NHS Central London Clinical Commissioning Group
NHS Hammersmith and Fulham Clinical Commissioning Group
NHS West London Clinical Commissioning Group

Neurological Rehabilitation Service

Memorandum of Information (MOI)

NHS Central London;
NHS Hammersmith and Fulham; and
NHS West London
Clinical Commissioning Groups (CCGs)

[Working together as "Tri-Borough CCGs"]

1. EXECUTIVE SUMMARY

Nationally, the demand for people with neurological conditions requiring rehabilitation following hospital admission is increasing. There is also substantial body of evidence to support both the clinical and cost effectiveness of providing adequate neurological rehabilitation (neuro rehab) services.

Depending on the nature of neurological condition and acquired injury, patients can present with a wide range of problems which require specialist neuro rehab intervention to address deficits, prevent and manage complications.

Specialist neuro rehab is a Level 2 specialist provision for people with moderate to severe physical, cognitive and/or behavioural needs, requiring complex disability management. The service is co-ordinated by a multi-disciplinary team of staff with specialist training and experience, and led by a Consultant with specialist accreditation in Rehabilitation Medicine (RM).

The level of service is defined nationally by the British Society of Rehabilitation Medicine (BSRM), and includes admission criteria, adherence to minimum staffing levels, skill mix, reporting and benchmarking requirements.

The Tri-Borough CCGs wish to commission a new Level 2 Specialist Neurological Rehabilitation Services (SNRS) with additional capacity to meet recognised demand across the 3 Inner North West London CCGs (Hammersmith & Fulham CCG, Central London CCG, and West London CCG). The need for this additional capacity has been determined through extensive sector work involving patients, carers, clinicians, practitioners and managers across Acute Hospital Trusts, Clinical Commissioning Groups, Community Health Care providers, Adult Social Care, Third Sector, Patients and Carers groups and representatives.

The current quantified capacity resource needed is equivalent to **19 SNRS Level 2 beds**.

Our current work with stakeholders and clinicians indicate that the need for both a bed based and outreach service model to facilitate patient flow and ensure close integration with acute and community pathways.
Therefore we are looking for an innovative provider to provide both a bed based and outreach (non-bed based) model of care for Level 2 to facilitate transitions in care.

The CCGs are planning for the new service to commence in March/April 2016 and within an annual financial envelope of up to £3.5M. Currently, there are only 10 SNRS Level 2 beds. The contract for this service ends early September 2015 and Commissioners are working with current providers to ensure service continuity at least until the new service starts.

2. INTRODUCTION

The Service will provide a high quality Level 2 specialist neuro rehab provision for people with moderate to severe physical, cognitive and/or behavioural needs – including those requiring complex disability management. The key components are:

- Consultant in RM led, well resourced and competent MDT service;
- In-patient bed based specialist interventions and disability management;
- Community outreach staff supporting successful transitions in community, and long-term care settings; and
- Follow up care (review) and specialist support to community rehab/case management teams.

3. PURPOSE AND STRUCTURE

3.1 Purpose of this document

The purpose of this Memorandum of Information **("MOI")** is to provide potential Providers with an overview of the NHS Central London (CL) CCG, NHS Hammersmith and Fulham (HF) CCG and NHS West London (WL) CCGs' Neurological Rehabilitation Service Procurement strategy. The CCGs are working as 'Tri-Borough CCGs' to procure a Neurological Rehabilitation Service (**"Service"**) for their registered populations. This MOI provides details of the:

- Our commissioning intention to secure a high quality level 2 specialist neuro rehab service
- Strategic drivers for our work and our approach to assuring
- A draft service outline and model – including population need/prevalence
- High level procurement table and objectives for assuring quality;
- Information on current service provision;
- Anticipated service requirements;
- Procurement process; and
- Governance and administration requirements.

The MOI includes the attached questionnaire to gain feedback from providers on whether:

- There are any key barriers and any issues with delivering the model of care and what needs to be done to address them;
- The Market understands commissioners' needs and is ready to respond through the procurement process;
- How the service interdependencies need to operate in the finalised service specification
- Potential pricing approach; and
- Procurement timescale and whether service commencement timescale is realistic.

The MOI is intended only as a preliminary background explanation of the Tri-Borough's joint procurement for the Service. It is in no way intended to form the basis of any decision on the terms upon which these CCGs will enter in to any contractual relationship.

4. DRAFT SERVICE OUTLINE

4.1 Introduction – service component and outcomes

The focus of this procurement is to commission the Service within the standard contract period (3 years plus a potential additional 2 years after review). The focus of SNRS is primarily on:

- Medical stability, and comprehensive multidisciplinary assessment to provide a measurable baseline of functions; level of dependency and care requirements (hours and cost);
- Disability management to reducing and preventing secondary complications (pathology), such as contractures, malnutrition, pressure sores, pneumonia etc.;
- Providing the required intensive rehabilitation needed to reduce impairment such regaining mobility, improving activity (reducing disability) and safety as much as possible;
- Supporting patients to learn new skills (including maximising the use of assistive technology, equipment etc.) and make both physical and psychology adjustment needed to manage their Activity of Daily Living (ADL) tasks; and
- Supporting successful transition back into community based provision.

4.2 Inpatient SNRS clinical interventions

Examples of the specialist rehabilitation and complex disability management interventions which will necessitate bed based care - to be provided in an appropriate location will be (but not limited to):

- Optimising medical condition for rehabilitation – including blood tests and investigations;
- Optimising respiratory and tracheostomy management whilst going through rehabilitation;
- Managing swallowing impairment and risk of aspiration;
- Maintaining adequate nutrition and hydration in the face ;
- Physical and occupation therapy to maintain muscle tone/reduce muscle wasting, maintain balance, transfer skills, etc.;
- 24-hour positioning/handling to avoid development of contractures and pressure sores;
- Effective bladder and bowel management;
- Establishing basic communication;
- Management of seizures and other absences;
- Provide specialist cognitive rehabilitation for patients;

- Managing challenging behaviours (as needed), psychological and emotional support; and
- Provision of information, counselling and support for person and relatives.

The nature and severity (or combinations) of these will determine whether or not this will require inpatient rehabilitation.

4.3 Specialist Neurological Rehabilitation Outreach Service (SNROS) interventions

People not requiring inpatient care should be transferred as soon as possible and practical. One of the biggest barriers to making effective use of specialist rehabilitation beds is the lack of specialist support in managing the transitions to the next phase of community based care.

For some patients, there will be a need to continue the level of specialist neuro rehab input to sustain gains made in inpatient care until community teams have the capacity and capability to support the person to continue to maximise their ability to function safely in their community based environment.

The focus of the SNROS will be to provide specialist neuro rehab to those patients needing this outside Tertiary, Acute, and Level 2 beds. This will ensure:

- Timely discharge from inpatient beds in Tertiary, Level 2 and Acute care settings;
- Ensure successful transition back into community services;
- Provide access to specialist neuro rehab interventions to sustain gains made in inpatient unit;
- Provide specialist input into community based services - such as the Community Independence Service (CIS) and Community Rehab Teams (CRTs) and other long-term care settings e.g. specialist nursing placements, with specialist neuro rehab input;
- Prevent avoidable admissions into inpatient SRNS from long-term care settings by providing specialist input.

The patient outcomes for service are - but not limited to:

- Outcome 1: Secure high quality service for patients by ensuring patient receive safe and effective care to prevent or minimise secondary complications as a result of a disabling illness or injury;
- Outcome 2: Reduce the inequality gap in the neuro rehab care pathway by providing timely specialist neuro rehab for people who need it;
- Outcome 3: Improve patient experience of care by reducing unwarranted delays in transfers of care for people requiring specialist neuro rehab;
- Outcome 4: Enable people to take more control of their health and wellbeing following a disabling condition/injury by providing rehabilitation to re-learning new skills to functions and helping the person to adapt /adjust to their losses.

4.4 Aims

The CCGs are seeking providers with the appropriate capability and capacity to deliver a high quality, patient centred neurological rehabilitation service. The Service will operate as an alternative to current hospital level 2 services for Category B patients (and potentially some Category A patients). The overarching aim of the service is to provide high quality, consultant-led care to the residents of the geographical areas covered by Tri-Borough CCGs. The aims of the Service are to:

- Support patients with disabilities associated with neurological impairment whose rehabilitation needs are beyond the scope of their local level 3 rehabilitation services;
- provide rehabilitation for patients with complex needs in order to assist them to achieve their maximum potential for physical, cognitive, social and psychological function, enhance their participation in society and improve their quality of life; and
- Relieve the pressure on acute services and facilitating discharge to the community or on-going placement.

4.5 Strategic Context

Nationally, the demand for people with neurological conditions requiring rehabilitation following hospital admission is increasing.

There is also substantial body of evidence to support both the clinical and cost effectiveness of providing adequate neuro rehab services[1].

Depending on the nature of neurological condition and acquired injury, patients can present with a wide range of problems which require neuro rehab intervention to address deficits, prevent and manage complications in the following areas, for example:

- Physical rehabilitation to manage motor deficits and improve muscle tone, ataxia, gait and coordination etc.;
- Disability management to address complications of spasticity and contractures, positioning and comfort; seating needs to prevent further damage and reduce pressure sores etc;
- Medical and nursing management to improve, manage and prevent further complications neurological (seizures), respiratory, nutrition, bladder and swallowing complications;
- Communication and sensory support to manage problems of low awareness states, visual and hearing loss, expression and comprehension of language etc;
- Cognitive rehabilitation to support impairment of memory, attention, social judgment, problem solving and safety awareness;
- Behavioral and Psychological/emotional support to manage adjustment problems, mood change, aggressive outburst, inhibitions and emotional state etc.

These deficits compromise a person's recovery process and impact on their long-term abilities and care dependency, but may also be largely avoided by effective and timely rehabilitation[2].

This rise in demand for inpatient neuro rehab is recognised in the Triborough. This is due to a lower than sufficient Level 2 Specialist Neuro rehab Services (SNRS) for these cohort of patients, but it also fits in with the wider alignment with the CCGs strategic plans and the national direction in the NHS '5 Year Forward View' to provide care closer home to patients and far greater control for individuals who need care[3].

This proposal to expand the service was developed in the context of the BCF and the strategic plans of the CCGs and Local Authorities.

The BCF plan is part of a radical overhaul to the way in which health and social care services are delivered in the Triborough and throughout North West London. The core change programmes that are alongside the BCF include:

- Out of Hospital Strategies;
- Adult Social Care Transformation;
- Whole Systems Integrated Care (WSIC);
- Primary Care Transformation; and
- Mental Health Programme.

There is a strong alignment between the vision of all six programmes and all focus on strengthening out of hospital care through bringing care closer to home. The overall objective is to work as a single team across health, adult social care, public health, housing, mental health, primary care, community care, hospital care and other allied services.

4.6 Scope of Service

At both the local and national level, there is a push towards ensuring individuals are treated in the most appropriate setting, ensuring NHS efficiencies and improving outcomes, experience and satisfaction for patients. This vision is embodied in the NHS '5 Year Forward View' Strategy. This is especially the case in the reduction of delayed transfers of care (DTOC) and the need to provide appropriate facilities and environments for rehabilitation and recovery closer

[1] Health and Social Care Information Centre, Tables showing finished admission episodes for a primary and secondary diagnosis of a neurological condition, ICD10 codes G00-G99, by primary care trust, 2007-08 to 2011

[2] Turner-Stokes L, Paul S, Williams H. Efficiency of specialist rehabilitation in reducing dependency and costs of continuing care for adults with complex acquired brain injuries. J Neurol Neurosurg Psychiatry 2006;77:634-9.

[3] http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

home. The new service will be available to all patients registered with GP practices within Tri-Borough CCG boundaries.

For those who require rehabilitation, there are three nationally defined levels of rehabilitation based on the extent of physical, cognitive and/or behavioural, social and medical support needed. Three levels of on-going care are defined as indicated in Table 1 below.

The below table shows how patient's needs are categorised and met by an appropriate level of service which is proportionate to the person's assessed needs.

Table 1: Categories of Needs and Levels of service for neuro rehabilitation

Categories of Patient needs and service requirements for Rehabilitation (including Neuro rehab)		
Tiers of Care	**Category of patient needs**	**Level and Type of Service**
Level 1 Commissioned by NHS England (Specialised commissioning portfolio)	**Category A needs** Severe physical, cognitive, communicative disabilities or challenging behaviours. Highly complex rehabilitation needs. Require intensive, co-ordinated interdisciplinary intervention from **4 or more therapy disciplines**.	**Tertiary 'Specialised' Rehabilitation Services** Provided by specialised rehab teams led by consultants trained and accredited in the specialty of rehabilitation medicine (RM) (and/or neuropsychiatry). Longer programmes - typically 2-4 months or more, but occasionally up to 12 months.
Level 2 Commissioned by CCGs as part of their specialist service provisions)	**Patients with category B needs** Moderate to severe physical, cognitive, communicative disabilities or challenging behaviours. Require rehabilitation from specialist staff providing coordinated interdisciplinary intervention from **2 or more therapy disciplines**. Use of special facilities & equipment.	**Specialist rehabilitation services** Provided by inter-disciplinary teams led/supported by a consultant in RM. Medium-Longer durations of stay, i.e. usually 8 - 12 weeks depending on patient complexity. Occasionally, and usually in extreme situations stays up to 6 months.
Level 3 Commissioned by CCGs as part of generic intermediate provisions	**Category C and D needs** Generic rehabilitation to restore function and maintain independence for people with a wide range of needs and conditions but medically stable. Provision often led by therapy staff, provided in the context of intermediate care in community facilities or at home.	**Local intermediate care and rehabilitation services.** Includes generic rehabilitation units and non-bed based intermediate care services for a wide range of conditions, provided in the community to maintain and support independence and reduce admissions.

4.7 Interdependencies

Patients progress through the different stages of their rehabilitation at very different rates. For example the majority of people with low dependency specialist neuro rehab needs do not require inpatient bed at all and should be able to pass straight on to services in the community.

The specialist outreach service will work closely with CIS and CRTs and support both the patient and staff with specialist neuro rehab input as needed in the following areas, for example:

- Outpatients medical and therapy reviews;
- Providing specialist assessment and care planning support to manage cases;
- Support in providing interventions to enhance participation in personal care tasks;
- Improvement in quality of life by supporting social integration and management of other activities of daily living (ADL) tasks;
- Providing psychological adjustment and managing carer stress etc.;
- Vocational rehabilitation activities with the emphasis on making meaningful use of occupational time to retain gains made; and
- Provide specialist education on neuro rehab to the person and staff in their care setting.

The service will also build strong working relationships with:

- GPs and Primary Care services;

- Adult Social Care services;
- Independent Care sector organisations;
- Third Sector organisations in identifying the most appropriate community based care setting for supporting individuals and their carers.

There will need to be an agreed process and clear protocols on service hand offs, joint assessment and interventions

4.8 Commissioning Organisations

The commissioning organisations for this procurement are:

- NHS Central London CCG;
- NHS Hammersmith and Fulham; and
- NHS West London CCG.

Each CCG is the statutory body responsible for commissioning healthcare services to their respective registered patient population. For the purposes of procurement, the three CCGs will work together as Tri-Borough CCGs to deliver the procurement process. The procurement will offer two 'phases' to bidders as below. One of the CCGs will act as Lead Commissioner and host the service.

5 POPULATION INFORMATION

The population of Kensington and Chelsea has seen a slight decline of 0.1% from 158,919 in 2001 to 158,700 in 2011. This is the only London borough to have decreased in population size. During this time, Westminster's population increased by 21% from 181,286 to 219,400. As the CCG and borough areas are not coterminous, the population for West London CCG (Kensington and Chelsea, Queens Park, and Paddington) is 225,000 and Central London CCG (the remainder of Westminster) is 188,000.

In Kensington and Chelsea there are more females (50.7%) than males (49.3%) whereas the opposite is true for Westminster (49.2% female; 50.8% male). Overall, there are more men than women living across the West London.

Table 2: *Tri-Borough CCG population information*

CCG	Population
NHS Central London CCG	188,000
NHS Hammersmith and Fulham CCG	190,000
NHS West London CCG	225,000

5.4 Joint Strategic Needs Assessment

A Joint Strategic Needs Assessment ("JSNA") report has been published for each Borough (which covers the Tri-Borough CCG areas). The JSNAs are developed jointly by local health and social care partners are available for more detailed information on Tri-Borough CCG demographics, including the health needs of the local populations. Interested parties can use the links below to access the JSNAs for Tri-Borough CCGs.

Table 3: *CCG Joint Strategic Needs Assessment*

Borough	Weblink to JSNA
Westminster (covering Central London CCG) highlight report 2013:	http://www.jsna.info/sites/default/files/Westminster%20JSNA%20Highlights%20Report%202013-14.pdf
Hammersmith and Fulham highlight report 2013:	http://www.jsna.info/sites/default/files/Hammersmith%20and%20Fulham%20JSNA%20Highlights%20Report%202013-14.pdf
Kensington and Chelsea (covering West London CCG) highlight report 2013:	http://www.jsna.info/sites/default/files/Kensington%20and%20Chelsea%20JSNA%20Highlights%20Report%202013-14.pdf

5.5 Population Need

In 2012/13, nationally 1.3 million patients were admitted to NHS acute treatment facilities due to neurological problems, representing a 500,000 increase in a five-year period (2007/8 and 2011/12), and equating to a 50% increase in the rate of neurological hospital admissions where a neurological condition was mentioned in diagnosis'. In parallel there has been a 200% increase in spend for neurological treatments over the last decade in England.

The current prevalence data on Long-term neurological conditions below shows a total prevalence total of 8723 patients with the most common long-term neurological conditions – including stroke. The data indicates there will be an impact of these neurological conditions on long-term care problems. Commissioning plans need to be able to support this group across the Triborough.

Table 4: *Prevalence Data on Long-Term Neurological Conditions*[4]

Triborough CCGs	West London	Central London	Hammersmith & Fulham	Total
Population	**222,315**	**189,584**	**187,314**	**599,213**
TBI prevalence 1200 per 100,000 with long-term needs	2668	2275	2248	7191
Spinal cord injury prevalence 50 per 100,000	111	95	94	300
Cerebral Palsy prevalence 144 per 100,000	320	273	270	863
Huntington's disease prevalence 13.5 per 100,000	30	26	25	81
Motor Neurone Disease prevalence 7 per 100,000	16	13	13	42
Parkinson's Disease prevalence 200 per 100,000	38	32	32	102
Spina bifida & hydrocephalus prevalence 24 per 100,000	53	46	45	144
Stroke Prevalence(men) 240 per 100,000	5,336	4,550	4,496	14,382
Stroke Prevalence (women) 220 per 100,000	4,891	4,171	4,121	13,183

6 CURRENT NEUROLOGICAL REHABILITATION SERVICES

6.1 Current Services

Within the tri-borough, there are facilities in place that serve the rehabilitation needs of patients with neurologically disease. Overall there are adequate community based Level 3 provision across the tri-borough CCGs areas providing both bed based and non-bed based services to support people with categories C and D rehabilitations needs – described in the table 1.

There is also a programme of work through the BCF to strengthen and further integrate these intermediate care services such as the development of the New Community Independence Service (CIS). These services will need to have a strong relationship and interdependency with the SNRS Level 2.

Currently, there only 10 SNRS beds at Level 2 commissioned by West London and Central London CCGs at the Albany Rehabilitation Unit (ARU), The National Hospital for Neurology and Neurosurgery, Queen Square. There are no dedicated beds commissioned by H&F CCG. The 2013/14 activity usage for ARU indicates 14% by H&F CCG, 38% by West London CCG and 48% by Central London CCG.

This strain on Level 2 provision results in DTOC between acute hospitals and rehabilitation facilities, as well as reducing the system's ability to maintain flow from Level 1 tertiary units for those who need to step down but who may not be ready to go home or directly into a level 3 services. By patients remaining in the acute hospital, the CCG

[4] Public Health Observatory (PHO) http://www.apho.org.uk/diseaseprevalencemodels

incurs additional charges for bed usage, vital space in acute facilities is not made available for other patients who need it, and patients requiring neuro rehab may experience delays in their on-going care.

6.2 Outline Service Specification

One of the key areas of debate in rehabilitation is the balance between bed based and non-bed based model of care and requirements. The evidence suggests that both inpatient and community based rehabilitation should be provided as part of a continuum of support for those who need it.

The proposed approach to the service delivery model is illustrated in the National Clinical Guidelines for Rehabilitation following Acquired Brain Injury (ABI) – indicating a phased approach to rehabilitation that is proportionate to need as depicted in figure 1 below.

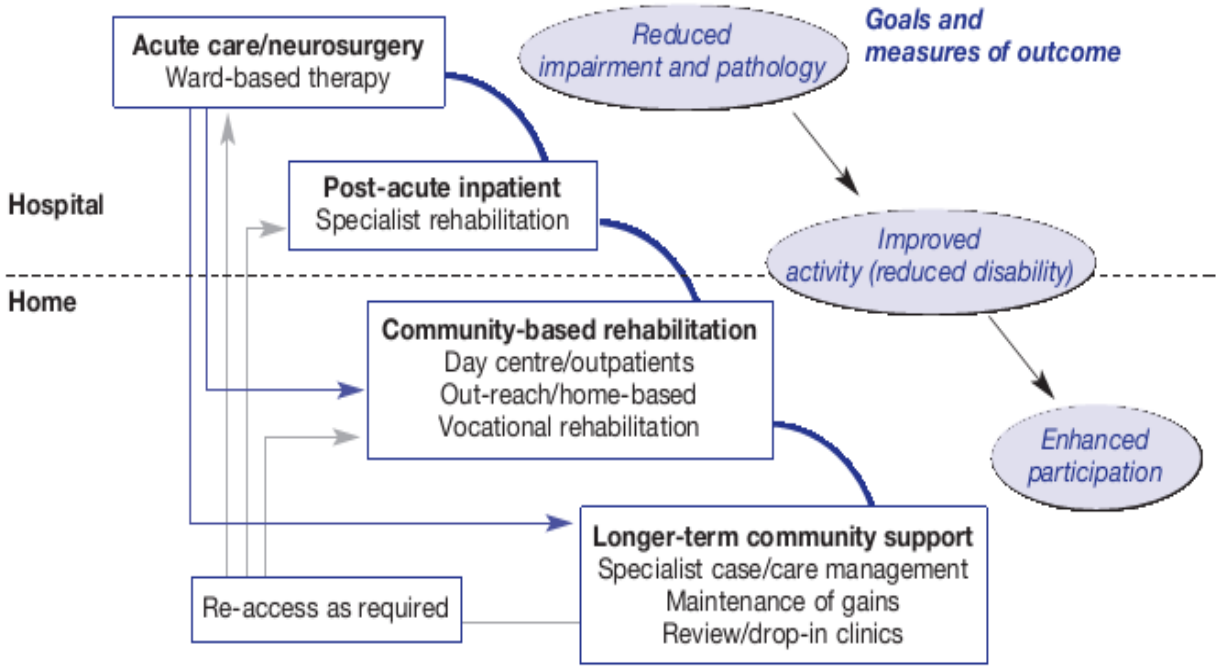

Figure 1: Phases of rehabilitation and intended outcome - Turner – Strokes L 2003: Rehabilitation following acquired brain injury: National Clinical Guidelines London: RCP, BSRM, 2003

6.2.1 Local Specialist rehabilitation

Services must adhere to BSRM guidelines for level 2 services which stipulate that a combination of individual and group-based interventions are used to work toward goal orientated functional and meaningful activities which promote social interaction and communication as well as other life and work skills.

The rehabilitation programme should be offered as time-limited to in-patients, but may sometimes include associated activity in follow-up day-patient / out-reach / community programmes (also time-limited) to extend support for patients in order to ensure carryover of gains in their community context.

Specialist rehabilitation will be provided by a multi-disciplinary team which has undergone recognised training in rehabilitation. The service will be led by a consultant neurologist with an interest in stroke and rehabilitation and a clinical specialist occupational therapist and will be supported by a consultant trained and accredited in Rehabilitation Medicine.

- The Service will accept patients with neurological rehabilitation needs (Category B and A) which require rehabilitation from expert staff with appropriate specialist facilities (in a dedicated unit or within the community).
- The service will be supported by a consultant trained and accredited in Rehabilitation medicine (RM), who will work in both inpatient and outpatient settings.
- The service will support local level 3 rehabilitation teams in bedded and community settings with a recognised role in education and training in the field of rehabilitation.
- The service will meet the national BSRM standards for specialist rehabilitation services.

- The service will report the minimum dataset to United Kingdom Rehabilitation Outcomes Collaborative (UKROC) and submit a data quarterly return (June, September, December and March).
- The service will report SSNAP data for all stroke patients admitted to the service.

6.3 Service locations

Bidders will be required to make proposals for Service locations and premises solutions for the Service. The Provider(s) will be responsible for securing facilities to deliver services within the Tri-Borough localities where possible (this is not mandated but will be favourably evaluated) and must meet BSRM Standards. The Contracting Authority reserves the right to reject any proposal in regard to Service locations assessed as not offering reasonable accessibility to patients.

7 COMMERCIAL FRAMEWORK

Potential applicant's attention is drawn to the following commercial information:

7.1 Contract

The contract to be entered into by the Commissioners and the selected Provider(s) for the Procurement will be based on the NHS Standard Contract and will comply with the mandatory requirements of the specification. The Contract(s) will be separate to and independent of any existing contract currently in place between a Provider and the CCGs either separately or jointly.

The Provider(s) will enter into separate contracts for each of the lots being procured. The CCGs will work jointly on contract monitoring and reporting arrangements. The Commissioners and the successful Provider will agree the period of mobilisation of the Service based on mobilisation plans set out in the Bid. The mobilisation period is likely to be no more than 3 months. Further information and details on contract mobilisation requirements will be set out in the ITT.

7.2 IM&T and Systems Integration

The provider will be solely responsible for the provision, cost, maintenance and up-grade of all IM&T hardware and software unless otherwise specified.

The provider will be expected to capture information and manage it in a secure electronic environment in line with the NHS guidelines for the management and security of information, connecting for Health and the data Protection Act.

The Provider must be able to accurately record, monitor and report data at a CCG level specific to the Service. This is an essential requirement of the Service. Providers will also be required to put appropriate information management and governance systems and processes in place to safeguard patient information. This will need to be supported by appropriate training of staff.