcing of rehabilitation services over recent years significant financial and human resource investment is critical to our success. Alongside this there is the opportunity to build on what already works and evolve how we deliver rehabilitation interventions by embracing technological advances and creating novel partnerships with businesses, the private and charitable sectors.

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Conflict of interest statement: The rehabilitation department at University College London Hospitals has received educational grants from Medtronic. Dr Farrell has received honoraria and hospitality from Merck, TEVA, Novartis, Genzyme, Allergan, Merz, Ipsen, GW Pharma and Biogen. Dr Farrell's current research activity is supported by the NIHR Biomedical Research Centre UCLH.

Provenance and peer review: Submitted and reviewed internally

Date first submitted: 28/5/2020
Acceptance date after peer review: 28/7/20
Published online: 30/7/20

To cite: Stevenson V, Farrell R, Ramdharry G, Swayne O, Ward N, Leary S, Holmes S, ACNR 2020;19(4):5-7

Specialist Rehabilitation: The impact of commissioning changes during the COVID-19 pandemic

Do not worry that your life is turning upside down. How do you know that the side you are used to is better than the one to come? – Rumi

On March 23rd 2020, the COVID-19 pandemic leapt out of the 24 hour news cycle and into the lives of everyone in the UK. That day, the Prime Minister announced the 'lockdown' of UK society and the country was suddenly faced with indefinite uncertainty and a profound change to its long established way of life. Meanwhile, the National Health Service was hurriedly preparing for the predicted 'tsunami' of COVID-19 cases on the horizon. Hospitals re-organised to create acute medical and intensive care treatment capacity. All elective and outpatient work was abruptly cancelled. Although not on the front line, specialist rehabilitation services were immediately affected. Some services were forced to close, in order to create space for new acute medical wards or allow for redeployment of staff to acute services. Others had their gyms repurposed as new wards or intensive care units. In order to prevent hospital trusts from facing financial penalty in responding to this unprecedented public health challenge, local and national commissioners quickly adapted their systems of payment. This article discusses changes in commissioning of specialist rehabilitation services, focusing on the particular experience of the Level 1 specialist rehabilitation service in Oxford. As the peak of the outbreak begins to fade into the rear-view mirror and services plan a return to some version of business as usual, it is worth stopping for a moment to reflect.

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Conflict of interest statement: None declared

Provenance and peer review: Submitted and externally reviewed

Date first submitted: 8/5/20
Date submitted after peer review: 8/6/20
Acceptance date: 16/6/20
Published online first: 29/6/20

To cite: Pick A. ACNR 2020;19(4):7-8

NHS England Specialised Commissioned Rehabilitation for patients with highly complex needs

NHS England published the Specialised Commissioning Contract for Rehabilitation of Patients with Highly Complex Needs in 2013.[1] Prior to this, services were remunerated on a block contract. The new contract was part of a general strategic shift in England away from block contracts, towards payment-by-results contracts. It stipulated strict criteria for services to be designated as 'specialist'. Services were broken down into 'Level 1' or 'Level 2a', determined by the type and level of need of patients being admitted. Tariffs were based on submitted outcome data for every patient admitted and calculated by a centrally operated database, known as the UK Rehabilitation Outcomes Collaborative (UKROC). One of the main criteria for services to maintain their status as 'specialist' providers, was the requirement to submit to UKROC a complete dataset for each patient; this included demographics, two weekly collected Rehabilitation Complexity Scales (RCS), two weekly collected Northwick Park Dependency Scores (NPDS), regularly collected Northwick Park Therapy Dependency Scores (NPDTA), admission and discharge Neurological Impairment Scale (NIS), FIM/FAM and admission Patient Categorisation Tool (PCAT) scores. This seven year old system changed overnight when the pandemic struck.

COVID-19 Commissioning changes

Within days of the start of the lockdown, NHS England issued a memorandum, outlining changes to the way specialist rehabilitation services were going to be reimbursed during the pandemic. The memorandum stated that, effective immediately, funding would be reverting back to a block contract system. Reimbursement would no longer be calculated on the basis of outcome data, but rather on the basis of the income a service received during the same period in the previous year. UKROC published a much smaller set of outcome measures it 'recommended' services submit during this period. This new dataset was made up of patient demographics, and a single RCS on admission and discharge. From a commissioning perspective, the remuneration change allowed services that were shut down or severely limited, not to lose funding during the pandemic. For those services that did remain operational, the change in data submission requirement and the loosening of admission constraints facilitated new autonomy to determine a service level response to the crisis.

Operational response at the Oxford Centre for Enablement

The Oxford Centre for Enablement (OCE) is a standalone building, removed from where much of the acute care is delivered within Oxford University NHS Foundation Trust. In addition to a range of outpatient services, it contains an inpatient Level 1 Specialist Rehabilitation Ward serving the entire South East of England. The service, adapted to follow national infection prevention guidance, remained operational throughout the early stages of the pandemic. At the beginning of the lockdown, as part of the effort to create acute capacity to accommodate the expected influx of patients with COVID-19, NHS England officially requested NHS hospitals to discharge all medically stable patients occupying acute beds. Regional inpatient rehabilitation facilities, including the nearby Spinal Cord Injury Centre, were either closed, no longer accepting admissions or overwhelmed with patients with COVID-19. As a result, very soon after the lockdown was announced, the OCE started receiving increased numbers of referrals. In addition, with few other rehabilitation options available, acute providers began referring patients that would not normally have been referred to OCE. Unconstrained from the commissioning contract, the team at OCE designed a system to both create capacity and enable the service to effectively respond to the needs of these different patient groups. Three admission 'tracks' were established:

Track A – Complex discharges

Track A was designed to accommodate patients requiring mainly disability management and intensive discharge planning. These patients had medical and nursing needs that were best met in a specialist rehabilitation environment. An example of a Track A patient was one with a spinal cord injury, and a large sacral pressure sore requiring them to remain on complete bed rest. Acute ward staff did not have the capacity, and in some cases the capability to coordinate discharges for these patients. Working collaboratively with NHS England and CCG partners, the team at OCE were able to enact these complex discharges and maintain patient flow.

Track B – Shorter term goal directed rehabilitation

Track B was designed to provide short goal-directed rehabilitation admissions. Patients admitted on this track had mostly sustained non-dominant hemispheric strokes, non-neurological trauma, or spinal cord injuries, and some were recovering from COVID-19. Multidisciplinary rehabilitation goals were set with these patients every two weeks. At the end of each two weeks, a collaborative decision was made to either set new goals for the coming two weeks or to trigger discharge in the next two weeks. Patients on Track B often had short admissions of two to six weeks.

Track C – Complex rehabilitation

Track C was designed to accommodate patients with particularly complex rehabilitation, nursing and medical needs. These patients included those in prolonged disorders of consciousness or those who had sustained severe acquired brain injuries. Patients on this track had their need for on-going admission reviewed every four weeks. Diagnosis and prognosis meetings and best interest meetings continued to be held, only now via a virtual platform.

Discussion

The 2013 Specialised Commissioning Contract for Rehabilitation of Patients with Highly Complex Needs proclaims on its first page that it would be due for review after 12 months. Seven years on, it does not appear that this or any later review happened. Just prior to the pandemic, NHS England Specialised Commissioning held the first of a series of planned workshops to begin the process of reviewing how it commissions specialist rehabilitation. This project was put on hold when the pandemic struck. Clinicians working in the field have long debated the merits and limitations of how rehabilitation is commissioned. Through its detailed service specifications and tightly controlled admission criteria, the system is likely to have raised the quality and improved the standardisation of rehabilitation care across England. Conversely, the huge amount of mandated data collection was arguably unwieldy and the unmistakable emphasis on neurological injury left patients with complex non-neurological rehabilitation needs, underserved. The absence of a robust review process and the excessively centralised control over services stipulated in the contract may have also stifled development in the field.

The complete reorganisation of healthcare services in the UK in response to the COVID-19 pandemic opened the door to, for the first time in many years, real innovation for some specialist rehabilitation services. This report describes the response of one such service in the UK during the early stages of the pandemic. A devastating number of people have already died from the virus, but some are at the beginning of a road to recovery. Creating additional rehabilitation capacity for these patients whilst also establishing a more dynamic and equitable system to meet the needs of all patients requiring rehabilitation is a huge challenge for the health service. Innovation will be needed to rise to this challenge and reverting back to the old commissioning contract may hinder this. Until a new, fit-for-purpose specialised commissioning contract for rehabilitation is approved, extension of the current block contract or establishment of a provisional pared down payment by results scheme will empower services to respond resourcefully to this evolving situation. Rehabilitation services in England could indeed rise from these ashes like a phoenix, but only if leaders in the field are bold enough to learn from what has happened, abandon redundant procedures, and truly start anew.

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