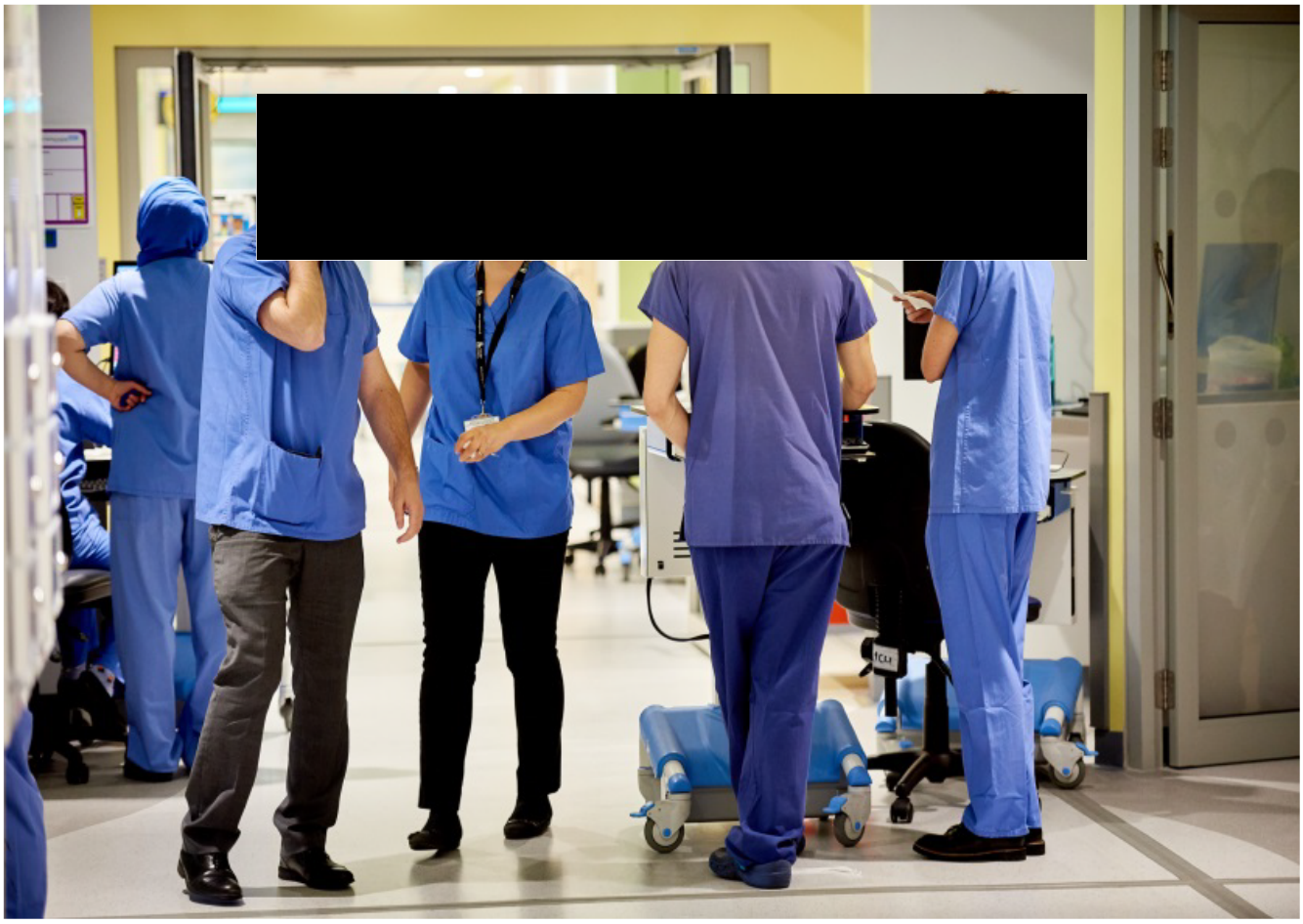

NHS Standard Contract 2019/20

Particulars (Full Length)

THE WALTON CENTRE NHS FOUNDATION TRUST

99A-1920-RO-RET

NHS Standard Contract 2019/20

Particulars (Full Length)

Version number: 1

First published: March 2019

Prepared by: NHS Standard Contract Team [redacted]

Classification: OFFICIAL

Publication Approval Number: 000248

Contract Reference	99A-1920-RO-RET

DATE OF CONTRACT	**AS OF LAST SIGNATURE**
SERVICE COMMENCEMENT DATE	**1 APRIL 2019**
CONTRACT TERM	**1 years commencing 1 APRIL 2019**
COMMISSIONERS	**NHS BURY (ODS 00V)** **NHS EAST LANCASHIRE CCG (ODS 01A)** **NHS EASTERN CHESHIRE CCG (ODS 01C)** **NHS HALTON CCG (ODS 01F)** **NHS KNOWSLEY CCG (ODS 01J)** **NHS LIVERPOOL CCG (ODS 99A)** **NHS SOUTH CHESHIRE CCG (ODS 01R)** **NHS SOUTH SEFTON CCG (ODS 01T)** **NHS SOUTHPORT AND FORMBY CCG (ODS 01V)** **NHS ST HELENS CCG (ODS 01X)** **NHS VALE ROYAL CCG (ODS 02D)** **NHS WARRINGTON CCG (ODS 02E)** **NHS WEST CHESHIRE CCG (ODS 02F)** **NHS WEST LANCASHIRE CCG (ODS 02G)** **NHS WIGAN BOROUGH CCG (ODS 02H)** **NHS WIRRAL CCG (ODS 12F)**
CO-ORDINATING COMMISSIONER	**NHS LIVERPOOL CCG (ODS 99A)** 
PROVIDER	**THE WALTON CENTRE NHS FOUNDATION TRUST (RET)** **Principal and/or registered office**

	address: [redacted]

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SC13 Equity of Access, Equality and Non-Discrimination
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CONTRACT

This Contract records the agreement between the Commissioners and the Provider and comprises

1. these **Particulars**;
2. the **Service Conditions (Full Length)**;
3. the **General Conditions (Full Length)**,

as completed and agreed by the Parties and as varied from time to time in accordance with GC13 (*Variations*).

IN WITNESS OF WHICH the Parties have signed this Contract on the date(s) shown below

SIGNED by [redacted]

Signature

[redacted]
For and on behalf of
NHS LIVERPOOL CCG

[redacted]

09 May 2019

Date

CONTRACT

This Contract records the agreement between the Commissioners and the Provider and comprises

1. the **Particulars**;
2. the **Service Conditions (Full Length)**;
3. the **General Conditions (Full Length)**,

as completed and agreed by the Parties and as varied from time to time in accordance with GC13 (*Variations*).

IN WITNESS OF WHICH the Parties have signed this Contract on the date(s) shown below

SIGNED by [redacted]

Signature

[redacted]
for
and on behalf of
NHS BURY CCG

[redacted]

27/6/19

Date

CONTRACT

This Contract records the agreement between the Commissioners and the Provider and comprises

1. the **Particulars**;
2. the **Service Conditions (Full Length)**;
3. the **General Conditions (Full Length)**,

as completed and agreed by the Parties and as varied from time to time in accordance with GC13 (*Variations*).

IN WITNESS OF WHICH the Parties have signed this Contract on the date(s) shown below

SIGNED by

..... [redacted] .....
Signature

[redacted]
for
and on behalf of
NHS EAST LANCASHIRE CCG

[redacted]

..... 22/05/2019 .....
Date

CONTRACT

This Contract records the agreement between the Commissioners and the Provider and comprises

1. the **Particulars**;
2. the **Service Conditions (Full Length)**;
3. the **General Conditions (Full Length)**,

as completed and agreed by the Parties and as varied from time to time in accordance with GC13 (*Variations*).

IN WITNESS OF WHICH the Parties have signed this Contract on the date(s) shown below

SIGNED by [redacted]

..... Signature

[redacted] [redacted]

and on behalf of
NHS EASTERN CHESHIRE CCG

26/06/2019 Date

CONTRACT

This Contract records the agreement between the Commissioners and the Provider and comprises

1. the **Particulars**;
2. the **Service Conditions (Full Length)**;
3. the **General Conditions (Full Length)**,

as completed and agreed by the Parties and as varied from time to time in accordance with GC13 (*Variations*).

IN WITNESS OF WHICH the Parties have signed this Contract on the date(s) shown below

SIGNED by [redacted] .....

[redacted]
for
and on behalf of
NHS HALTON CCG

[redacted]
.....14/5/19.....
Date

CONTRACT

This Contract records the agreement between the Commissioners and the Provider and comprises

1. the **Particulars**;
2. the **Service Conditions (Full Length)**;
3. the **General Conditions (Full Length)**,

as completed and agreed by the Parties and as varied from time to time in accordance with GC13 (*Variations*).

IN WITNESS OF WHICH the Parties have signed this Contract on the date(s) shown below

SIGNED by

[redacted]

Signat[redacted]

[redacted]

for
and on behalf of
NHS KNOWSLEY CCG

13/5/19

Date

CONTRACT

This Contract records the agreement between the Commissioners and the Provider and comprises

1. the **Particulars**;
2. the **Service Conditions (Full Length)**;
3. the **General Conditions (Full Length)**,

as completed and agreed by the Parties and as varied from time to time in accordance with GC13 (*Variations*).

IN WITNESS OF WHICH the Parties have signed this Contract on the date(s) shown below

SIGNED by [redacted]

.....
Signature

[redacted]
for
and on behalf of
NHS SOUTH CHESHIRE CCG

[redacted]

21/05/2019
.....
Date

CONTRACT

This Contract records the agreement between the Commissioners and the Provider and comprises

1. the **Particulars;**
2. the **Service Conditions (Full Length);**
3. the **General Conditions (Full Length),**

as completed and agreed by the Parties and as varied from time to time in accordance with GC13 (*Variations*).

IN WITNESS OF WHICH the Parties have signed this Contract on the date(s) shown below

SIGNED by

[redacted]

Signature

[redacted]

for
and on behalf of
NHS SOUTH SEFTON CCG

27/06/2019

Date

CONTRACT

This Contract records the agreement between the Commissioners and the Provider and comprises

1. the **Particulars;**
2. the **Service Conditions (Full Length)**;
3. the **General Conditions (Full Length)**,

as completed and agreed by the Parties and as varied from time to time in accordance with GC13 (*Variations*).

IN WITNESS OF WHICH the Parties have signed this Contract on the date(s) shown below

SIGNED by

[redacted]

Sign

[redacted]

for
and on behalf of
NHS SOUTHPORT AND FORMBY CCG

27/06/2019

Date

CONTRACT

This Contract records the agreement between the Commissioners and the Provider and comprises

1. the **Particulars**;
2. the **Service Conditions (Full Length)**;
3. the **General Conditions (Full Length),**

as completed and agreed by the Parties and as varied from time to time in accordance with GC13 (*Variations*).

IN WITNESS OF WHICH the Parties have signed this Contract on the date(s) shown below

SIGNED by [redacted]

..... Signature

[redacted]

for
and on behalf of
NHS ST HELENS CCG

21/5/19.
Date

CONTRACT

This Contract records the agreement between the Commissioners and the Provider and comprises

1. the **Particulars;**
2. the **Service Conditions (Full Length);**
3. the **General Conditions (Full Length),**

as completed and agreed by the Parties and as varied from time to time in accordance with GC13 (*Variations*).

IN WITNESS OF WHICH the Parties have signed this Contract on the date(s) shown below

SIGNED by [redacted]

Signature

[redacted]

for
and on behalf of
NHS VALE ROYAL CCG

[redacted]

21/05/2019

Date

CONTRACT

This Contract records the agreement between the Commissioners and the Provider and comprises

1. the **Particulars**;
2. the **Service Conditions (Full Length)**;
3. the **General Conditions (Full Length)**,

as completed and agreed by the Parties and as varied from time to time in accordance with GC13 (*Variations*).

IN WITNESS OF WHICH the Parties have signed this Contract on the date(s) shown below

SIGNED by [redacted] .....
Signature

[redacted]
for
and on behalf of
NHS WARRINGTON CCG

[redacted]
15. 5. 2019
Date

CONTRACT

This Contract records the agreement between the Commissioners and the Provider and comprises

1. the **Particulars**;
2. the **Service Conditions (Full Length)**;
3. the **General Conditions (Full Length)**,

as completed and agreed by the Parties and as varied from time to time in accordance with GC13 (*Variations*).

IN WITNESS OF WHICH the Parties have signed this Contract on the date(s) shown below

SIGNED by

[redacted]

Sig[redacted]

[redacted]

and on behalf of
NHS WEST CHESHIRE CCG

30/5/19

Date

CONTRACT

This Contract records the agreement between the Commissioners and the Provider and comprises

1. the **Particulars**;
2. the **Service Conditions (Full Length)**;
3. the **General Conditions (Full Length)**,

as completed and agreed by the Parties and as varied from time to time in accordance with GC13 (*Variations*).

IN WITNESS OF WHICH the Parties have signed this Contract on the date(s) shown below

[redacted] 20/6/19

SIGNED by PP .....[redacted]..... Signature

[redacted]

for
and on behalf of
NHS WEST LANCASHIRE CCG .....20/6/19..... Date

CONTRACT

This Contract records the agreement between the Commissioners and the Provider and comprises

1. the **Particulars**;
2. the **Service Conditions (Full Length)**;
3. the **General Conditions (Full Length)**,

as completed and agreed by the Parties and as varied from time to time in accordance with GC13 (*Variations*).

IN WITNESS OF WHICH the Parties have signed this Contract on the date(s) shown below

SIGNED by [redacted]

Signature

[redacted]
for
and on behalf of
NHS WIGAN BOROUGH CCG

[redacted]

13/5/19

Date\\

CONTRACT

This Contract records the agreement between the Commissioners and the Provider and comprises

1. the **Particulars**;
2. the **Service Conditions (Full Length)**;
3. the **General Conditions (Full Length)**,

as completed and agreed by the Parties and as varied from time to time in accordance with GC13 (*Variations*).

IN WITNESS OF WHICH the Parties have signed this Contract on the date(s) shown below

SIGNED by [redacted] .....
Signature

[redacted]
for
and on behalf of
NHS WIRRAL CCG

[redacted]

19.06.19
Date

CONTRACT

This Contract records the agreement between the Commissioners and the Provider and comprises

1. the **Particulars**;
2. the **Service Conditions (Full Length)**;
3. the **General Conditions (Full Length)**,

as completed and agreed by the Parties and as varied from time to time in accordance with GC13 (*Variations*).

IN WITNESS OF WHICH the Parties have signed this Contract on the date(s) shown below

SIGNED by .....
Signatu[redacted]

[redacted]
for
and on behalf of
THE WALTON CENTRE NHS FOUNDATION TRUST .....1/5/19.....
Date

SERVICE COMMENCEMENT AND CONTRACT TERM	
Effective Date	1 APRIL 2019
Expected Service Commencement Date	1 APRIL 2019
Longstop Date	30 JUNE 2019
Service Commencement Date	1 APRIL 2019
Contract Term	1 years commencing 1 APRIL 2019
Option to extend Contract Term	NO
Commissioner Notice Period (for termination under GC17.2)	6 months
Commissioner Earliest Termination Date	6 months after the Service Commencement Date
Provider Notice Period (for termination under GC17.3)	6 months
Provider Earliest Termination Date	6 months after the Service Commencement Date

SERVICES	
Service Categories	**Indicate all that apply**
Accident and Emergency (A+E)	NO
Acute Services (A)	**YES**
Ambulance Services (AM)	NO
Cancer Services (CR)	**YES**
Continuing Healthcare Services (CHC)	NO
Community Services (CS)	NO
Diagnostic, Screening and/or Pathology Services (D)	**YES**
End of Life Care Services (ELC)	NO
Mental Health and Learning Disability Services (MH)	NO
Mental Health and Learning Disability Secure Services (MHSS)	NO
NHS 111 Services (111)	NO
Patient Transport Services (PT)	NO
Radiotherapy Services (R)	NO
Urgent Care/Walk-in Centre Services/Minor Injuries Unit (U)	NO
Services commissioned by NHS England	
Services comprise or include Specialised Services and/or other services directly commissioned by NHS England	**YES**
Service Requirements	
Indicative Activity Plan	**YES**
Activity Planning Assumptions	**YES**
Essential Services (NHS Trusts only)	**NO**
Services to which 18 Weeks applies	**YES**
Prior Approval Response Time Standard	**Within 10 Operational Days following the date of request**
Is the Provider acting as a Data Processor on behalf of one or more Commissioners for the purposes of this Contract?	**NO**
Is the Provider providing CCG-commissioned Services which are to be listed in the UEC DoS?	**NO**
PAYMENT	

Expected Annual Contract Value Agreed	**YES**
Must data be submitted to SUS for any of the Services?	**YES**
QUALITY	
Provider type	**NHS Foundation Trust**
Clostridium difficile Baseline Threshold (Acute Services only)	**8**
GOVERNANCE AND REGULATORY	
Nominated Mediation Body	**CEDR**
Provider's Nominated Individual	[redacted] **EMAIL:** [redacted] **TEL:** [redacted]
Provider's Information Governance Lead	[redacted] **EMAIL:** [redacted] **TEL:** [redacted]
Provider's Data Protection Officer (if required by Data Protection Legislation)	[redacted] **EMAIL:** [redacted] **TEL:** [redacted]
Provider's Caldicott Guardian	[redacted] **EMAIL:** [redacted] **TEL:** [redacted]
Provider's Senior Information Risk Owner	[redacted] **EMAIL:** [redacted] **TEL:** [redacted]
Provider's Accountable Emergency Officer	[redacted] TEL: [redacted]
Provider's Safeguarding Lead	[redacted] **EMAIL:** [redacted] **TEL:** [redacted]
Provider's Child Sexual Abuse and Exploitation Lead	[redacted]

	[redacted] EMAIL: [redacted] TEL: [redacted]
Provider's Mental Capacity and Deprivation of Liberty Lead	[redacted] EMAIL: [redacted] TEL: [redacted]
Provider's Prevent Lead	[redacted] EMAIL: [redacted] TEL: [redacted]
Provider's Freedom To Speak Up Guardian(s)	[redacted] TEL [redacted]
Provider's UEC DoS Contact	**NOT APPLICABLE**
Commissioners' UEC DoS Leads	**NOT APPLICABLE**
CONTRACT MANAGEMENT	
Addresses for service of Notices	**CO-ORDINATING COMMISSIONER:** **NHS LIVERPOOL CCG** [redacted] **EMAIL:** [redacted] **COPY TO** [redacted] **AND** [redacted] **EMAIL:** [redacted] **NHS BURY CCG** [redacted] **EMAIL:** [redacted] **NHS EAST LANCASHIRE CCG** [redacted] **EMAIL:** [redacted]

	NHS EASTERN CHESHIRE CCG [redacted] **EMAIL:** [redacted] **NHS HALTON CCG** [redacted] **EMAIL:** [redacted] **NHS HEYWOOD, MIDDLETON AND** [redacted] **EMAIL:** [redacted] **NHS KNOWSLEY CCG** [redacted] **EMAIL:** [redacted] **NHS ST HELENS CCG** [redacted] **EMAIL:** [redacted] **NHS SOUTH CHESHIRE CCG** [redacted] **EMAIL:** [redacted] **NHS SOUTH SEFTON CCG** [redacted] **EMAIL:** [redacted] **NHS SOUTHPORT AND FORMBY CCG** [redacted] **EMAIL:** [redacted] **NHS VALE ROYAL CCG** [redacted]

	[redacted] EMAIL: [redacted] NHS WARRINGTON CCG [redacted] EMAIL: [redacted] NHS WEST CHESHIRE CCG [redacted] EMAIL: [redacted] NHS WEST LANCASHIRE CCG [redacted] EMAIL: [redacted] NHS WIGAN BOROUGH CCG [redacted] EMAIL: [redacted] NHS WIRRAL CCG [redacted] EMAIL: [redacted] PROVIDER: THE WALTON CENTRE NHS FOUNDATION TRUST [redacted]
Frequency of Review Meetings	**CONTRACT REVIEW - MONTHLY**
Commissioner Representative(s)	**NHS LIVERPOOL CCG –** [redacted] [redacted] EMAIL: [redacted]

	[redacted] **NHS BURY CCG –** [redacted] [redacted] **EMAIL:** [redacted] **NHS EAST LANCASHIRE CCG –** [redacted] [redacted] **EMAIL:** [redacted] **NHS EASTERN CHESHIRE CCG –** [redacted] [redacted] **EMAIL:** [redacted] **NHS HALTON CCG -** [redacted] [redacted] **EMAIL:** [redacted] **NHS KNOWSLEY CCG –** [redacted] [redacted] **EMAIL:** [redacted] **NHS ST HELENS CCG –** [redacted] [redacted] **EMAIL:** [redacted] **NHS SOUTH CHESHIRE CCG -** [redacted] [redacted] **EMAIL:** [redacted] **NHS SOUTH SEFTON CCG –** [redacted] [redacted]

	[redacted] EMAIL: [redacted] NHS SOUTHPORT AND FOMBY CCG – [redacted] EMAIL: [redacted] NHS VALE ROYAL CCG - [redacted] EMAIL: [redacted] NHS WARRINGTON CCG – [redacted] EMAIL: [redacted] NHS WEST CHESHIRE CCG – [redacted] EMAIL: [redacted] NHS WEST LANCASHIRE CCG – [redacted] EMAIL: [redacted] NHS WIGAN CCG – [redacted] EMAIL: [redacted] NHS WIRRAL AND CARE COMMISSIONING CCG – [redacted] EMAIL: [redacted]

Provider Representative	**THE WALTON CENTRE NHS FOUNDATION** [redacted] **EMAIL:** [redacted]

SCHEDULE 1 – SERVICE COMMENCEMENT AND CONTRACT TERM

A. Conditions Precedent

The Provider must provide the Co-ordinating Commissioner with the following documents:

1. Evidence of appropriate Indemnity Arrangements

The Walton Centre NHS Foundation Trust membership no T149 of NHS Litigation Authority.

2. Evidence of CQC registration in respect of Provider and Material Sub-Contractors

The Walton Centre NHS Foundation Trust certificate number 1-232155391

3. Evidence of Monitor's Licence in respect of Provider and Material Sub-Contractors-

The Walton Centre NHS Foundation Trust Monitor Licence number 130132

4. Copies of the following Material Sub-Contracts, signed and dated and in a form approved by the Co-ordinating Commissioner [*LIST ONLY THOSE REQUIRED FOR SERVICE COMMENCEMENT AND NOT PROVIDED ON OR BEFORE THE DATE OF THIS CONTRACT]* - SEE SCHEDULE 5B

The Provider must complete the following actions:

The Provider must complete the following actions:

Forward the following by the Longstop Date: *(30th June 2019)*

- Schedule 1A 2019/20 Indemnity Arrangements (CNST and LTPS)
- Schedule 2J Discharge Policy and Procedure
- Schedule 2K Safeguarding Children's Policy and Procedure
- Schedule 2M Development Plan for Personalised Care
- Schedule 6B Data Quality and Improvement Plan (Contract Management, Reporting & Information Requirements)
- Schedule 2B activity planning assumptions
- Schedule 3A Local Prices

The following items to be forwarded by the Provider during the term of the contract:

- Schedule 2K Safeguarding Adults and Procedure
- Schedule 2K Mental Capacity Act Policy

From Service Conditions:

- SC19.1 Food and Drink Strategy
- SC18.2 Sustainability Development Plan
- GC 21 Annual Security Management Report
- SC34.2 Death of a Service User Policy

SCHEDULE 1 – SERVICE COMMENCEMENT AND CONTRACT TERM

B. Commissioner Documents

Date	Document	Description
NOT APPLICABLE		

SCHEDULE 1 – SERVICE COMMENCEMENT AND CONTRACT TERM

C. Extension of Contract Term

To be included only in accordance with the Contract Technical Guidance.

NOT USED

SCHEDULE 2 – THE SERVICES

A. Service Specifications

SPECIALISED REHABILITATION FOR PATIENTS WITH COMPLEX NEEDS – LEVEL 2 (SPOKE SPECIALIST REHABILITATION UNIT) LEVEL 3 (EXTENDED SPECIALIST REHABILITATION UNIT) AND COMMUNITY SPECIALIST REHABILITATION SERVICES – APRIL 2017 TO MARCH 2020

SCH 2 A CMRN
Service Specification

SCHEDULE 2 – THE SERVICES

B. Indicative Activity Plan

The Walton Centre - Financial Offer 19-20

SCHEDULE 2 – THE SERVICES

C. Activity Planning Assumptions

Insert text locally in respect of one or more Contract Years, or state Not Applicable

SCHEDULE 2 – THE SERVICES

D. Essential Services (NHS Trusts only)

Not Applicable

SCHEDULE 2 – THE SERVICES

E. Essential Services Continuity Plan (NHS Trusts only)

Not Applicable

SCHEDULE 2 – THE SERVICES

F. Clinical Networks

CRITICAL CARE AND MAJOR TRAUMA NETWORK 2019/20

Sch 2F Critical Care
& Major Trauma Netw

Critical Care PbR Tariff Process 2018

Standards for Critical
Care PbR, Tariff Proce

Appendix 1

Schedule 20 Annex B
Appendix 1.doc

SCHEDULE 2 – THE SERVICES

G. Other Local Agreements, Policies and Procedures

Policy	Date	Weblink or Document
Merseyside Criteria Based Clinical Treatment Policy 2018-20	2018 - 20	https://www.liverpoolccg.nhs.uk/media/3655/cbct-ebi-public-doc-2019-20-final-policy-document-v18-2019-03-01-2.pdf
Knowsley CCG Criteria Based Clinical Treatments Policy 2018-21	2018 - 21	http://www.knowsleyccg.nhs.uk/assets/uploaded/documents/27907_Appendix%201%20-%20commissioningpolicy.cp.v02%20Appendix%20A.pdf
High Cost Drugs and Technologies	2019/20	 19-20HCDs_Technologies.pdf
Safe Use and Management of Controlled Drugs	2019	 Safe Use and Management of Cont

*** ie details of and/or web links to local agreement, policy or procedure as at date of Contract. Subsequent changes to those agreements, policies or procedures, or the incorporation of new ones, must be agreed between the Parties.**

SCHEDULE 2 – THE SERVICES

H. Transition Arrangements

Not Applicable

SCHEDULE 2 – THE SERVICES

I. Exit Arrangements

NOT APPLICABLE

SCHEDULE 2 – THE SERVICES

J. Transfer of and Discharge from Care Protocols

NORTH WEST TRANSFER DISCHARGE POLICY

SCH 2J Transfer
Discharge Policy gene

WCFT DISCHARGE POLICY AND PROCEDURE, REVIEW DATE: DECEMBER 2018

SCH 2 J WCFT
DISCHARGE POLICY \

TRUST TO FORWARD UPDATED VERSION ONCE RATIFIED

SCHEDULE 2 – THE SERVICES

K. Safeguarding Policies and Mental Capacity Act Policies

WCFT SAFEGUARDING CHILDREN POLICY AND PROCEDURE, REVIEW NOVEMBER 2018

SCH 2 K WCFT SAFEGUARDING CHIL

WCFT SAFEGUARDING ADULTS POLICY AND PROCEDURE, REVIEW JANUARY 2020

SCH 2 K WCFT SAFEGUARDING ADU

WCFT MENTAL CAPACITY ACT POLICY, REVIEW NOVEMBER 2019

SCH 2 J WCFT MENTAL CAPACITY A

SCHEDULE 2 – THE SERVICES

L. Provisions Applicable to Primary Medical Services

NOT APPLICABLE

SCHEDULE 2 – THE SERVICES

M. Development Plan for Personalised Care

The guidance below sets out some considerations to be taken into account in populating this Schedule 2M.

Local initiatives to support implementation of personalised care

This Schedule 2M can be used to set out specific actions which the Commissioner and/or Provider will take to give Service Users greater choice and control over the way their care is planned and delivered. This could include taking forward any of the six key aspects of the personalised care model:

1. *Shared decision making*
2. *Personalised care and support planning*
3. *Enabling choice, including legal rights to choice*
4. *Social prescribing and community-based support*
5. *Supported self-management*
6. *Personal health budgets and integrated personal budgets.*

Actions set out in this Schedule 2M could focus on making across-the-board improvements applying to all of the Provider's services – or on pathways for specific conditions which have been identified locally as needing particular attention.

Implementation of personal health budgets

More specifically, this Schedule 2M can be used to set out the detailed actions which the Commissioner and/or Provider will take to facilitate the roll-out of personal health budgets to appropriate Service Users.

Not all of the examples below will be relevant to every type of personal budget and the locally-populated Schedule 2M will likely need to distinguish between different types of personal budgets to ensure that it is consistent with the CCG's statutory obligations.

<u>Key statutory obligations</u>

Regulation 32B of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012

- *This entitles individuals who receive Continuing Healthcare or Continuing Care for Children to personal health budgets, where appropriate.*
- *The CCG must retain responsibility for, amongst other things:*
    - *deciding whether to grant a request for a personal health budget;*
    - *if a request for a personal health budget is granted, deciding whether the most appropriate way to manage the personal health budget is:*
        - *by the making of a direct payment;*
        - *by the application of the personal health budget by the CCG itself; or*
        - *by the transfer of the personal health budget to a third party (for example, the Provider) who will apply the personal health budget.*

- *If the CCG decides that the most appropriate way of managing a personal health budget is by the transfer of the personal health budget to the Provider, the Provider must still obtain the agreement of the CCG in respect of the choices of services / treatment that Service Users/Carers have made.*

Section 12A of the National Health Service Act 2006 and the National Health Service (Direct Payments) Regulations 2013 (the "2013 Regulations")

- *Direct payments by definition can only be made by the Secretary of State, NHS England a CCG or Local Authority, therefore any direct payments would have to be made by the CCG and not the Provider.*

- *The CCG must make the decision as to whether to make a direct payment, and it must be made in accordance with the 2013 Regulations.*

Examples of the matters this Schedule 2M should cover in relation to personal health budgets

- *which identified groups of Service Users are to be supported through a personalised care approach and which particular cohorts are to be offered personal health budgets and/or integrated personal budgets*

- *the funding arrangements, including what is within the Price and what is not;*

- *a roll-out plan, with timescales and target levels of uptake (aimed at delivering the CCG's contribution towards the targets set out in the [NHS Framework for Universal Personalised Care]) for the Provider to implement personalised care and to offer personal health budgets and integrated personal budgets to Service Users/Carers from particular care groups, including, but not limited to, people eligible for NHS Continuing Healthcare and children eligible for Continuing Care for Children; people with multiple long-term conditions; people with mental ill health including those who are under s117 aftercare; people with learning disabilities; and people who use wheelchairs;*

- *how the process of personal health budgets is aligned with delivery of personal budgets in social care and education, to ensure a seamless offer to Service Users/Carers*

- *require the Provider to implement the roll-out plan, supporting Service Users/Carers, through the care and support planning process, to identify, choose between and access services and treatments that are more suitable for them, including services and treatments from non-NHS providers – and to report on progress in implementation;*

- *require the Provider to agree appropriate financial and contractual arrangements to support the choices Service Users/Carers have made;*

- *set out any necessary arrangements for financial audit of personal health budgets, and integrated personal budgets, including for clawback of funding in the event of improper use and clawback in the event of underspends of the person's budget, ensuring this is discussed and agreed with the person beforehand.*

SCHEDULE 3 – PAYMENT

A. Local Prices

Enter text below which, for each separately priced Service:

- *identifies the Service;*
- *describes any agreement to depart from an applicable national currency (in respect of which the appropriate summary template (available at: https://www.gov.uk/guidance/nhs-providers-and-commissioners-submit-locally-determined-prices-to-monitor) should be copied or attached)*
- *describes any currencies (including national currencies) to be used to measure activity*
- *describes the basis on which payment is to be made (that is, whether dependent on activity, quality or outcomes (and if so how), a block payment, or made on any other basis)*
- *sets out prices for the first Contract Year*
- *sets out prices and/or any agreed regime for adjustment of prices for the second and any subsequent Contract Year(s)*.

Insert template in respect of any departure from an applicable national currency; insert text and/or attach spreadsheets or documents locally – or state Not Applicable

SCHEDULE 3 – PAYMENT

B. Local Variations

For each Local Variation which has been agreed for this Contract, copy or attach the completed publication template required by NHS Improvement (available at: https://www.gov.uk/guidance/nhs-providers-and-commissioners-submit-locally-determined-prices-to-monitor) – or state Not Applicable. Additional locally-agreed detail may be included as necessary by attaching further documents or spreadsheets.

NOT APPLICABLE

SCHEDULE 3 – PAYMENT

C. Local Modifications

For each Local Modification Agreement (as defined in the National Tariff) which applies to this Contract, copy or attach the completed submission template required by NHS Improvement (available at: https://www.gov.uk/guidance/nhs-providers-and-commissioners-submit-locally-determined-prices-to-monitor). For each Local Modification application granted by NHS Improvement, copy or attach the decision notice published by NHS Improvement. Additional locally-agreed detail may be included as necessary by attaching further documents or spreadsheets.

NOT APPLICABLE

SCHEDULE 3 – PAYMENT

D. Emergency Care Rule: Agreed Blended Payment Arrangements – NOT APPLICABLE

SCHEDULE 3 – PAYMENT

E. Intentionally omitted

SCHEDULE 3 – PAYMENT

F. Expected Annual Contract Values

Commissioner Name	2019/20 Contract Offer excluding CQUIN £
NHS BURY CCG	[redacted]
NHS EAST LANCASHIRE CCG	[redacted]
NHS EASTERN CHESHIRE CCG	[redacted]
NHS HALTON CCG	[redacted]
NHS KNOWSLEY CCG	[redacted]
NHS SOUTH CHESHIRE CCG	[redacted]
NHS SOUTH SEFTON CCG	[redacted]
NHS SOUTHPORT AND FORMBY CCG	[redacted]
NHS ST HELENS CCG	[redacted]
NHS VALE ROYAL CCG	[redacted]
NHS WARRINGTON CCG	[redacted]
NHS WEST CHESHIRE CCG	[redacted]
NHS WEST LANCASHIRE CCG	[redacted]
NHS WIGAN BOROUGH CCG	[redacted]
NHS WIRRAL CCG	[redacted]
NHS LIVERPOOL CCG	[redacted]
TOTAL	[redacted]

Detail included in the spreadsheet embedded at Schedule 2B

SCHEDULE 3 – PAYMENT

G. Timing and Amounts of Payments in First and/or Final Contract Year

NOT APPLICABLE

SCHEDULE 4 – QUALITY REQUIREMENTS

A. Operational Standards

Ref	Operational Standards	Threshold	Guidance on definition	Consequence of breach	Timing of application of consequence	Application
	RTT waiting times for non-urgent consultant-led treatment					
E.B.3	***Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral***	***Operating standard of 92% at specialty level (as reported to NHS Digital)***	***See RTT Rules Suite and Recording and Reporting FAQs at: https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-guidance/***	***Where the number of Service Users waiting more than 18 weeks at the end of the month exceeds the tolerance permitted by the threshold, £300 in respect of each such Service User above that threshold***	***Monthly***	***Services to which 18 Weeks applies***
	Diagnostic test waiting times					
E.B.4	***Percentage of Service Users waiting 6 weeks or more from Referral for a diagnostic test***	***Operating standard of no more than 1%***	***See Diagnostics Definitions and Diagnostics FAQs at: https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/monthly-diagnostics-waiting-times-and-activity/***	***Where the number of Service Users waiting 6 weeks or more at the end of the month exceeds the tolerance permitted by the threshold, £200 in respect of each such Service User above that threshold***	***Monthly***	***A CS CR D***

Ref	Operational Standards	Threshold	Guidance on definition	Consequence of breach	Timing of application of consequence	Application
	Cancer waits - 2 week wait					
E.B.6	***Percentage of Service Users referred urgently with suspected cancer by a GP waiting no more than two weeks for first outpatient appointment***	***Operating standard of 93%***	***See Annex F, 2019/20 Planning Guidance at: https://www.england.nhs.uk/publication/preparing-for-2019-20-operational-planning-and-contracting-annex-f/***	***Where the number of Service Users who have waited more than two weeks during the Quarter exceeds the tolerance permitted by the threshold, £200 in respect of each such Service User above that threshold***	***Quarterly***	***A CR R***
E.B.7	***Percentage of Service Users referred urgently with breast symptoms (where cancer was not initially suspected) waiting no more than two weeks for first outpatient appointment***	***Operating standard of 93%***	***See Annex F, 2019/20 Planning Guidance at: https://www.england.nhs.uk/publication/preparing-for-2019-20-operational-planning-and-contracting-annex-f/***	***Where the number of Service Users who have waited more than two weeks during the Quarter exceeds the tolerance permitted by the threshold, £200 in respect of each such Service User above that threshold***	***Quarterly***	***A CR R***
	Cancer waits – 31 days					
E.B.8	***Percentage of Service Users waiting no more than one month (31 days) from diagnosis to first definitive treatment for all cancers***	***Operating standard of 96%***	***See Annex F, 2019/20 Planning Guidance at: https://www.england.nhs.uk/publication/preparing-for-2019-20-operational-planning-and-contracting-annex-f/***	***Where the number of Service Users who have waited more than 31 days during the Quarter exceeds the tolerance permitted by the threshold, £1,000 in respect of each such Service User above that threshold***	***Quarterly***	***A CR R***
E.B.9	***Percentage of Service Users waiting no more***	***Operating standard of***	***See Annex F, 2019/20 Planning Guidance at:***	***Where the number of Service Users who have***	***Quarterly***	***A***

Ref	Operational Standards	Threshold	Guidance on definition	Consequence of breach	Timing of application of consequence	Application
	than 31 days for subsequent treatment where that treatment is surgery	*94%*	*https://www.england.nhs.uk/publication/preparing-for-2019-20-operational-planning-and-contracting-annex-f/*	*waited more than 31 days during the Quarter exceeds the tolerance permitted by the threshold, £1,000 in respect of each such Service User above that threshold*		*CR R*
E.B.10	*Percentage of Service Users waiting no more than 31 days for subsequent treatment where that treatment is an anti-cancer drug regimen*	*Operating standard of 98%*	*See Annex F, 2019/20 Planning Guidance at: https://www.england.nhs.uk/publication/preparing-for-2019-20-operational-planning-and-contracting-annex-f/*	*Where the number of Service Users who have waited more than 31 days during the Quarter exceeds the tolerance permitted by the threshold, £1,000 in respect of each such Service User above that threshold*	*Quarterly*	*A CR R*
E.B.11	*Percentage of Service Users waiting no more than 31 days for subsequent treatment where the treatment is a course of radiotherapy*	*Operating standard of 94%*	*See Annex F, 2019/20 Planning Guidance at: https://www.england.nhs.uk/publication/preparing-for-2019-20-operational-planning-and-contracting-annex-f/*	*Where the number of Service Users who have waited more than 31 days during the Quarter exceeds the tolerance permitted by the threshold, £1,000 in respect of each such Service User above that threshold*	*Quarterly*	*A CR R*
	Cancer waits – 62 days					
E.B.12	*Percentage of Service Users waiting no more than two months (62 days) from urgent GP*	*Operating standard of 85%*	*See Annex F, 2019/20 Planning Guidance at: https://www.england.nhs.uk/publication/preparing-*	*Where the number of Service Users who have waited more than 62 days during the Quarter exceeds*	*Quarterly*	*A CR R*

Ref	Operational Standards	Threshold	Guidance on definition	Consequence of breach	Timing of application of consequence	Application
	referral to first definitive treatment for cancer		***for-2019-20-operational-planning-and-contracting-annex-f/***	***the tolerance permitted by the threshold, £1,000 in respect of each such Service User above that threshold***		
E.B.13	***Percentage of Service Users waiting no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers***	***Operating standard of 90%***	***See Annex F, 2019/20 Planning Guidance at: https://www.england.nhs.uk/publication/preparing-for-2019-20-operational-planning-and-contracting-annex-f/***	***Where the number of Service Users in the Quarter who have waited more than 62 days during the Quarter exceeds the tolerance permitted by the threshold, £1,000 in respect of each such Service User above that threshold***	***Quarterly***	***A CR R***
	Mixed-sex accommodation breaches					
E.B.S.1	Mixed-sex accommodation breach	>0	See Mixed-Sex Accommodation Guidance, Mixed-Sex Accommodation FAQ and Professional Letter at: https://www.england.nhs.uk/statistics/statistical-work-areas/mixed-sex-accommodation/	£250 per day per Service User affected	Monthly	A CR MH
	Cancelled operations					
E.B.S.2	All Service Users who have operations cancelled, on or after the	Number of Service Users who are not	See Cancelled Operations Guidance and Cancelled Operations FAQ at:	Non-payment of costs associated with cancellation and non- payment or	Monthly	A CR

Ref	Operational Standards	Threshold	Guidance on definition	Consequence of breach	Timing of application of consequence	Application
	day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the Service User's treatment to be funded at the time and hospital of the Service User's choice	offered another binding date within 28 days >0	https://www.england.nhs.uk/statistics/statistical-work-areas/cancelled-elective-operations/	reimbursement (as applicable) of re-scheduled episode of care		

The Provider must report its performance against each applicable Operational Standard through its Service Quality Performance Report, in accordance with Schedule 6A.

In respect of those Operational Standards shown in ***bold italics***, the provisions of SC36.38 apply.

SCHEDULE 4 – QUALITY REQUIREMENTS

B. National Quality Requirements

	National Quality Requirement	Threshold	Guidance on definition	Consequence of breach	Timing of application of consequence	Application
E.A.S.4	Zero tolerance methicillin-resistant *Staphylococcus aureus*	>0	See Contract Technical Guidance Appendix 3	£10,000 in respect of each incidence in the relevant month	Monthly	A
E.A.S.5	Minimise rates of Clostridium difficile	8	See Contract Technical Guidance Appendix 3	As set out in Schedule 4F, in accordance with applicable Guidance	Annual	A
E.B.S.4	Zero tolerance RTT waits over 52 weeks for incomplete pathways	>0	See RTT Rules Suite and Recording and Reporting FAQs at: https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-guidance/	£2,500 per Service User with an incomplete RTT pathway waiting over 52 weeks at the end of the relevant month	Monthly	Services to which 18 Weeks applies
E.B.S.6	No urgent operation should be cancelled for a second time	>0	See Contract Technical Guidance Appendix 3	£5,000 per incidence in the relevant month	Monthly	A CR
	VTE risk assessment: all inpatient Service Users undergoing risk assessment for VTE	***95%***	***See Contract Technical Guidance Appendix 3***	***Issue of Contract Performance Notice and subsequent process in accordance with GC9***	***Quarterly***	***A***
	Duty of candour	Each failure to notify the Relevant Person of a suspected or actual	See CQC guidance on Regulation 20 at: https://www.cqc.org.uk/guidance-providers/regulations-	Recovery of the cost of the episode of care, or £10,000 if the cost of the episode of care is unknown or indeterminate	Monthly	All

	National Quality Requirement	Threshold	Guidance on definition	Consequence of breach	Timing of application of consequence	Application
		Notifiable Safety Incident in accordance with Regulation 20 of the 2014 Regulations	enforcement/regulation-20-duty-candour			
	Full implementation of an effective e-Prescribing system for chemotherapy across all relevant clinical teams within the Provider (other than those dealing with children, teenagers and young adults) across all tumour sites	***Failure to achieve full implementation as described under Service Specification B15/S/a Cancer: Chemotherapy (Adult)***	***Service Specification at: https://www.england.nhs.uk/specialised-commissioning-document-library/service-specifications/***	***Issue of Contract Performance Notice and subsequent process in accordance with GC9***	***Monthly***	***Where both Specialised Services and Cancer apply***
	Full implementation of an effective e-Prescribing system for chemotherapy across all relevant clinical teams within the Provider dealing with children, teenagers and young adults across all tumour sites	***Failure to achieve full implementation as described under Service Specification B15/S/b Cancer: Chemotherapy (Children, Teenagers and Young Adults)***	***Service Specification at: https://www.england.nhs.uk/specialised-commissioning-document-library/service-specifications/***	***Issue of Contract Performance Notice and subsequent process in accordance with GC9***	***Monthly***	***Where both Specialised Services and Cancer apply***
	Proportion of Service Users presenting as	***Operating standard of***	***See Contract Technical Guidance Appendix 3***	***Issue of Contract Performance Notice and***	***Quarterly***	***A, A&E***

	National Quality Requirement	Threshold	Guidance on definition	Consequence of breach	Timing of application of consequence	Application
	emergencies who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within one hour of diagnosis	***90% (based on a sample of 50 Service Users each Quarter)***		***subsequent process in accordance with GC9***		
	Proportion of Service User inpatients who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within one hour of diagnosis	***Operating standard of 90% (based on a sample of 50 Service Users each Quarter)***	***See Contract Technical Guidance Appendix 3***	***Issue of Contract Performance Notice and subsequent process in accordance with GC9***	***Quarterly***	***A***

The Provider must report its performance against each applicable National Quality Requirement through its Service Quality Performance Report, in accordance with Schedule 6A.

In respect of the National Quality Requirements shown in ***bold italics,*** the provisions of SC36.38 apply.

SCHEDULE 4 – QUALITY REQUIREMENTS

C. Local Quality Requirements

Quality Requirement	Threshold	Method of Measurement	Consequence of breach	Timing of application of consequence	Applicable Service Specification
See embedded documents below for details of local quality requirements for 19/20					

Quality Schedule shared by NHSE on 25.3.19. Including provider agreement (The Walton Centre)


The Walton Centre - Quality Schedule 19-2


20190228 CDI briefing document - Q

Safeguarding Indicators


1. functioning MASTER Template 20

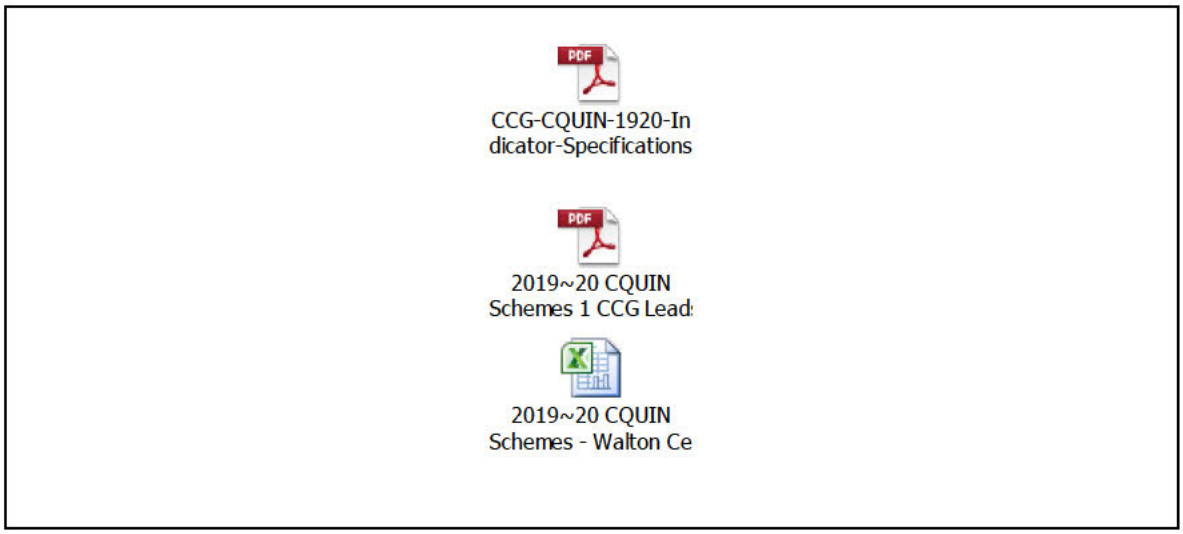

2. Updated commissioning standa


KPI Safeguarding Process 2019-2020 (3

SCHEDULE 4 – QUALITY REQUIREMENTS

D. Commissioning for Quality and Innovation (CQUIN)

CQUIN Table 1: CQUIN Indicators



CQUIN Table 2: CQUIN Payments on Account

Commissioner	Payment	Frequency/ Timing	Agreed provisions for adjustment of CQUIN Payments on Account based on performance
NHS BURY CCG	[redacted]	1/12th Monthly with main payments	Quarterly reconciliation to performance
NHS EAST LANCASHIRE CCG	[redacted]		
NHS EASTERN CHESHIRE CCG	[redacted]		
NHS HALTON CCG	[redacted]		
NHS KNOWSLEY CCG	[redacted]		
NHS SOUTH CHESHIRE CCG	[redacted]		
NHS SOUTH SEFTON CCG	[redacted]		
NHS SOUTHPORT AND FORMBY CCG	[redacted]		
NHS ST HELENS CCG	[redacted]		
NHS VALE ROYAL CCG	[redacted]		
NHS WARRINGTON CCG	[redacted]		
NHS WEST CHESHIRE CCG	[redacted]		
NHS WEST LANCASHIRE CCG	[redacted]		
NHS WIGAN BOROUGH CCG	[redacted]		
NHS WIRRAL CCG	[redacted]		
NHS LIVERPOOL CCG	[redacted]		
TOTAL	[redacted]		

SCHEDULE 4 – QUALITY REQUIREMENTS

E. Local Incentive Scheme

NOT APPLICABLE

SCHEDULE 4 – QUALITY REQUIREMENTS

F. Clostridium difficile

Clostridium difficile adjustment: NHS Foundation Trust/NHS Trust (Acute Services only)

The financial adjustment (£) is the sum which is the greater of Y and Z, where:

Y = 0

Z = ((A – B) x 10,000) x C

where:

A = the actual number of cases of Clostridium difficile in respect of all NHS patients treated by the Provider in the Contract Year

B = the baseline threshold (the figure as notified to the Provider and recorded in the Particulars), being the Provider's threshold for the number of cases of Clostridium difficile for the Contract Year, in accordance with Guidance:

https://www.england.nhs.uk/patientsafety/associated-infections/clostridium-difficile/)

C = $\frac{\text{no. of inpatient bed days in respect of Service Users in the Contract Year}}{\text{no. of inpatient bed days in respect of all NHS patients treated by the Provider in the Contract Year}}$

The financial adjustment is calculated on the basis of annual performance. For the purposes of SC36.37 (*Operational Standards, National Quality Requirements and Local Quality Requirements*), any repayment or withholding in respect of Clostridium difficile performance will be made in respect of the final Quarter of the Contract Year.

Clostridium difficile adjustment: Other Providers (Acute Services only)

The financial adjustment (£) is the sum equal to A x 10,000, where:

A = the actual number of cases of Clostridium difficile in respect of Service Users in the Contract Year.

The financial adjustment is calculated on the basis of annual performance. For the purposes of SC36.37 (*Operational Standards, National Quality Requirements and Local Quality Requirements*), any repayment or withholding in respect of Clostridium difficile performance will be made in respect of the final Quarter of the Contract Year.

SCHEDULE 5 – GOVERNANCE

A. Documents Relied On

Documents supplied by Provider

Date	Document
2018/19	INDEMNITY ARRANGEMENTS 2018/19  SCH 5 A INDEMNITY CERTIFICATE T149 2 LTPS
13 APRIL 2011	CQC CERTIFCATE  SCH 5 A WCFT CQC Cert.pdf
1 APRIL 2013	MONITOR TOA  SCH 5 A WCFT MONITOR LICENCE.p

Documents supplied by Commissioners

Date	Document
Not Applicable	

SCHEDULE 5 - GOVERNANCE

B. Provider's Material Sub-Contracts

Sub-Contractor [Name] [Registered Office] [Company number]	Service Description	Start date/expiry date	Processing Personal Data – Yes/No	If the Sub-Contractor is processing Personal Data, state whether the Sub-Contractor is a Data Processor OR a Data Controller OR a joint Data Controller
NOT APPLICABLE				

SCHEDULE 5 - GOVERNANCE

C. Commissioner Roles and Responsibilities

Co-ordinating Commissioner/Commissioner	Role/Responsibility
NHS LIVERPOOL CCG	To undertake the functions of the Co-ordinating Commissioner as outlined in the contract, with specific roles and responsibilities for itself and for the other commissioners to be agreed as set out in the Collaborative Commissioning Agreement

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

A. Reporting Requirements

	Reporting Period	Format of Report	Timing and Method for delivery of Report	Application
National Requirements Reported Centrally				
1. As specified in the DCB Schedule of Approved Collections published on the NHS Digital website at https://digital.nhs.uk/isce/publication/nhs-standard-contract-approved-collections where mandated for and as applicable to the Provider and the Services	As set out in relevant Guidance	As set out in relevant Guidance	As set out in relevant Guidance	**All**
2. Patient Reported Outcome Measures (PROMS) https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/patient-reported-outcome-measures-proms	As set out in relevant Guidance	As set out in relevant Guidance	As set out in relevant Guidance	**All**
National Requirements Reported Locally				
1. Activity and Finance Report (*note that, if appropriately designed, this report may also serve as the reconciliation account to be sent by the Provider by the First Reconciliation Date under SC36.28, or under SC36.31*)	Monthly	[For local agreement]	By no later than the First Reconciliation Date for the month to which it relates, consistent with data submitted to SUS, where applicable	**All**
2. Service Quality Performance Report, detailing performance against Operational Standards, National Quality Requirements, Local Quality Requirements, Never Events and the duty of candour, including, without limitation: a. details of any thresholds that have been breached and any Never Events and breaches in respect of the duty of candour that have occurred; b. details of all requirements satisfied; c. details of, and reasons for, any failure to meet requirements; d. the outcome of all Root Cause Analyses and audits performed pursuant to SC22 (*Assessment and Treatment for Acute*	Monthly	[For local agreement]	Within 15 Operational Days of the end of the month to which it relates.	**All** **All** **All** **A**

		Reporting Period	Format of Report	Timing and Method for delivery of Report	Application
	Illness); e. report on performance against the HCAI Reduction Plan				**All except 111**
3.	CQUIN Performance Report and details of progress towards satisfying any Quality Incentive Scheme Indicators, including details of all Quality Incentive Scheme Indicators satisfied or not satisfied	[For local agreement]	[For local agreement]	[For local agreement]	**All**
4.	NHS Safety Thermometer Report, detailing and analysing: a. data collected in relation to each relevant NHS Safety Thermometer; b. trends and progress; c. actions to be taken to improve performance.	[Monthly, or as agreed locally]	[For local agreement], according to published NHS Safety Thermometer reporting routes	[For local agreement], according to published NHS Safety Thermometer reporting routes	**All (not AM, CS, D, 111, PT, U)**
5.	Complaints monitoring report, setting out numbers of complaints received and including analysis of key themes in content of complaints	[For local agreement]	[For local agreement]	[For local agreement]	**All**
6.	Report against performance of Service Development and Improvement Plan (SDIP)	In accordance with relevant SDIP	In accordance with relevant SDIP	In accordance with relevant SDIP	**All**
7.	Summary report of all incidents requiring reporting	Monthly	[For local agreement]	[For local agreement]	**All**
8.	Data Quality Improvement Plan: report of progress against milestones	In accordance with relevant DQIP	In accordance with relevant DQIP	In accordance with relevant DQIP	**All**
9.	Report and provide monthly data and detailed information relating to violence-related injury resulting in treatment being sought from Staff in A&E departments, urgent care and walk-in centres to the local community safety partnership and the relevant police force, in accordance with applicable Guidance (Information Sharing to Tackle Violence (ISTV)) Initial Standard Specification https://digital.nhs.uk/isce/publication/isb1594	Monthly	As set out in relevant Guidance	As set out in relevant Guidance	**A** **A+E** **U**
10.	Report on outcome of reviews and evaluations in relation to Staff numbers and skill mix in accordance with GC5.2 (*Staff*)	Annually (or more frequently if and as required by the Co-	[For local agreement]	[For local agreement]	**All**

		Reporting Period	Format of Report	Timing and Method for delivery of Report	Application
		ordinating Commissioner from time to time)			
11.	Report on compliance with the National Workforce Race Equality Standard.	Annually	[For local agreement]	[For local agreement]	**All**
12.	Specific reports required by NHS England in relation to Specialised Services and other services directly commissioned by NHS England, as set out at http://www.england.nhs.uk/nhs-standard-contract/ss-reporting (where not otherwise required to be submitted as a national requirement reported centrally or locally)	As set out at http://www.england.nhs.uk/nhs-standard-contract/ss-reporting	As set out at http://www.england.nhs.uk/nhs-standard-contract/ss-reporting	As set out at http://www.england.nhs.uk/nhs-standard-contract/ss-reporting	**Specialised Services**
13.	Report on performance in reducing Antibiotic Usage in accordance with SC21.4 *(Antimicrobial Resistance and Healthcare Associated Infections)*	Annually	[For local agreement]	[For local agreement]	**A**
14.	Report on progress against sustainable development management plan in accordance with SC18.2	Annually	[For local agreement]	[For local agreement]	**All**
Local Requirements Reported Locally					
201920 Information Schedule Version 0 4 Annexes as of email correspondence of the 26th March 2019.				The Provider must submit any patient-level data required in relation to Local Requirements Reported Locally via the Data Landing Portal in accordance with the Data Landing Portal Acceptable Use Statement. [Otherwise, for local agreement]	

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SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

B. Data Quality Improvement Plans

This is a non-mandatory model template for population locally. Commissioners may retain the structure below, or may determine their own. Refer to s43 of the Contract Technical Guidance, which requires commissioners and providers to agree DQIPs in the areas below.

Data Quality Indicator	Data Quality Threshold	Method of Measurement	Milestone Date	Consequence
[Data Quality Maturity Index in accordance with SC28.2.7]				

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

C. Incidents Requiring Reporting Procedure

Procedure(s) for reporting, investigating, and implementing and sharing Lessons Learned from: (1) Serious Incidents (2) Notifiable Safety Incidents (3) other Patient Safety Incidents
WCFT INCIDENT AND NEAR MISS REPORTING POLICY, REVIEW DATE: AUGUST 2021  SCH 6C INCIDENT REPORT POLICY, rev **TRUST TO FORWARD UPDATED POLICY** **NHS LIVERPOOL CCG:** **https://www.liverpoolccg.nhs.uk/media/3341/lccg-serious-incidents-policy-october-2018.pdf**

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

D. Service Development and Improvement Plans

This is a non-mandatory model template for population locally. Commissioners may retain the structure below, or may determine their own. Refer to s41 of the Contract Technical Guidance, which requires commissioners and providers to agree SDIPs in the areas below.

	Milestones	Timescales	Expected Benefit	Consequence of Achievement/ Breach
Staff Mental Health and Wellbeing Plan	This plan will cover the following three areas; a) Introducing a range of **physical activity schemes** for staff. Providers would be expected to offer physical activity schemes with an emphasis on promoting active travel, building physical activity into working hours and reducing sedentary behaviour. They could also introduce physical activity sessions for staff which could include a range of physical activities such as; team sports, fitness classes, running clubs and team challenges. b) Improving **access to physiotherapy services** for staff. A fast track physiotherapy service for staff suffering from musculoskeletal (MSK) issues to ensure staff who are referred via GPs or Occupational Health can access it in a timely manner without delay; and c) Introducing a range of **mental health initiatives** for staff. Providers would be expected to offer support to staff such as, but not restricted to; stress management courses, line management training, mindfulness courses, counselling services including sleep counselling and mental health first aid training;	Bi-Annual submission – Q2 and Q4	Staff mental health and wellbeing plan in place to support the workforce of the organisation	Subject to GC9 (*Contract Management*)

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

E. Surveys

Type of Survey	Frequency	Method of Reporting	Method of Publication	Application
Friends and Family Test (where required in accordance with FFT Guidance)	As required by FFT Guidance	As required by FFT Guidance	As required by FFT Guidance	**All**
Service User Survey	As required by local quality schedule requirements	As stated within the local quality schedule requirements	As required by local Guidance	**All**
Staff Survey (appropriate NHS staff surveys where required by Staff Survey Guidance)	Annual	As required by National survey progreamme	As required by National Guidance	**All**
Carer Survey	Annual	As required by national/local programme	As required by National/Local Guidance	**All**

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

F. Provider Data Processing Agreement

[NOTE: This Schedule 6F applies only where the Provider is appointed to act as a Data Processor under this Contract]

1. SCOPE

1.1 The Co-ordinating Commissioner appoints the Provider as a Data Processor to perform the Data Processing Services.

1.2 When delivering the Data Processing Services, the Provider must, in addition to its other obligations under this Contract, comply with the provisions of this Schedule 6F.

1.3 This Schedule 6F applies for so long as the Provider acts as a Data Processor in connection with this Contract.

2. DATA PROTECTION

2.1 The Parties acknowledge that for the purposes of Data Protection Legislation in relation to the Data Processing Services the Co-ordinating Commissioner is the Data Controller and the Provider is the Data Processor. The Provider must process the Processor Data only to the extent necessary to perform the Data Processing Services and only in accordance with written instructions set out in this Schedule, including instructions regarding transfers of Personal Data outside the EU or to an international organisation unless such transfer is required by Law, in which case the Provider must inform the Co-ordinating Commissioner of that requirement before processing takes place, unless this is prohibited by Law on the grounds of public interest.

2.2 The Provider must notify the Co-ordinating Commissioner immediately if it considers that carrying out any of the Co-ordinating Commissioner's instructions would infringe Data Protection Legislation.

2.3 The Provider must provide all reasonable assistance to the Co-ordinating Commissioner in the preparation of any Data Protection Impact Assessment prior to commencing any processing. Such assistance may, at the discretion of the Co-ordinating Commissioner, include:

(a) a systematic description of the envisaged processing operations and the purpose of the processing;

(b) an assessment of the necessity and proportionality of the processing operations in relation to the Data Processing Services;

(c) an assessment of the risks to the rights and freedoms of Data Subjects; and

(d) the measures envisaged to address the risks, including safeguards, security measures and mechanisms to ensure the protection of Personal Data.

2.4 The Provider must, in relation to any Personal Data processed in connection with its obligations under this Schedule 6F:

(a) process that Personal Data only in accordance with Annex A, unless the Provider is required to do otherwise by Law. If it is so required the Provider must promptly notify the Co-ordinating Commissioner before processing the Personal Data unless prohibited by Law;

(b) ensure that it has in place Protective Measures, which have been reviewed and approved by the Co-ordinating Commissioner as appropriate to protect against a Data Loss Event having taken account of the:

(i) nature, scope, context and purposes of processing the data to be protected;

(ii) likelihood and level of harm that might result from a Data Loss Event;

(iii) state of technological development; and

(iv) cost of implementing any measures;

(c) ensure that:

(i) when delivering the Data Processing Services the Provider Staff only process Personal Data in accordance with this Schedule 6F (and in particular Annex A);

(ii) it takes all reasonable steps to ensure the reliability and integrity of any Provider Staff who have access to the Personal Data and ensure that they:

(A) are aware of and comply with the Provider's duties under this paragraph;

(B) are subject to appropriate confidentiality undertakings with the Provider and any Sub-processor;

(C) are informed of the confidential nature of the Personal Data and do not publish, disclose or divulge any of the Personal Data to any third party unless directed in writing to do so by the Co-ordinating Commissioner or as otherwise permitted by this Contract;

(D) have undergone adequate training in the use, care, protection and handling of Personal Data; and

(E) are aware of and trained in the policies and procedures identified in GC21.11 (*Patient Confidentiality, Data Protection, Freedom of Information and Transparency*).

(d) not transfer Personal Data outside of the EU unless the prior written consent of the Co-ordinating Commissioner has been obtained and the following conditions are fulfilled:

(i) the Co-ordinating Commissioner or the Provider has provided appropriate safeguards in relation to the transfer as determined by the Co-ordinating Commissioner;

(ii) the Data Subject has enforceable rights and effective legal remedies;

(iii) the Provider complies with its obligations under Data Protection Legislation by providing an adequate level of protection to any Personal Data that is transferred (or, if it is not so bound, uses its best endeavours to assist the Co-ordinating Commissioner in meeting its obligations); and

(iv) the Provider complies with any reasonable instructions notified to it in advance by the Co-ordinating Commissioner with respect to the processing of the Personal Data;

(e) at the written direction of the Co-ordinating Commissioner, delete or return Personal Data (and any copies of it) to the Co-ordinating Commissioner on termination of the Data Processing Services and certify to the Co-ordinating Commissioner that it has done so within five Operational Days of any such instructions being issued, unless the Provider is required by Law to retain the Personal Data;

(f) if the Provider is required by any Law or Regulatory or Supervisory Body to retain any Processor Data that it would otherwise be required to destroy under this paragraph 2.4, notify the Co-ordinating Commissioner in writing of that retention giving details of the Processor Data that it must retain and the reasons for its retention; and

(g) co-operate fully with the Co-ordinating Commissioner during any handover arising from the cessation of any part of the Data Processing Services, and if the Co-ordinating Commissioner directs the Provider to migrate Processor Data to the Co-ordinating Commissioner or to a third party, provide all reasonable assistance with ensuring safe migration including ensuring the integrity of Processor Data and the nomination of a named point of contact for the Co-ordinating Commissioner.

2.5 Subject to paragraph 2.6, the Provider must notify the Co-ordinating Commissioner immediately if, in relation to any Personal Data processed in connection with its obligations under this Schedule 6F, it:

(a) receives a Data Subject Access Request (or purported Data Subject Access Request);

(b) receives a request to rectify, block or erase any Personal Data;

(c) receives any other request, complaint or communication relating to obligations under Data Protection Legislation owed by the Provider or any Commissioner;

(d) receives any communication from the Information Commissioner or any other Regulatory or Supervisory Body (including any communication concerned with the systems on which Personal Data is processed under this Schedule 6F);

(e) receives a request from any third party for disclosure of Personal Data where compliance with such request is required or purported to be required by Law;

(f) becomes aware of or reasonably suspects a Data Loss Event; or

(g) becomes aware of or reasonably suspects that it has in any way caused the Co-ordinating Commissioner or other Commissioner to breach Data Protection Legislation.

2.6 The Provider's obligation to notify under paragraph 2.5 includes the provision of further information to the Co-ordinating Commissioner in phases, as details become available.

2.7 The Provider must provide whatever co-operation the Co-ordinating Commissioner reasonably requires to remedy any issue notified to the Co-ordinating Commissioner under paragraphs 2.5 and 2.6 as soon as reasonably practicable.

2.8 Taking into account the nature of the processing, the Provider must provide the Co-ordinating Commissioner with full assistance in relation to either Party's obligations under Data Protection Legislation and any complaint, communication or request made under paragraph 2.5 (and insofar as possible within the timescales reasonably required by the Co-ordinating Commissioner) including by promptly providing:

(a) the Co-ordinating Commissioner with full details and copies of the complaint, communication or request;

(b) such assistance as is reasonably requested by the Co-ordinating Commissioner to enable the Co-ordinating Commissioner to comply with a Data Subject Access Request within the relevant timescales set out in Data Protection Legislation;

(c) assistance as requested by the Co-ordinating Commissioner following any Data Loss Event;

(d) assistance as requested by the Co-ordinating Commissioner with respect to any request from the Information Commissioner's Office, or any consultation by the Co-ordinating Commissioner with the Information Commissioner's Office.

2.9 Without prejudice to the generality of GC15 *(Governance, Transaction Records and Audit),* the Provider must allow for audits of its delivery of the Data Processing Services by the Co-ordinating Commissioner or the Co-ordinating Commissioner's designated auditor.

2.10 For the avoidance of doubt the provisions of GC12 *(Assignment and Sub-contracting)* apply to the delivery of any Data Processing Services.

2.11 Without prejudice to GC12, before allowing any Sub-processor to process any Personal Data related to this Schedule 6F, the Provider must:

(a) notify the Co-ordinating Commissioner in writing of the intended Sub-processor and processing;

(b) obtain the written consent of the Co-ordinating Commissioner;

(c) carry out appropriate due diligence of the Sub-processor and ensure this is documented;

(d) enter into a binding written agreement with the Sub-processor which as far as practicable includes equivalent terms to those set out in this Schedule 6F and in any event includes the requirements set out at GC21.16.3; and

(e) provide the Co-ordinating Commissioner with such information regarding the Sub-processor as the Co-ordinating Commissioner may reasonably require.

2.12 The Provider must create and maintain a record of all categories of data processing activities carried out under this Schedule 6F, containing:

(a) the categories of processing carried out under this Schedule 6F;

(b) where applicable, transfers of Personal Data to a third country or an international organisation, including the identification of that third country or international organisation and, where relevant, the documentation of suitable safeguards;

(c) a general description of the Protective Measures taken to ensure the security and integrity of the Personal Data processed under this Schedule 6F; and

(d) a log recording the processing of the Processor Data by or on behalf of the Provider comprising, as a minimum, details of the Processor Data concerned, how the Processor Data was processed, when the Processor Data was processed and the identity of any individual carrying out the processing.

2.13 The Provider warrants and undertakes that it will deliver the Data Processing Services in accordance with all Data Protection Legislation and this Contract and in particular that it has in place Protective Measures that are sufficient to ensure that the delivery of the Data Processing Services complies with Data Protection Legislation and ensures that the rights of Data Subjects are protected.

2.14 The Provider must comply at all times with those obligations set out at Article 32 of the GDPR and equivalent provisions implemented into Law by DPA 2018.

2.15 The Provider must assist the Commissioners in ensuring compliance with the obligations set out at Article 32 to 36 of the GDPR and equivalent provisions implemented into Law, taking into account the nature of processing and the information available to the Provider.

2.16 The Provider must take prompt and proper remedial action regarding any Data Loss Event.

2.17 The Provider must assist the Co-ordinating Commissioner by taking appropriate technical and organisational measures, insofar as this is possible, for the fulfilment of the Commissioners' obligation to respond to requests for exercising rights granted to individuals by Data Protection Legislation.

Annex A

Data Processing Services

Processing, Personal Data and Data Subjects

1. The Provider must comply with any further written instructions with respect to processing by the Co-ordinating Commissioner.

2. Any such further instructions shall be incorporated into this Annex.

Description	Details
Subject matter of the processing	*[This should be a high level, short description of what the processing is about i.e. its subject matter]*
Duration of the processing	*[Clearly set out the duration of the processing including dates]*
Nature and purposes of the processing	*[Please be as specific as possible, but make sure that you cover all intended purposes. The nature of the processing means any operation such as collection, recording, organisation, structuring, storage, adaptation or alteration, retrieval, consultation, use, disclosure by transmission, dissemination or otherwise making available, alignment or combination, restriction, erasure or destruction of data (whether or not by automated means) etc. The purpose might include: employment processing, statutory obligation, recruitment assessment etc]*
Type of Personal Data	*[Examples here include: name, address, date of birth, NI number, telephone number, pay, images, biometric data etc]*
Categories of Data Subject	*[Examples include: Staff (including volunteers, agents, and temporary workers), Co-ordinating Commissioners/ clients, suppliers, patients, students / pupils, members of the public, users of a particular website etc]*
Plan for return and destruction of the data once the processing is complete UNLESS requirement under union or member state law to preserve that type of data	*[Describe how long the data will be retained for, how it be returned or destroyed]*

SCHEDULE 7 – PENSIONS

NOT APPLICABLE

SCHEDULE 8 – LOCAL SYSTEM OPERATING PLAN OBLIGATIONS

Liverpool CCG and local providers will have due regard to the Vision, Aims and Objectives contained within the 'One Liverpool Plan' and agree to work together to support the three main aims of:

- a radical upgrade in population health and prevention
- integrated community services
- sustainable acute and specialist services.

During 2019/20 Liverpool CCG and Providers will collectively agree detailed operational delivery plans setting out how change will be delivered.

First published: March 2019
Published in electronic format only

SCHEDULE 2 – THE SERVICES

Specialist Rehabilitation Service Specification FINAL DRAFT V7 JULY 2016

DOCUMENT CONTROL

Title	Specialist Rehabilitation Service Specification: Specialist rehabilitation for patients with complex needs - Level 2 (Spoke Specialist Rehabilitation Unit) Level 3 (Extended Specialist Rehabilitation Unit) and Community Specialist Rehabilitation Services
Prepared By	[redacted]
To be Approved By	[redacted]
Date Effective From	01/04/2017 Shadow reporting 01/04/2016-31/03/2017
Version Number	Final Draft v7 July 2016

Revision History:

Version	Meeting with	Date	Summary of Changes	Changes Made (Initials)
Draft v6	CMRN Strategic Board	March 2016	Commissioner and Contracts CCG Leads and Provider Lead	Yes ([redacted])
Draft v6	Community Locality 1 ([redacted]) & 2 ([redacted])	May 2016	Performance KPIs: - Clarify definition re-referral - within 28 days of discharge (community)	Yes ([redacted])
Draft v6	Hub HARU/CRU ([redacted]/[redacted]/[redacted]/[redacted])	May 2016	Performance KPIs: - Clarify definition of re-admission - within 28 days of discharge (inpatient)	Yes ([redacted])
			Quality KPIs for all inpatient units: - Include 'set' to clarify expected date of discharge set within 10 working days of admission - Delete KPI for 'Prescription and Passport' (N.B. will be reported in KPI CMRN IDT Discharge Summary/Prescription and Passport	Yes ([redacted])
			Additional Safety KPIs for all inpatients units unless specified: - No. incidents outstanding - No. patients on a 1:1 - No. Hospital Acquired Infections (e.g. CDT, VRE, CDiff, DVT and CPE) - No. patients with a tracheostomy (Hub HARU and Extended Rehabilitation Units	Yes ([redacted])

			only) - No. patients with a tracheostomy waiting admission (Hub HARU and Extended Rehabilitation Units only)	
Draft v6	St Helens Spoke ([redacted]/ [redacted]/ [redacted])	May 2016	Staff FFT monthly not quarterly	Yes ([redacted])
Draft v6	CRC Spoke ([redacted]/[redacted]/[redacted])	May 2016	Additional safety KPI for all inpatients units: - No. urgent DoLS applications not completed within 14 days	Yes ([redacted])
Draft v6	OVG Extended ([redacted]/[redacted])	May 2016	Quality KPIs: - Replace 'prescription/passport' with '24 hours care plan'	Yes ([redacted])
			Additional Safety KPIs: -No. safeguarding referrals	Yes ([redacted])
Draft v6	RCS ([redacted]/ [redacted])	June 2016	Performance KPIs: - Clarify definition of re-admission (inpatient) & re-referral (community)	Yes ([redacted])
			- Amend No. of working days referral to assessment by SPOC from 3 days to 2 working days	Yes ([redacted])
Draft v6	All Services	May-June 2016	Staff experience: to include frequency as per Trust Policy	Yes ([redacted])

SCHEDULE 2 – THE SERVICES

Specialist Rehabilitation Service Specification FINAL DRAFT V7 JULY 2016

Mandatory headings 1 – 4: mandatory but detail for local determination and agreement
Optional headings 5-7: optional to use, detail for local determination and agreement.
All subheadings for local determination and agreement

Service Specification No.	
Service	Specialist rehabilitation for patients with complex needs - Level 2 (Spoke Specialist Rehabilitation Unit) Level 3 (Extended Specialist Rehabilitation Unit) and Community Specialist Rehabilitation Services
Commissioner Lead	South Sefton CCG on behalf of all NHS Merseyside CCGs [redacted]
Contracts Lead	Liverpool CCG on behalf of all NHS Merseyside CCGs [redacted]
Provider Lead	The Walton Centre NHS Foundation Trust
Period	3 years (&2) April 2017 – March 2020 (2022)
Date of Review	Annually

1. POPULATION NEEDS

1.1 National/Local Context

This specification covers Level 2 (Spoke Specialist Rehabilitation Unit) Level 3 (Extended Specialist Rehabilitation Unit) and Community Specialist Rehabilitation Services for patients following traumatic injury or illness with complex needs regardless of diagnosis.

Rehabilitation is a process of assessment, treatment and management by which the patient, involving their family/carers, are supported to achieve their maximum potential for physical, cognitive, social and psychological function, participation in society and quality of living (3rd edition Specialised Services, National Defintion Set No.7 Brain Injury and Complex Rehabilitation) Patient goals for rehabilitation vary according to the recovery trajectory and stage of their condition.

Following traumatic injury or illness some patients will progress satisfactorily with the support of local non-specialist rehabilitation services. Those with more complex rehabilitation needs will require treatment and management by their locally delivered Level 2, 3 or community specialist rehabilitation services.

Specialist rehabilitation provided in the Spoke and Extended Specialist Rehabilitation Units and Community Specialist Rehabilitation Services is accessible for all patients with complex rehabilitation needs that cannot be met within local or non-specialist services.

Specialist rehabilitation should be provided based on need rather than diagnosis. Specialist rehabilitation is led /supported by a consultant trained and accredited in rehabilitation medicine (RM), and neuropsychiatry and clinical/neuro-psychology for

those with cognitive/behavioural rehabilitation needs, and delivered by an inter-disciplinary team (IDT) who has undergone specialist training in rehabilitation. Within a given geographical area there should be access to a range of Spoke, Extended and Community Specialist Rehabilitation Services including:

- Programmes for people with complex physical disability and /or cognitive behavioural needs.
- Programmes for patients with profound disability requiring very high level nursing /medical and/or therapy needs (eg those with tracheostomies or requiring assisted ventilation).
- Assessment /management of prolonged disorders of consciousness (PDOC).
- Specialist community integration / vocational rehabilitation programmes.
- Programmes for adolescents (16-18 year olds)

Patients may be more usefully described by their levels of impairment or disability or the complexity of their needs for rehabilitation (See Table1).

Table 1: Some of the conditions that commonly give rise to complex disability as classified by the Long Term Conditions National Service Framework

Sudden onset conditions	• **Acquired brain injury**, due to any cause including trauma, severe stroke, subarachnoid haemorrhage, meningitis, encephalitis, vasculitis, post-surgical, tumour, anoxia • **Spinal cord conditions** e.g. trauma with incomplete spinal cord injury, myelitis, myelopathy, vascular, tumour, combined brain/spinal cord injury • **Peripheral nervous system conditions** e.g. Guillane-Barre Syndrome, Neuropathy, chronic inflammatory demyelinating poly neuropathy (CIDP) • **Multiple trauma/ Polytrauma**
Progressive and Intermittent Conditions	• **Neurological and neuromuscular conditions** (e.g. multiple sclerosis, motor neurone disease, Huntington's disease, muscular dystrophies, neoplasm, inherited metabolic disorders) • **Severe musculoskeletal or multi-organ disease** (e.g. rheumatoid arthritis with neurological complications) • **Physical illness / injury** complicated by psychiatric or behavioural manifestations
Stable conditions (with/without degenerative change)	• **Congenital conditions** e.g. cerebral palsy or spina bifida in children or adults • **Post-polio or other previous neurological injury.** Many of these conditions may remain stable for years but subsequently progress with accrual of problems due to age-related change or other secondary complications.

1.2 The Evidence Base

There is now strong research based evidence to show that:

- Rehabilitation in specialist settings for people with traumatic injury or illness is effective and provides value for money in terms of reducing length of stay in hospital and reducing the costs of long-term care (3-5 see below for reference)
- Early transfer to specialist centres and more intense rehabilitation programmes are cost effective (6) the latter particularly in the small group of people who have high care costs due to traumatic injury or illness (7-8)
- Clinical and cost-benefits are similar for people with severe behavioural problems following brain injury (9)
- Continued co-ordinated multidisciplinary rehabilitation in the community improves long-term outcomes and can help to reduce hospital re-admissions (3).

Key Publications and References

1. National Definition Set for Specialised Services No 7: "Complex specialised rehabilitation for brain injury and complex disability (Adult)". Third Edition. London: Department of Health 2009.
2. Specialist neuro-rehabilitation services: providing for patients with complex rehabilitation needs. London: British Society of Rehabilitation Medicine 2010.
3. Turner-Stokes L, Nair A, Disler P, et al. Cochrane Review: Multi-disciplinary rehabilitation for acquired brain injury in adults of working age. The Cochrane Database of Systematic Reviews Oxford: Update software 2005; Issue 3.
4. Turner-Stokes L. Evidence for the effectiveness of multi-disciplinary rehabilitation following acquired brain injury: a synthesis of two systematic approaches. J Rehab Med. 2008;40(9):691- 701.
5. The National Service Framework for Long-term Conditions, Department of Health March 2005
6. Turner-Stokes L. The evidence for the cost-effectiveness of rehabilitation
7. 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. JNNP 2006; 77: 634- 639
8. Turner-Stokes L. Cost-efficiency of longer-stay rehabilitation programmes: Can they provide value for money? Brain Injury 2007 21(10):1015-21.
9. Oddy M and Ramos S. The clinical and cost-benefits of longer stay neurobehavioural rehabilitation. Brain Injury. in press 2013

2. OUTCOMES

2.1 NHS Outcomes Framework Domains & Indicators

Table 2: NHS Outcomes Framework Domains and Indicators for Specialist Rehabilitation Services

Domain 1	Preventing people from dying prematurely	
Domain 2	Enhancing quality of life for people with long-term conditions	x
Domain 3	Helping people to recover from episodes of ill-health or following injury	x
Domain 4	Ensuring people have a positive experience of care	x
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	x

2.2 Local Defined Outcomes

Spoke, Extended and Community Specialist Rehabilitation Services play an important role in providing the right level of rehabilitation, to the right patient, in the right place and at the right time. Specialist rehabilitation service provision also plays an important role on relieving pressure on acute services and facilitating timely and appropriate discharge.

Each Service will demonstrate quality and effective provision through the following:

- Adherence to Service Standards (Schedule 2 – Section B) as demonstrated by an Evidence Portfolio
- Performance against Key Performance, Quality and Safety Indicators (Schedule 2 –Sections C, D, and E) as demonstrated in quarterly performance reports

2.3 Key Outcome Measurement Tools

A range of tools have been developed by the UK Rehabilitation Outcomes Collaborative (UKROC) team for inpatient services to describe complexity of rehabilitation needs, the inputs provided to meet those needs, and the resulting outcomes. (N.B. Key outcome measurement tools for Community Specialist Rehabilitation Services are currently in development by the UKROC team. Providers will be required to collate and report on the agreed tools).

An agreed set of the following key outcome measurement tools will be completed by each Service to demonstrate improvement in function and outcome, patient reported outcome measures and patient reported experience measures:

- UKROC Functional Independence Measure (FIM) and Functional Assessment Measure (FAM)
- UKROC Categorisation Tool for identification of complexity of rehabilitation need
- UKROC Rehabilitation Complexity Scale (RCS)
- UKROC Neurological Impairment Set
- UKROC Northwick Park Nursing Dependency Scale (NPTDS)
- UKROC Northwick Park Therapy Dependency Scale (NPTDA)

- American Spinal Injury Association (ASIA) / Spinal Cord Independence Measure (SCIM)
- Identification of severity of risk
- Improvement in pain and pain management
- Quality of Life Survey (e.g. EQ5D)
- Patient Reported Outcome Measures
- Patient Reported Experience Measures (e.g. Patient Satisfaction Survey)

3. SCOPE

3.1 Key Service Aims and Objectives

- Provide equity of access through an inpatient, day case, outpatient and community rehabilitation service that meets the required standards for specialist rehabilitation
- Provide timely post-acute specialist active rehabilitation for individuals with complex to moderate rehabilitation needs who are recovering from a traumatic injury or illness to enable patients to achieve their maximum potential
- With an inter-disciplinary approach, provide a wide range of assessment and treatment modalities to meet patients' needs, including physical, emotional, cognitive, psycho-social and vocational interventions in line with best evidence. This will include medical, nursing and therapy
- Work as part of a wider multiagency team to provide integrated and coordinated care
- Provide tailored education and information to patients and their family/carers to support their rehabilitation pathway
- Act as a resource for advice to generic community rehabilitation teams in the management of complex disabilities
- Be pivotal in the development and delivery of staff education and training, audit, research and innovation for specialised rehabilitation across the pathway
- Empower patients and their family/carers in all aspects of planning and delivery of rehabilitation programmes
- Assess and identify specialist rehabilitation equipment required (e.g. specialist wheelchairs, electronic assistive technology)
- Participate in care planning, case conferences, best interest meetings and discharge planning meetings
- Play an important role in relieving pressure on acute services and facilitating discharge home or on-going placement

3.2 Population Covered

Patients registered with an NHS Merseyside, Wirral, Warrington, West Cheshire, South Cheshire, Vale Royal or North Wales GP/CCG's (see Table 3) who have a complex rehabilitation need and meet CMRN inclusion criteria (see Section 3.4).

Table 3: Commissioning Arrangements by Service Level

GP/CCG	Specialist Rehabilitation Service Level	Current Provider
NHS Merseyside GP/CCG	Spoke Specialist Rehabilitation Unit	Seddon Suite Specialist Rehabilitation Spoke Unit: St Helens and Knowsley Teaching Hospitals NHS Trust (St Helens Hospital site)
		The Phoenix Centre Specialist Rehabilitation Spoke Unit (Ward 5): Royal Liverpool and Broadgreen University Hospitals NHS Trust (Broadgreen Hospital site)
West Cheshire GP/CCG, South Cheshire GP/CCG, Vale Royal GP/CCG, North Wales GPs/BCHB	Spoke Specialist Rehabilitation Unit	Clatterbridge Rehabilitation Centre – Wirral University Teaching Hospital NHS Trust *(Funding to be confirmed)*
Warrington GP/CCG	Spoke Specialist Rehabilitation Unit	Sid Watkins Spoke – The Walton Centre NHS Foundation
NHS Merseyside GP/CCG	Extended Specialist Rehabilitation Unit	Oak Vale Gardens Extended Rehabilitation Unit: Partnerships in Care
St Helens GP/CCG, Knowsley GP/CCG	Community Specialist Rehabilitation Service	Bridgewater Community Healthcare NHS Trust
Liverpool GP/CCG, South Sefton GP/CCG, Southport and Formby GP/CCG	Community Specialist Rehabilitation Service	The Walton Centre NHS Foundation Trust

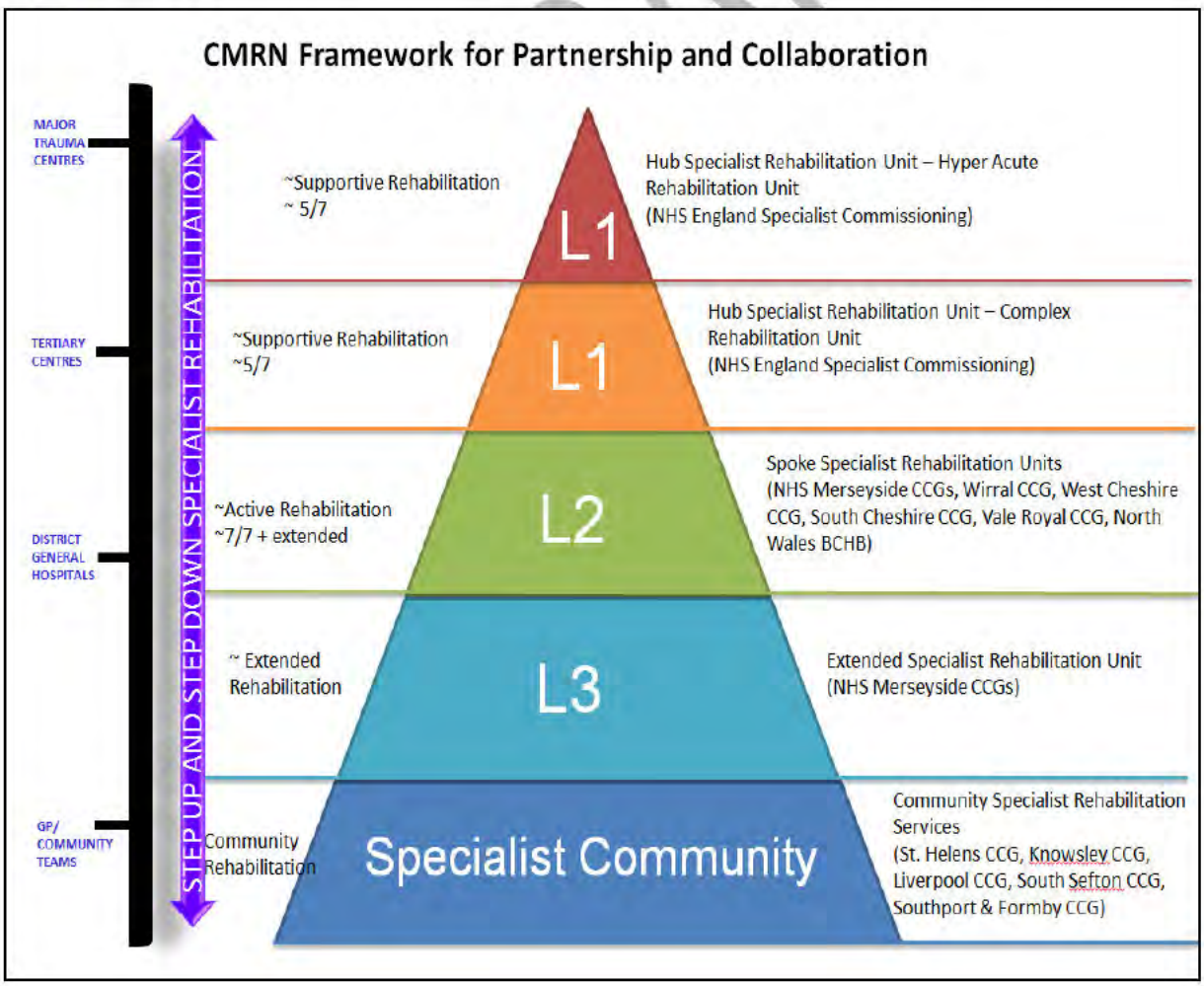
3.3 Service Description

Level 2 Specialist Rehabilitation Services are provided on a dedicated ward in the Spoke Rehabilitation Units. This is an inpatient service for patients who can tolerate active rehabilitation to enable them to reach their maximum goal potential.
This Service is led by a Rehabilitation Consultant.

Level 3 Extended Specialist Rehabilitation Services are provided on a dedicated ward in the Extended Rehabilitation Unit. This is an inpatient service for patients who require a longer term intervention to enable them to reach their maximum goal potential. The Service is supported through a medical model delivered by Rehabilitation Consultants and local General Practitioners.

Community Specialist Rehabilitation Services are provided in patient's own homes or in local community clinics for those patients who require a longer term intervention to enable them to reach their maximum goal potential. The Service is therapy led and will be supported through a medical model with access to/advice from a Rehabilitation Consultant.

Figure 1 below illustrates the Cheshire and Merseyside Rehabilitation Network collaborative pathway for patients with complex rehabilitation needs following traumatic injury or illness.



3.4 Criteria

Inclusion Criteria

- Registered with a NHS GP/CCG according to level of service provision (see Table 3)
- Adults 18 years and over
- Patients who: 1) have suffered a significant deterioration as a result of traumatic injury or illness, AND 2) have functional impairment or activity limitation, AND 3) have had a realistic assessment of (a) the likelihood of improvement, within the constraints of the medical prognosis and the degree/complexity of the functional impairment, and (b) the complexity of rehabilitation needs
- Patients are anticipated to be able and willing to participate and benefit from rehabilitation at the level of intensity
- Inclusion will not be diagnosis-specific but will based on the extent of the patient's rehabilitation needs (Spoke and Extended Rehabilitation)
- Inclusion will not be diagnosis-specific but will based on the extent of the patient's rehabilitation needs which will be to a level of complexity requiring 2 or more therapy disciplines from Physiotherapy, Occupational Therapy, Speech and Language Therapy, Neuro / Clinical Psychology and Vocational Rehabilitation. The rehabilitation programme required to achieve rehabilitation goals may be typically 6-12 months (Community Rehabilitation)

Exclusion Criteria

- Patients not registered with a GP/CCG identified in Table 3
- Patients under 18 years unless agreed under the criteria for individual case considerations
- Patients with little or no rehabilitation potential or the inability to engage in rehabilitation at this time following comprehensive assessment
- Patients with active severe mental health issues
- Patients with rehabilitation needs that can be met within existing well-established disease-specific rehabilitation services (e.g. stroke (excluding sub-arachnoid strokes where the patient has required neuro-surgical intervention), oncology) or system-specific rehabilitation services (e.g. intermediate care, transitional care).
- Uni-disciplinary referrals (Community Rehabilitation)
- Patients who are physically well with cognitive impairments only

Individual Case Considerations

Those patients whose needs and 'functional impairment', or limitation in ability to respond to rehabilitation is debatable. The following examples (not exhaustive list) are indications of where individual case considerations will be considered:

- Patients under 18 years (because of its effect on rehabilitation potential, and/or patient/societal expectations e.g. as advocated for young stroke patients)
- Where the complexities of functional deficit may favour the need for rehabilitation whilst an irresolvable co-morbidity may limit rehabilitation potential
- Patients who require rehabilitation in the context of their specialist treatment/specialist medical investigation/procedures but require management by Rehabilitative Consultants and can tolerate rehabilitation interventions
- Family/carer situation e.g. multiple members of one family requiring rehabilitation

3.5 Specialist Rehabilitation Care

3.5.1 Referral and Assessment

Referrals for inpatient specialist rehabilitation in the Spoke and Extended Specialist Rehabilitation Units are made by the referrer (e.g. Consultant/MDT or GP/Community Teams) to the Rehabilitation Co-ordination Service (CMRN Inpatient Referral Form).

Referrals for community specialist rehabilitation are made by the referrer (e.g. Consultant/MDT or GP/Community Teams) directly to the Community Service (CMRN Community Service Referral Form).

The Rehabilitation Prescription and Passport may be used as an adjunct to the referral.

Assessment should be completed within the agreed number of days as set out in the Service KPIs of the initial referral. It is best undertaken by a consultant in RM or their deputy from the IDT who is able to determine the category of rehabilitation need and has a good knowledge of the range of alternative rehabilitation and care service options available within the region.

Wherever possible assessment should also involve the patients' family/carer.

The outcome of the assessment should be reported back to the referrer. Assessment Reports will include:

- An evaluation of clinical need
- A recommendation of the specialist rehabilitation service level most likely to meet the assessed need (or signposting if the patient does not meet criteria)
- An indication of the ability to benefit from rehabilitation and possible outcomes
- Overview of aims of admission
- An indication of the likely duration of specialist rehabilitation
- An indication of potential discharge destination and care and support needs on discharge

Patients will be admitted to the Service identified as best to meet their needs within the agreed number of days as set out in the Service KPIs of being medically accepted for rehabilitation.

Local Clinical Commissioning Groups (CCGs) will retain overall funding responsibility for patients admitted to each service. CCGs will work proactively with Providers to support timely discharges and prevent delays to provide a positive patient experience.

3.5.2 Rehabilitation Programmes

Rehabilitation is a process of assessment, treatment and management where patients are supported to achieve their maximum potential for physical, cognitive, social, psychological and vocational function, participation in society and quality of life.

Rehabilitation is primarily offered as a time-limited programme in an appropriate rehabilitative environment (in-patient or community). Inpatient rehabilitation may also include associated activity such as:

- In-reach – review and triage for patients in acute care services awaiting transfer to specialised rehabilitation.
- Intermittent review/surveillance for specific groups of patients with highly complex needs e.g. patients in PDOC until either they emerge or a diagnosis of permanent Minimally Conscious Stage (MCS) is made.

Rehabilitation is a collaborative process between the rehabilitation IDT and the patient and family/carers. It is important that patients and their family/carers are involved and empowered in all aspects of the rehabilitation process (including assessment, goal setting and review, rehabilitation and discharge planning) in order that the rehabilitation itself is most effective on an individual basis; and the effectiveness of the service as a whole is optimised.

Each Service will be led by (Spoke)/ supported by (Extended) or have access to (Community) a Rehabilitation Consultant. The Inter Disciplinary Team (IDT) for each Service includes input from a range of health and social care professionals, including: Rehabilitation Consultants, Physiotherapists, Occupational Therapist, Clinical and Neuro Psychologists, Consultant Neuro-Psychiatrists, Mental Health Liaison Nurses, Speech and Language Therapists, Dieticians, Vocational Rehabilitation Therapists, Rehabilitation Co-ordinators and Social Workers who have undergone training in specialist rehabilitation. The team will work towards an agreed set of rehabilitation goals to assist patients to reach their maximum rehabilitation potential.

Effective IDT working should be in place including:

- Inter-disciplinary notes
- Combined goal setting, combined objectives and combined evaluation process
- Regular opportunities for inter-disciplinary training.

In each Service, all patients will receive an individualised specialist assessment and tailored management plan. Capacity will be regularly assessed and when appropriate Deprivation of Liberty Standards (DOLS) will be applied.

The initial assessment period will involve a goal setting meeting within 2 weeks of

admission and will include an outline of the goals agreed, an indication of the discharge date and destination, including anticipated needs on discharge. Progress against goals should be reviewed at least four weekly. Patient goals for rehabilitation vary according to the recovery trajectory and stage of their condition. Specialist rehabilitation services may be provided along three main (frequently overlapping) pathways:

- **Restoration of function** (e.g. for those recovering from a 'sudden onset' or 'intermittent' condition) where the patient goals are focussed not only on improving independence in daily living activities, but also on participatory roles such as work, parenting, etc.
- **Disability management** (e.g. for those with stable or progressive conditions) where the patient / family goals are focussed on maintaining existing levels of functioning and participation; compensating for lost function (e.g. through provision of equipment / adaptations); or supporting adjustment to change in the context of deteriorating physical, cognitive, and psychosocial function
- **Neuro-palliative rehabilitation** where the goals are focussed on symptom management and interventions to improve quality of life during the later stages of a progressive condition or very severe disability, at the interface between rehabilitation and palliative care.

Each Service will provide a combination of individual and group-based interventions to optimise clinical outcomes, support appropriate social interaction, communication, life and work skills and improve patient experience.

Spoke, Extended and Community Specialist Rehabilitation Services vary in their emphasis, but encompass some or all of the following elements:

- Medical care in the context of the individual's rehabilitation (including specialist procedures / investigations, and acute out-of-hours medical cover – depending on the caseload)
- Tracheostomy and / or ventilator care
- Assessment / management of PDOC, including medico-legal issues and support for families in extreme distress
- Cognitive and / or behavioural management, including challenging, aggressive or violent behaviours
- Neuropsychiatric Care, including identification and assessment of risk management and treatment under sections of the Mental Health Act 1983 as amended by the 2007 Mental Health Act
- Assessment and treatment of function and mobility
- Promoting motor function and control
- Promoting continence
- Management of sensory disturbance
- Communication and language interventions
- Cognitive, emotional and behavioural management
- Assessment and treatment for nutrition and hydration
- Maintenance of skin integrity and wound management
- Optimising performance in daily living
- Special facilities: assistive technology such as specialist seating systems,

orthotics, environmental control systems / computers or communication aids
- Specialist interventions e.g. spasticity management with botulinum toxin
- Surgical implants/interventions (e.g. intrathecal baclofen or follow-up procedures e.g. tenotomy, dorsal rhizotomy, deep brain stimulation) may be arranged in conjunction with the rehabilitation service subject to appropriate specific funding arrangements
- Specialist vocational rehabilitation services to support return to work or education
- Assessment and planning for leisure/recreational activities
- Provision of information, counselling and support for relatives
- Identification of onward referrals for specialist intervention
- Discharge planning (Depending on their ongoing rehabilitation need, patients may be transferred to another service level within the CMRN pathway or discharged home or to local service provision)

Clinical leads of each Service will facilitate the CMRN governance arrangements to provide a high quality, accessible, efficient and equitable rehabilitation service for patients across a co-ordinated pathway.

3.5.3 Discharge Planning and Reporting

Discharge planning should start immediately following IDT assessment within the Service. If the patient is to be discharged home, a home visit should be conducted as appropriate to establish access and equipment needs.

Equipment for on-going needs post-discharge is essential to ensure that the gains from specialist rehabilitation are carried over after discharge. CCGs should be informed of equipment needs as soon as they are identified. Service Providers and Commissioners will work closely together to ensure that the patients' needs for equipment are identified and needs are established and ordered as soon as provision and funding has been agreed. CCGs will be responsible for ensuring that essential equipment to meet on going needs for 24 hour positioning/ postural management in particular appropriate special seating, wheelchair, standing frame, pressure management etc. is provided in a timely manner to support discharge and avoid delayed discharges.

Prior to discharge, a discharge planning meeting should be organised involving the:
- Patient
- Family/Carer
- Treating Rehabilitation Clinical Team
- Rehabilitation Co-ordinator
- Specialist Rehabilitation Community Service as appropriate (i.e. when the patient will be receiving on-going rehabilitation)

Family/Carers should receive advice and/or training with respect to managing on-going needs as appropriate including:
- Physical Management: positioning, transfer methods, nutrition, continence management communication methods
- Communications needs
- Dealing with cognitive and behavioural problems

A comprehensive Discharge Report should be produced and given to the patient and a copy sent to the patients' GP, including:

- An evaluation of progress during rehabilitation, and continuing needs for intervention, equipment and care
- Summary reports from each discipline
- Anticipated future rehabilitation needs and recommendations for on-going care
- The role of the family/carers in future rehabilitation goals
- Specialist Rehabilitation Community Service as appropriate (i.e. when the patient will be receiving on-going rehabilitation)

3.6 Patient and Family/Carer Information

This should include:

- Up-to-date information about the Service
- Information about patient support groups relevant to patient diagnosis
- Information and advice about disability benefits as appropriate

Information should be provided in a variety of formats to enable it to be available to all who need it, including those with communication and cognitive difficulties.

3.7 Support for Family/Carers

This should include:

- individual and group support (including psychological support / counselling / psychotherapy)
- education relating to diagnosis and management of particular difficulties (physical /cognitive/ behavioural)
- support in considering their own role vis-à-vis other (paid) care and support services
- support with developing coping strategies

3.8 Interdependence with Other Services/Providers

Specialised Rehabilitation Services share service co-dependencies with a number of specialities, services and providers, including:

- Imaging and Diagnostic Services
- Adult Neurosurgery
- Neurosciences
- Major Trauma
- Critical Care
- Spinal Injury
- Burns Care
- Complex Disability Equipment
- Specialist Rheumatology
- Specialist Pain
- Specialist Orthopaedic Services
- Specialist Mental Health Services
- Specialist Equipment Services

- Acute emergency medical and surgical cover out of hours
- Expertise from other medical specialties including neurology, neurosurgery, neuropsychiatry, stroke services, cardiovascular services, PEG and tracheostomy services, trauma and orthopaedics, maxillary facial services, paediatrics
- Voluntary Sector
- Continuing Health Care
- Local Authorities
- Patient Support Groups

This is not an exhaustive list.

3.9 Education and Training

Clinical leads of each Service will support the development of clinical competencies. Profession specific training and on-going professional support in rehabilitation assessment and therapeutic techniques across the patient pathway will be provided.

Dedicated time will be allocated to Network staff to enable them to attend relevant training and education sessions and service and personal development opportunities.

Clear policies should be in place to ensure that staff maintain and develop their specialist skills and knowledge which should include access and time to attend specialist rehabilitation education/training and conferences.

3.10 Clinical Audit and Research

Each Service will have an active clinical audit programme and be able to demonstrate that they are working towards the implementation of the service standards (see Sections B and C).

Each Service will play an important role in research and innovation to support continuous development of specialist rehabilitation and the evidence base.

Audit, research and innovation is to be included in Network staff personal development reviews (PDRs) to support personal and service development.

4. GENERAL INFORMATION

4.1 Governance

This contract is let under a lead provider model. Under this model, the commissioners enter into a contract with a provider (the prime contractor or lead provider). That contract allocates risk and reward as between the commissioner and the Lead Provider. The lead provider then sub-contracts specific roles and responsibilities (and allocates risk associated with their performance) to other providers. The lead provider remains responsible to the commissioners for the delivery of the entire service, and for the co-ordination of its 'supply chain' (ie its sub-contractor providers) in order to ensure that it can and does deliver that entire service.

Each Service Provider will ensure that the service is integrated and managed in line with the Trusts corporate and clinical governance systems. The Service Provider must ensure that the principles of good clinical governance are applied in order to deliver optimum quality of care. The essential standards of quality and service delivery set out by the Care Quality Commission must be adhered to. Providers will be expected to have systems and mechanism in place to ensure that compliance is maintained. Any potential or actual area of non-compliance must be reported to the lead provider and lead commissioner (See NHS standard contract- General Conditions).

The Lead Commissioner will hold three-monthly contract review meetings with the Lead Provider, and three monthly quality review meetings. These meetings will consider the areas set out in part GC 8 of NHS Standard Contract 2015/16 [1]General Conditions.

The Lead Provider will hold monthly contract review meetings with each of the sub-contracted providers, these will cover the areas set out in the NHS contract, general conditions (as above).

Terms of reference will be agreed within one month of the award of the contract. Sample terms of reference are included in Appendix 1.

4.2 Freedom of Information Act (FOIA)

The Services will recognise that they are subject to legal duties which may require the release of information under FOIA or the Environmental Information Regulations 2002 or any other applicable legislation or codes governing access to information ("Access Duties") and that we may be under an obligation to provide information on request. Such information may include matters relating to arising out of or under this Agreement.

Notwithstanding anything in this Agreement to the contrary including, but without limitation, the general obligation of confidentiality imposed on the parties to this Agreement, in the event that we receive a request for information under our Access Duties, we shall be entitled to disclose all such information and documentation (in whatever form) as we are obliged to disclose under our Access Duties. In respect of any disclosure under our Access Duties, we shall advise you of the intention to disclose the information, prior to such disclosure being made.

The providers will be responsible for determining whether information is exempt from disclosure under FOIA and for determining, in our absolute discretion, the information to be disclosed in response to a request for information.
The Service will assist us in complying with our obligations under our Access Duties. In the event that we receive a request for information under our Access Duties and require your assistance in obtaining the information that is subject to such request or otherwise, you will respond to any such request for assistance from us at your own cost and promptly and in any event within 10 days of receiving our request.

[1] To be replaced with 2016/17 when published.

If at your request we seek to rely upon a FOIA exemption, you shall indemnify us for any costs including but not limited to responding to information notices or lodging appeals against a decision of the Information Commissioner.
The providers shall not be liable for any loss, damage, harm or other detriment however caused arising from the disclosure of any information relating to this Agreement, which we are obliged to disclose under our Access Duties.

4.3 Records & Information Sharing

The Service must compile and maintain such information as the provider may reasonably require enabling us to submit to government bodies any information or data required by them for the purposes of evaluating the Performance Returns. In specifying the information to be compiled and maintained for this purpose we will have regard to any directions, guidance and deadlines that the provider may issue.

The Service must make available to the lead provider the information required (Quality Assurance, Monitoring and Evaluation) at quarterly intervals or if stated otherwise

In addition, at the commissioner/lead providers request you must provide us with such information which we may require for the purpose of assessing how you are carrying out your obligations under this Agreement and the safety and welfare of the staff and patients; including:-
Any information (including original contracts, invoices, receipts, credit notes, vouchers, statements and books) relating to your claim(s) for Payment. Providers should ensure they comply with all NHS standards regarding information governance, data protection and information sharing protocols.

5. APPLICABLE SERVICE STANDARDS

5.1 Applicable National Standards (eg NICE)

N/A

5.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

Service Standards for Inpatient Spoke and Extended Specialist Rehabilitation Services (Section B) and Community Specialist Rehabilitation Services (Section C) include: Facilities; Operational Requirements; Workforce; Multi-Disciplinary Training and Education and Training; and Audit, Research and Innovation.

Standards have been drawn from nationally recognised policies, recommendations and guidelines, including: (1) Royal College of Physicians & British Society of Rehabilitation Medicine (2010); (2) British Society of Rehabilitation Medicine & National Service Framework for Long Term Conditions (2009); (3) The Francis Inquiry (2013); The Berwick Report (2013).

5.3 Applicable local standards

Where gaps in standards exist consensus has been reached by the Cheshire and Merseyside Rehabilitation Network.

6. APPLICABLE QUALITY REQUIREMENTS AND CQUIN GOALS

6.1 Applicable Quality Requirements

- Spoke Specialist Rehabilitation Unit (see Section C)
- Extended Specialist Rehabilitation unit (see Section D)
- Community Specialist Rehabilitation Service (see Section E)

6.2 Applicable CQUIN goals (TBC) CHRISSIE please advise

7. LOCATION OF PROVIDER PREMISES

The Provider's Premises are located at:

Spoke Specialist Rehabilitation Units:

- Seddon Suite Specialist Rehabilitation Spoke Unit: St Helens and Knowsley Teaching Hospitals NHS Trust (St Helens Hospital site)
- The Phoenix Centre Specialist Rehabilitation Spoke Unit (Ward 5): Royal Liverpool and Broadgreen University Hospitals NHS Trust (Broadgreen Hospital site)
- Sid Watkins Spoke: The Walton Centre NHS Foundation (Sid Watkins Hospital site)
- Clatterbridge Rehabilitation Centre: Wirral University Teaching Hospital NHS Trust (Clatterbridge Hospital site)

Extended Specialist Rehabilitation Units:

- Oak Vale Gardens Extended Rehabilitation Unit: Partnerships in Care

Community Specialist Rehabilitation Servives:

- Bridgewater Community Healthcare NHS Trust
- The Walton Centre NHS Foundation Trust

8. INDIVIDUAL SERVICE USER PLACEMENT

N/A

SCHEDULE 2 – THE SERVICES

A. Service Standards – Spoke (Level 2) and Extended (Level 3) Specialist Rehabilitation Units and Community Specialist Rehabilitation Services

	SERVICE STANDARD	Spoke Unit	Extended Unit	Community Service
1.	**FACILITIES**			
1.1	* Inpatient beds must be located together on a single site	✓	✓	x
	* Sufficient space and layout accessible for patients requiring wheelchairs	✓	✓	✓
	* Secured access to meet the requirements of patients who as a result of accident/injury are disorientated	✓	✓	✓
	* Bays to have no more than four beds compliant with single sex regulations	✓	x	x
	* Some single room accommodation is required	✓	✓	✓
	* Recreational area, IT equipment and software for patient use	✓	✓	✓
1.2	* Physiotherapy gymnasium and facilities	✓	✓	✓
	* Occupational therapy facilities including Activities of Daily Living (ADL) environment	✓	✓	x
	* Facilities and equipment for individual treatment	✓	✓	✓
	* Designated outpatient area for Therapists, Rehabilitation Consultants	✓	✓	✓
1.3	Facilities for team meetings and case conferences	✓	✓	✓
	Office space for Rehabilitation Consultant and secretary	✓	x	x
	Office space for Community Team	x	x	✓
1.4	Appropriate supply/access of unit equipment e.g. wheelchairs/electric powered wheelchairs, other postural support equipment, communication aids, pressure relief equipment, manual handling equipment, and equipment to meet bariatric needs	✓	✓	✓

	SERVICE STANDARD	Spoke Unit	Extended Unit	Community Service
2.	**OPERATIONAL REQUIREMENTS**			
2.1	* Rehabilitation Consultant led service with named designated lead for the rehabilitation unit	✓	x	x
	* Weekly Rehabilitation Consultant led ward rounds	✓	✓	x
	* Clear identification of nursing and therapy leads (as appropriate) to ensure accountability and linkages with other services	✓	✓	x
	* Rehabilitation Consultant led unit (supported by middle grade/SPR and SHO) between 9:00 to 17:00	✓	x	x
	* Rehabilitation Consultant and Middle Grade/SpR on-call on a rota basis between 17:00 and 09:00 hours,	✓	x	x
	* Appropriately trained medical team available 24/7	✓	✓	x
	* GP led service with support and access to a Rehabilitation Consultant	x	✓	✓
	* Covers a population of >1 million patients, therefore requires collaborative commissioning	x	x	x
	* It covers an extended catchment population (600K-1m).	✓	✓	✓
	* Registered with the UKROC and contributes the full UKROC dataset for every patient enrolled for treatment within the rehabilitation programme under the specialist commissioning programme	✓	x	x
2.2	* All new admissions should be assessed by a medic on the day of admission and seen by a middle grade or Consultant within 24 hours of admission;	✓	x	x
	* All new admissions should be assessed by a fully qualified nurse on the day of admission and seen by GP/ Rehabilitation Consultant within 5 working days of admission;	✓	✓	x
	* All admitted patients will be under a named Rehabilitation Consultant who is responsible for the management of their on-going care and rehabilitation	✓	✓	x
	* Medical, Nursing and Therapy initial assessments must commence within 24-48 hours of patient admission/ community assessment and completed within one week	✓	✓	✓
	* Rehabilitation commences within the first 24-48 hours of patient admission/ community assessment and matches the severity and complexity of the patients rehabilitation needs	✓	✓	✓
	* Access to specialist intervention (e.g. surgery, orthopaedics) as and when required	✓	✓	✓
	* All appropriate referrals for clinical investigations to be undertaken within 48 hours in the first instance, subject to review (e.g. diagnostics, imaging, radiology, haematology/laboratory services)	✓	✓	✓
2.3	* Every patient has an agreed inter-disciplinary team rehabilitation programme	✓	✓	✓
	* Inter-disciplinary team rehabilitation goals are set and with the patient and family/carers and updated throughout the patients rehabilitation programme at four weekly goal setting meetings	✓	✓	✓
	* Vocational rehabilitation (VR) screening, general advice and signposting (VR Level 1 and 2) is provided by Occupational Therapy and Psychology	✓	✓	✓
	* VR specialist intervention (VR Level 3) is provided by a VR Therapist with measured educational/work related outcomes	✓	✓	✓
2.4	* Clearly defined times for provision of IDT services and its members are available and adhered to (e.g. including extended hours and weekends)	✓	✓	✓
	* Inpatient inter-disciplinary team meetings should occur at least weekly, and led by the Rehabilitation Consultant	✓	✓	✓
2.5	* Full handover of care should be provided when transferring responsibility for on-going rehabilitation (pathway transfers)	✓	✓	✓
	* Inter-disciplinary team Discharge/Passport Report should be provided for all transfers/discharges within 24 hours	✓	✓	✓
2.6	Governance arrangements should include:			
	* Use of Rehabilitation Network policies	✓	✓	✓
	* Use of local Trust specific policies	✓	✓	✓
	* Compliance with all relevant national and NICE Guidelines	✓	✓	✓
	* Reporting of Critical Incidents (Datix) and process in place for lessons learned	✓	✓	✓
	* Measurement of quality and patient outcomes against agreed clinical standards	✓	✓	✓
	* All professionals must adhere to their own professional body code of conduct and professional standards	✓	✓	✓
	* Attendance at monthly Rehabilitation Network Operational Committee meetings to inform, participate in, and action to support continuous service developments	✓	✓	✓
	* Attendance at Rehabilitation Network meetings/workshops to inform, participate in, and action to support continuous service developments	✓	✓	✓
	* Rehabilitation Network staff to identify and action opportunities to promote Network activities and share good practice with internal and external stakeholders	✓	✓	✓
2.7	Submission of full data set:			
	* UKROC Database	✓	x	x
	* Rehabilitation Network Database	✓	✓	✓
	* Evidence of clinical case review, audit and clinical research	✓	✓	✓

	SERVICE STANDARD	Spoke Unit	Extended Unit	Community Service
3.	**WORKFORCE**			
3.1	Rehabilitation Consultants:			
	* A minimum of 1 WTE Consultants accredited in rehabilitation medicine	✓	x	x
	* Rehabilitation Consultants should be experienced and qualified to meet the requirements of the post and complexity of patients	✓	✓	✓
	* All medical staff must cooperate with the Trust appraisal and revalidation process	✓	✓	✓
	* Rehabilitation Consultants should have dedicated PAs per week to include inpatient rehabilitation, outpatient, day-case patientsand community related to rehabilitation network, education, training, research, audit and innovation	✓	✓	x
	* Rehabilitation Consultants should have a paid on-call rota	✓	✓	x
	* During working hours, the Rehabilitation Consultants should spend the majority of time on the Unit and must be immediately available on the Unit	✓	x	x
3.2	SPRs:			
	* A minimum of 1 WTE specialist trainee (SPR) Trust Grade Doctor or equivalent	✓	x	x
	* SPRs should be experienced and qualified to meet the requirements of the post and complexity of patients	✓	x	x
	* SpRs should be part of the Medical Clinical Team and assigned to the Rehabilitation Network (i.e. Hub and Spoke Units) full time with no cross cover to other areas	✓	x	x
	* All specialist trainee medical staff must be working towards specialist training in rehabilitation medicine	✓	x	x
	* Locum medical cover for SPR level doctors will be managed as a team approach by the hub (at a standard and quality for rehabilitation)	✓	x	x
	* For unexpected leave of SPR staff (longer than 2 weeks) this will be managed by the hub and will be authorised by the medical director	✓	x	x
3.3	Junior Doctors:			
	* A minimum of 1 WTE training grades	✓	x	x
	* Junior doctors must be experienced and qualified to meet the requirements of the post and trained to the equivalent of the foundation level	✓	x	x
	* A Network training programme run by the Rehabilitation Consultants should provide additional training for junior doctors and SPR staffing on aspects of specialist rehabilitation	✓	x	x
3.4	Nursing:			
	* A minimum staffing ratio of 1 WTE Qualified Nurse to 8 patients (Francis and Berwick Reports)	✓	✓	x
	* All qualified Nurses should be trained in rehabilitation	✓	✓	x
	* All nursing staff should be qualified and experienced to meet the requirements of the post and complexity of patients	✓	✓	x
	* Health Care Assistants should be appropriately trained to support and assist nursing staff in all aspects of care	✓	✓	x
3.5	Physiotherapy:			
	* A minimum 1 WTE qualified Physiotherapists per 5 beds	✓	✓	x
	* Physiotherapists should be qualified and experienced to meet the requirements of the post and complexity of patients	✓	✓	✓
	* Trained Therapy Assistants or Rehabilitation Assistants should be appropriately trained to support and assist with therapeutic handling at the earliest point of rehabilitation and appropriate rehabilitation programmes	✓	✓	✓
	* Physiotherapists should have the appropriate skills and expertise to initiate active/extended/ongoing rehabilitation programmes to meet the patients' needs	✓	✓	✓
	* Respiratory physiotherapy out of hours cover should be sufficient to meet demand	✓	✓	✓

	SERVICE STANDARD	Spoke Unit	Extended Unit	Community Service
3.6	Occupational Therapy:			
	* A minimum 1 WTE qualified Occupational Therapist per 5 beds	✓	✓	x
	* Occupational Therapists should be qualified and experienced to meet the requirements of the post and complexity of patients	✓	✓	✓
	* Occupational Therapy Assistants or Rehabilitation Assistants should be appropriately trained to support and assist with therapeutic handling at the earliest point of rehabilitation	✓	✓	✓
	* Occupational therapy staffing should be sufficiently trained to provide specialist assessments and treatment (e.g. cognitive assessments and treatments, SMART assessments, static seating assessments)	✓	✓	✓
	* Occupational Therapists should have the appropriate skills and expertise to initiate active/extended/ongoing rehabilitation programmes to meet patients need	✓	✓	✓
	* Occupational therapy staff should be appropriately trained to provide screening, general advice and signpost patients regarding vocational rehabilitation needs	✓	✓	✓
3.7	Vocational Rehabilitation Therapy:			
	* Minimum staffing levels for Vocational Rehabilitation (VR) Therapists are currently under review to meet patients needs in the hub, spoke, extended and community services	✓	✓	✓
	* VR Therapists should be qualified and experienced to meet the requirements of the post and complexity of patients	✓	✓	✓
	* VR Therapists should be appropriately trained to assess and identify patients VR work or educational needs and liaise with educational establishments, employers (e.g. Managers, Occupational Health) and benefits agencies	✓	✓	✓
	* VR Therapists should be appropriately trained to identify patients need for psychological assessment and management and signpost to the Network psychologists	✓	✓	✓
3.8	Speech and Language Therapy:			
	* A minimum of 1.5 - 2 WTE Speech and Language Therapists (SaLTs) per 20 beds	✓	✓	x
	* SaLTs should be qualified and experienced to meet the requirements of the post and complexity of patients	✓	✓	✓
	* SaLTs should be appropriately trained in dysphagia and dysphasia management	✓	✓	✓
	* SaLTs should work/train rehabilitation staff and families in appropriate communication techniques and aids for those with communication difficulties	✓	✓	✓
3.9	Dietetics:			
	* A minimum of 0.75 - 1 WTE Dietitians per 20 beds to ensure nutritional assessment/reassessment is carried out within 48 hours of admission, provide weekly review and training, and provide support to nursing staff to ensure optimal patient management	✓	✓	x
	* Dietetians should be qualified and experienced to meet the requirements of the post and complexity of patients	✓	✓	x
	* Dietitians should be appropriately trained in managing patients with dysphagia and/or risk of malnutrition to maintain optimal nutrition and hydration	✓	✓	x
3.10	Other Ward Staff:			
	* Housekeeping staff should be of sufficient numbers to ensure a good standard of environmental maintenance, hygiene standards and to support bed utilisation	✓	✓	x
	* Clerical staff should be of sufficient numbers to provide dedicated provision to the Rehabilitation Spoke and Extended Units to facilitate admissions, transfer and discharge processes including booking of transport	✓	✓	x

	SERVICE STANDARD	Spoke Unit	Extended Unit	Community Service
3.	**WORKFORCE**			
3.11	Rehabilitation Co-ordinator: * A mimimum of 1 WTE Rehabilitation Co-ordinator (RC) per inpatient beds/ community case load * RCs should be a Registered General Nurse (RGN) or a registered Allied Health Professional (AHP) experienced and qualified to meet the requirements of the post and complexity of the patients * RCs will be a key point of contact for patients, families/carers and the inter-disciplinary team	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓
3.12	Single Point of Contact: * Each inpatient service will have access to a Single Point of Contact (SPOC) to facilitate timely management of inpatient referrals and admissions, including bed management (e.g. waiting times, supporting timely and appropriate pathway transfers and discharges) * The SPOC should be qualified and experienced to meet the requirements of the post and complexity of patients * The SPOC should be an RGN or registered AHP * The SPOC will be the key point of contact for referrers, patients, families/carers and the inter-disciplinary teams * Where patients do not meet the Rehabilitation Network Criteria for inpatient admission the SPOC will provide advice and signpost as appropriate	✓ ✓ ✓ ✓ ✓	✓ ✓ ✓ ✓ ✓	× × × × ×
3.13	Social Worker: * A mimimum of 0.5 WTE Social Worker (SW) per 20 beds to identify issues early, support and facilitate complex discharges and packages of care * The SW will have appropriate qualifications and be experienced and qualified to meet the requirements of the post and complexity of patients * The SW will work with patients, their families/caerers and as part of the inter-disciplinary team to identify early on complex discharge needs * The SW will liaise with external stakeholders to support and facilitate timely discharges and prevent delays in discharge	✓ ✓ ✓ ✓	✓ ✓ ✓ ✓	× × × ×
3.14	Discharge Co-ordinator: * A mimimum of 1 WTE Discharge Co-ordinator (DC) for network inpatient beds to identify issues early, support and facilitate complex discharges and packages of care * The DC will be a RGN or registered AHP and will be experienced and qualified to meet the requirements of the post and complexity of patients * The DC will work with patients, their families/caerers and as part of the inter-disciplinary team to identify early on complex discharge needs * The DC will liaise with external stakeholders to support and facilitate timely discharges and prevent delays in discharge	✓ ✓ ✓ ✓	✓ ✓ ✓ ✓	× × × ×
3.15	Clinical Psychology and Neuropsychology: * A minimum of 1 WTE qualified Psychologist per 20 bedded rehabilitation unit, with support from Assistant Psychologists who work under the supervision of the qualified clinician * A minimum of 4 WTE qualified Psychologist in Community Services (per 1 million population), with support from Assistant Psychologists who work under the supervision of the qualified clinician * Qualified Psychologists and Assisant Psychologists should be qualified and experienced to meet the requirements of the post and complexity of patients * Specialist clinical psychological supervision and complex care work is allocated to the Consultant Psychologist who is registered with the HCPC and British Psychological Society (BPS) * Specialist neuropsychological supervision is provided by the Consultant Neuropsychologist on the specialist register for Neuropsychologists, also regsitered with HCPC and BPS * All qualified Psychologists are professionally registered with Health and Care Professions Council (HPC) and follow appropriate code of practice/conduct * Access to specialist Neuropsychology across Hub, Spoke and Community Service * Clinical Neuropsychology services to be led by Consultant Neuropsychologist, with clinical experience in assessment and rehabilitation * Clinical Neuropsychology should be provided by those with appropriate training and experience. Band 7 and 8a psychologists should be working toward further qualification in Neuropsychology * Staff offering Neuropsychological input should have access to clinical supervision by a Consultant Clinical Neuropsychologist, with a Qualification in Clinical Neuropsychology (QiCN) and membership of the Specialist Register of Clinical Neuropsychologists * Clinical Neuropsychology to form part of the minimum set of a clinical MDT, including input into MDT treatment and care plans	✓ × ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓	✓ × ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓	× ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓
3.16	Neuropsychiatry: * A minimum of 0.4 WTE Consultant Neuropsychiatrist for the Network Hub and Spoke Units *A mimimum of 0.2 WTE Mental Health Liaison Nurse per Spoke unit and 0.6 WTE in the Hub Units * Consultant Neuropsychiatrist and Mental Health Liaison Nurse should be qualified and experienced to meet the requirements of the post and complexity of patients * Mental Health Liaison Nurse to be available to give telephone advice as and when required when not on site * Consultant Neuropsychiatrist to jointly review patients on Spoke Units with Mental the Health Liaison Nurse as and when required * Consultant Neuropsychiatrist and Mental Health Liaison Nurse to lead and facilitate staff education and training relating to mental health management	✓ ✓ ✓ ✓ ✓ ✓	× × × × × ×	× × × × × ×

	SERVICE STANDARD	Spoke Unit	Extended Unit	Community Service
4.	**TRAINING AND EDUCATION & AUDIT, RESEARCH AND INNOVATION**			
4.1	* All staff to be allocated dedicated time to access Rehabilitation Network Training and Education and service and personal development opportunities	✓	✓	✓
	* Rehabilitation Consultant, Nursing, Therapy, Clinical and Neuro-Psychology and Neuropsychiatry Leads should identify and establish opportunities for staff in service training, individual staff support and provide induction programme for all new starters	✓	✓	✓
4.2	* All staff should have the opportunity to participate to undertake clinical audit, research and innovation activities and be allocated dedicated time.	✓	✓	✓
	* Audit, research and innovation is to be included in Rehabilitation Network staff Personal Development Reviews (PDRs) to support personal and service development	✓	✓	✓
	* Each Service will have an active clinical audit programme and be able to demonstrate that they are working towards the implementation of the service specification standards	✓	✓	✓
	* Each Service will undertake research and innovation activities to support continuous development of specialist rehabilitation and the evidence base	✓	✓	✓

SCHEDULE 2 – THE SERVICES

B. Inpatient Spoke Specialist Rehabilitation Unit (Level 2)
Key Performance, Quality and Safety Indicators

Theme	Indicator/Target	Threshold	Description and Measure	National/Local
Performance - Responsive and Effective	No. of Referrals for inpatient spoke rehabilitation meeting criteria	50%	Referrals for inpatient spoke rehabilitation meeting criteria for acceptance onto the unit to ensure that admissions are appropriate	Local
Performance - Responsive and Effective	No. of Referrals for inpatient spoke rehabilitation not meeting criteria	50%	Referrals for inpatient spoke rehabilitation not meeting criteria for acceptance onto the unit. These are monitored and advice given to referrers. Threshold to be set based on 2016-17 data then revised annually	Local
Performance - Responsive and Effective	Waiting Times - 14 days referral to admission	95%	Patients who are assessed as medically fit for rehabilitation. 95% of patients must be admitted within 14 days. Threshold set locally based on the level at which it is deemed the Units would be able to continue running services without significant problems.	Local
Performance - Responsive and Effective	No. of Inpatient Admissions v Plan	Within 20% of unit target.	Monitors admissions against contractual target by CCG	Local
Performance - Responsive and Effective	Maxmimum Length of Stay	Category A: 98 days (14 weeks), Category B: 84 days (12 weeks)	Length of stay is the time from admission to discharge in days. This is to monitor progress against forecast length of stay to improve operational efficiency, patient experience and safety.	Local
Performance - Responsive and Effective	Bed occupancy	90%	Monitors the Units occupancy, being an indicator of both operational effectiveness and potential risks to service provision. Threshold based on 90% as it is deemed this level would be manageable but any more would be a concern.	Local
Performance - Responsive and Effective	No. of Discharges	TBC	Monitors the Units overall discharges, being an indicator of both operational effectiveness, patient experience and potential risks to service provision.	Local
Performance - Responsive and Effective	Delayed rehabilitation pathway transfers	0%	A delayed transfer of care occurs when a patient has completed their rehabilitation goals in the current setting and is ready for transfer to the next rehabilitation service level in the pathway, but is still occupying a bed. A patient is ready for transfer when a clinical decision has been made by the MDT that the patient is medically fit and safe to transfer. Monitors length of delay, reason and CCG	Local
Performance - Responsive and Effective	Delayed Discharges	TBC	A delayed discharge of care occurs when a patient is ready for discharge from an inpatient hub/spoke/extended rehabilitation bed, but is still occupying a bed designated for such care. A patient is ready for discharge when a clinical decision has been made by the MDT that patient is medically fit and safe for discharge. Monitors length of delay, reason and CCG	Local
Performance - Responsive and Effective	Referral to assessment 2 working days	100%	Monitors service efficiency in referral to assessment to identify patient level of rehabilitation	Local
Performance - Responsive and Effective	Rehabilitation Complexity Score (>10)	(>=) 50%	The RCS is used as a measure of outcome but also as a proxy of needs for rehabilitation intervention. It records the level of care, nursing, therapy and medical needs of the patient and is recorded for all patients on the Units as part of the multi-disciplinary rounds.	National
Performance - Responsive and Effective	Rehabilitation Categorisation A	(>=) 50%	The Rehabilitation Categorisation Tool is used as a measure of outcome but also as a proxy of needs for rehabilitation intervention. It identifies the level of care, nursing, therapy and medical needs of the patient and is recorded for all patients on admission to the Units.	National
Performance - Responsive and Effective	Clinical Interruptions in days	Maximum 14 days	Monitors the total number of clinical interruptions, length of interruption, reason, mode (planned, unplanned or emergency) and transferring hospital/ward. Measures patient complexity and service effecteiveness	Local
Performance - Responsive and Effective	No. of re-admissions	TBC	Number of patients with an emergency re-admission within 28 days of original discharge date and reason why. Measures service effectiveness. Threshold to be set based on 2016-17 data then revised annually	National

Theme	Indicator/Target	Threshold	Description and Measure	National/Local
Quality - Caring and Experience	Percentage of admitted patients receiving a comprehensive inter-disciplinary rehabilitation assesssment	100%	Percentage of admitted patients receiving a comprehensive multi-disciplinary rehabilitation assesssment	National
Quality - Caring and Experience	Percentage of patients with a rehabilitation inter-disciplinary team discharge/passport summary within 24 hours following discharge	95%	Percentage of patients with a rehabilitation multidisciplinary team discharge/passport summary	Local
Quality - Caring and Experience	Percentage of admitted patients requiring vocational rehabilitation advice/signposting as appropriate (Level 1 & Level 2)	100%	Measures service effectiveness and capacity	Local
Quality - Caring and Experience	Percentage of admitted patients requiring specilaist vocational rehabilitation management and measurement of outcome on discharge (Level 3)	100%	Measures service effectiveness and capacity	Local
Quality - Caring and Experience	Percentage of admitted patients with a named Rehabilitation Co-ordinator	100%	All patient will have a named co-ordinator throughout their stay.	Local
Quality - Caring and Experience	No. of Complaints	TBC	Measures No. of complaints - Threshold to be set based on 2016/17 data then revised annually to show year on year reduction. Themes to be collated and reported. Threshold to be set based on 2016-17 data then revised annually	Local
Quality - Caring and Experience	No. of Compliments	N/A	Measures service effectiveness	Local
Quality - Caring and Experience	Percentage of patients reported very satisfied with overall rehabilitation experience	75%	Measures patient satisfaction	Local
Quality - Caring and Experience	Percentage of patients who would recommend the service (Friends and Family Test)	75%	Measures patient and family/carer satisfaction	National
Quality - Well led	Expected Date of Discharge is set within 10 working days of admission	100%	Measures service effectiveness and responsiveness	Local
Quality - Well led	UKROC Data Completeness	Fully Compliant	Measures compliance against UKROC standards	Local
Quality - Well led	Percentage of agency staff: Medical, Nursing and Therapy	TBC	Measurement of agency staffing by discipline WTE	Local
Quality - Well led	No. of vacancies: Medical, Nursing and Therapy	TBC	Measurement of vacancies by discipline WTE	Local
Quality - Well led	Absence - sickness	TBC	Measurement of sickness	Local
Quality - Well led	Staff - Friends and Family Test (Response Rate)	TBC	Measurement of staff satisfaction. Frequency as per Trust policy	Local
Quality - Well led	Staff - Friends and family Test (Care / Treatment)	TBC	Measurement of staff satisfaction. Frequency as per Trust policy	Local
Quality - Well led	Staff - Friends and Family Test (Place to work)	TBC	Measurement of staff satisfaction. Frequency as per Trust policy	Local

Theme	Indicator/Target	Threshold	Description and Measure	National/Local
Safety	No. of adverse and near miss incidents investigated and actions taken	TBC	Measures patient and staff safety on the Unit - Threshold to be set based on 2016/17 data then revised annually	Local
Safety	No. of Patient Falls with minor harm (cuts bruises)	TBC	Measures patient safety on the Unit- Threshold to be set based on 2016/17 data then revised annually	Local
Safety	No. Patient Falls Causing moderate, major or catastrophic harm	0	Measures patient safety on the Unit	Local
Safety	No. of Pressure Ulcers (Grade 2)	TBC	Measures patient safety on the Unit- Threshold to be set based on 2016/17 data then revised annually to show year on year reduction	Local
Safety	No. of Pressure Ulcers (Grade 3 & 4)	0	Measures patient safety on the Unit	Local
Safety	Nutrition (MUST) Risk Assessment <12 hours	100%	Measures patient safety on the Unit	Local
Safety	Infection Control Risk Assessment <12 Hours	100%	Measures patient safety on the Unit	Local
Safety	Slips, Trips and Falls Risk assessment <12 Hours	100%	Measures patient safety on the Unit	Local
Safety	No. of Incidents Responded to within 48 hours	95%	Measures patient safety on the Unit	Local
Safety	No. of Incidents moderate harm & above	0	Measures patient safety on the Unit	Local
Safety	Mortality	TBC	Measures Hospital Standard Mortality Rate (HSMR) - TBC with each Hospital/Spoke Unit	National
Safety	No. of DOLS Applications	N/A	Measures patient dependency levels on Unit	Local
Safety	No. of successful DOLS Applications	N/A	Measures patient dependency levels on Unit	Local
Safety	Total No. of patients on DOLS	N/A	Measures patient dependency levels on Unit and informs staffing level requirements	Local
Safety	No. of urgent DOLS applications not completed within 14 days	N/A	Measures patient dependency levels on Unit and informs staffing level requirements	Local
Safety	Total No. of patients on 1:1	N/A	Measures patient dependency levels on Unit and informs staffing level requirements	Local
Safety	No. Incidents outstanding	0	Measures patient and staff safety on the Unit	Local
Safety	No. of Hospital Acquired Infections (e.g. CDT, VRE, CDiff, DVT, and CPE)	0	Measures patient safety on the Unit- Threshold to be set based on 2016/17 data then revised annually to show year on year reduction	Local

SCHEDULE 2 – THE SERVICES

C. Inpatient Extended Specialist Rehabilitation Unit (Level 3)
Key Performance, Quality and Safety Indicators

Theme	Indicator/Target	Threshold	Description and Measure	National/Local
Performance - Responsive and Effective	Referrals for inpatient extended rehabilitation meeting criteria	50%	Referrals for inpatient spoke rehabilitation meeting criteria for acceptance onto the unit to ensure that admissions are appropriate	Local
Performance - Responsive and Effective	Referrals for inpatient extended rehabilitation not meeting criteria	50%	Referrals for inpatient spoke rehabilitation not meeting criteria for acceptance onto the unit. These are monitored and advice given to referrers	Local
Performance - Responsive and Effective	Waiting Times - 14 days referral to admission	95%	Patients who are assessed as medically fit for rehabilitation. 95% of patients must be admitted within 14 days. Threshold set locally based on the level at which it is deemed the Units would be able to continue running services without significant problems.	Local
Performance - Responsive and Effective	No. of Inpatient Admissions v Plan	Within 20% of unit target.	Monitors admissions against contractual target by CCG	Local
Performance - Responsive and Effective	Maximum Length of Stay	Category A: 548 days (18 months), Category B: 365 days (12 months)	Length of stay is the time from admission to discharge in days. This is to monitor progress against forecast length of stay to improve operational efficiency, patient experience and safety.	Local
Performance - Responsive and Effective	Bed occupancy	90%	Monitors the Units occupancy, being an indicator of both operational effectiveness and potential risks to service provision. Threshold based on 90% as it is deemed this level would be manageable but any more would be a concern.	Local
Performance - Responsive and Effective	No. of Discharges	TBC	Monitors the Units overall discharges, being an indicator of both operational effectiveness, patient experience and potential risks to service provision.	Local
Performance - Responsive and Effective	Delayed rehabilitation pathway transfers	0%	A delayed transfer of care occurs when a patient has completed their rehabilitation goals in the current setting and is ready for transfer to the next rehabilitation service level in the pathway, but is still occupying a bed. A patient is ready for transfer when a clinical decision has been made by the MDT that the patient is medically fit and safe to transfer. Monitors length of delay, reason and CCG	Local
Performance - Responsive and Effective	Delayed Discharges	TBC	A delayed discharge of care occurs when a patient is ready for discharge from an inpatient hub/spoke/extended rehabilitation bed, but is still occupying a bed designated for such care. A patient is ready for discharge when a clinical decision has been made by the MDT that patient is medically fit and safe for discharge. Monitors length of delay, reason and CCG	Local
Performance - Responsive and Effective	Referral to assessment 5 working days	100%	Monitors service efficiency in referral to assessment to identify patient level of rehabilitation	Local
Performance - Responsive and Effective	Rehabilitation Complexity Score (>10)	(>=)50%	The RCS is used as a measure of outcome but also as a proxy of needs for rehabilitation intervention. It records the level of care, nursing, therapy and medical needs of the patient and is recorded for all patients on the Units as part of the multi-disciplinary rounds.	National
Performance - Responsive and Effective	Rehabilitation Categorisation A	(>=)50%	The Rehabilitation Categorisation Tool is used as a measure of outcome but also as a proxy of needs for rehabilitation intervention. It identifies the level of care, nursing, therapy and medical needs of the patient and is recorded for all patients on admission to the Units.	National
Performance - Responsive and Effective	Clinical Interruptions in days	Maximum 14 days	Monitors the total number of clinical interruptions, length of interruption, reason, mode (planned, unplanned or emergency) and transferring hospital/ward. Measures patient complexity and service effecteiveness	Local
Performance - Responsive and Effective	No. of re-admissions	TBC	Number of patients who are re-admitted within x days and reason why. Measures service effectiveness. Threshold to be set based on 2016-17 data then revised annually	Local

Theme	Indicator/Target	Threshold	Description and Measure	National/Local
Quality - Caring and Experience	Percentage of admitted patients receiving a comprehensive inter-disciplinary rehabilitation assesssment within 10 days of admission	100%	Percentage of admitted patients receiving a comprehensive multi-disciplinary rehabilitation assesssment	National
Quality - Caring and Experience	Percentage of patients with a rehabilitation inter-disciplinary team discharge/24 hour care plan within 24 hours following discharge	95%	Percentage of patients with a rehabilitation multidisciplinary team discharge/passport summary	Local
Quality - Caring and Experience	Percentage of admitted patients requiring vocational rehabilitation advice/signposting as appropriate (Level 1 & Level 2)	100%	Measures service effectiveness and capacity	Local
Quality - Caring and Experience	Percentage of admitted patients requiring specilaist vocational rehabilitation management and measurement of outcome on discharge (Level 3)	100%	Measures service effectiveness and capacity	Local
Quality - Caring and Experience	Percentage of admitted patients with a named Rehabilitation Co-ordinator	100%	All patient will have a named co-ordinator throughout their stay.	Local
Quality - Caring and Experience	No. of Complaints	TBC	Measures No. of complaints - Threshold to be set based on 2016/17 data then revised annually to show year on year reduction. Themes to be collated and reported. Threshold to be set based on 2016-17 data then revised annually	Local
Quality - Caring and Experience	No. of Compliments	N/A	Measures service effectiveness	Local
Quality - Caring and Experience	Percentage of patients reported very satisfied with overall rehabilitation experience	75%	Measures patient satisfaction	Local
Quality - Caring and Experience	Percentage of patients who would recommend the service (Friends and Family Test)	75%	Measures patient and family/carer satisfaction	National
Quality - Well led	Expected Date of Discharge is indicated within 10 working days of admission	100%	Measures service effectiveness and responsiveness	Local
Quality - Well led	CMRN Data Completeness	Fully Compliant	Measures compliance against UKROC standards	Local
Quality - Well led	Percentage of agency staff: Medical, Nursing and Therapy	TBC	Measurement of agency staffing by discipline WTE	Local
Quality - Well led	No. of vacancies: Medical, Nursing and Therapy	TBC	Measurement of vacancies by discipline WTE	Local
Quality - Well led	Absence - sickness	TBC	Measurement of sickness	Local
Quality - Well led	Staff - Friends and Family Test (Response Rate)	TBC	Measurement of staff satisfaction. Frequency as per Trust policy	Local
Quality - Well led	Staff - Friends and family Test (Care / Treatment)	TBC	Measurement of staff satisfaction. Frequency as per Trust policy	Local
Quality - Well led	Staff - Friends and Family Test (Place to work)	TBC	Measurement of staff satisfaction. Frequency as per Trust policy	Local

Theme	Indicator/Target	Threshold	Description and Measure	National/Local
Safety	No. of adverse and near miss incidents investigated and actions taken	TBC	Measures patient and staff safety on the Unit - Threshold to be set based on 2016/17 data then revised annually	Local
Safety	No. of Patient Falls with minor harm (cuts bruises)	TBC	Measures patient safety on the Unit- Threshold to be set based on 2016/17 data then revised annually	Local
Safety	No. Patient Falls Causing moderate, major or catastrophic harm	0	Measures patient safety on the Unit	Local
Safety	No. of Pressure Ulcers (Grade 2)	TBC	Measures patient safety on the Unit- Threshold to be set based on 2016/17 data then revised annually to show year on year reduction	Local
Safety	No. of Pressure Ulcers (Grade 3 & 4)	0	Measures patient safety on the Unit	Local
Safety	Nutrition (MUST) Risk Assessment <12 hours	100%	Measures patient safety on the Unit	Local
Safety	Infection Control Risk Assessment <12 Hours	100%	Measures patient safety on the Unit	Local
Safety	Slips, Trips and Falls Risk assessment <12 Hours	100%	Measures patient safety on the Unit	Local
Safety	No. of Incidents Responded to within 48 hours	95%	Measures patient safety on the Unit	Local
Safety	No. of Incidents moderate harm & above	0	Measures patient safety on the Unit	Local
Safety	Mortality	TBC	Measures Hospital Standard Mortality Rate (HSMR) - TBC with each Hospital/Spoke Unit	National
Safety	No. of DOLS Applications	N/A	Measures patient dependency levels on Unit	Local
Safety	No. of successful DOLS Applications	N/A	Measures patient dependency levels on Unit	Local
Safety	Total No. of patients on DOLS	N/A	Measures patient dependency levels on Unit and informs staffing level requirements	Local
Safety	No. of urgent DOLS applications not completed within 14 days	N/A	Measures patient dependency levels on Unit and informs staffing level requirements	Local
Safety	Total No. of patients on 1:1	N/A	Measures patient dependency levels on Unit and informs staffing level requirements	Local
Safety	No. Incidents outstanding	0	Measures patient and staff safety on the Unit	Local
Safety	No. of Hospital Acquired Infections (e.g. CDT, VRE, CDiff, DVT, and CPE)	TBC	Measures patient safety on the Unit- Threshold to be set based on 2016/17 data then revised annually to show year on year reduction	Local
Safety	No. patients with a tracheostomy	N/A	Measures patient dependency levels on Unit and informs staffing level requirements	Local
Safety	No. patients with a tracheostomy waiting admission	N/A	Measures patient dependency levels on Unit and informs staffing level requirements	Local
Safety	No. safeguarding referrals	N/A	Measures patient and staff safety on the Unit	Local

SCHEDULE 2 – THE SERVICES

D. Community Specialist Rehabilitation Service
Key Performance, Quality and Safety Indicators

Theme	Indicator/Target	Threshold	Description and Measure	National/Local
Performance - Responsive and Effective	Referrals for community rehabilitation meeting criteria	70%	Referrals for inpatient spoke rehabilitation meeting criteria for acceptance onto the unit to ensure that admissions are appropriate. Threshold to be set based on 2016-17 data then revised annually	Local
Performance - Responsive and Effective	Referrals for community rehabilitation not meeting criteria	30%	Referrals for inpatient spoke rehabilitation not meeting criteria for acceptance onto the unit. These are monitored and advice given to referrers . Threshold to be set based on 2016-17 data then revised annually	Local
Performance - Responsive and Effective	Waiting Times - 3 working days urgent referral to first assessment	95%	Patients who are identified for urgent for rehabilitation assessment in the community. Measures service responsiveness	Local
Performance - Responsive and Effective	Waiting Times - 14 working days routine referral to first assessment	95%	Patients who are identified for routine rehabilitation assessment in the community. Measures service responsiveness	Local
Performance - Responsive and Effective	No. of Patients on active caseload (within 20% of service target)	TBC	Monitors active case load against contract by CCG. Measures capacity	Local
Performance - Responsive and Effective	Maximum Length of episode	365 days (52 weeks)	Length of stay is the time from initial assessment to discharge in days. This is to monitor progress against forecast length of stay to improve operational efficiency, patient experience and safety. Measures service effectiveness	Local
Performance - Responsive and Effective	No. of Discharges	TBC	Monitors the Services overall discharges, being an indicator of both operational effectiveness, patient experience and potential risks to service provision.	Local
Performance - Responsive and Effective	No. of re-referrals	TBC	Number of patients with an emergency re-referral within 28 days of original discharge date and reason why. Measures service effectiveness. Threshold to be set based on 2016-17 data then revised annually	Local
Performance - Responsive and Effective	Percentage of patients whose goals are fully achieved	90%	Percentage of patients whose goals are fully achieved	Local

Theme	Indicator/Target	Threshold	Description and Measure	National/Local
Quality - Caring and Experience	Percentage of admitted patients receiving a comprehensive inter-disciplinary rehabilitation assesssment following referral	100%	Percentage of admitted patients receiving a comprehensive multi-disciplinary rehabilitation assesssment	National
Quality - Caring and Experience	Percentage of patients with a rehabilitation summary report to referring Consultant at 12-weeks	95%	Percentage of patients with a rehabilitation summary report at 12-weeks	Local
Quality - Caring and Experience	Percentage of patients with a rehabilitation inter-disciplinary team discharge/passport summary within 2 weeks following discharge	95%	Percentage of patients with a rehabilitation multidisciplinary team discharge/passport summary	Local
Quality - Caring and Experience	Percentage of patients requiring vocational rehabilitation advice/signposting as appropriate (Level 1 & Level 2)	100%	Measures service effectiveness and capacity	Local
Quality - Caring and Experience	Percentage of admitted patients requiring specilaist vocational rehabilitation management and measurement of outcome on discharge (Level 3)	100%	Measures service effectiveness and capacity	Local
Quality - Caring and Experience	Percentage of admitted patients with a named Rehabilitation Co-ordinator	100%	All patient will have a named co-ordinator throughout their rehabilitation.	Local
Quality - Caring and Experience	No. of Complaints	TBC	Number of complaints investigated, type and % resolved in month and action taken. Threshold to be set based on 2016-17 data then revised annually	Local
Quality - Caring and Experience	No. of Compliments	N/A	Number of compliments	Local
Quality - Caring and Experience	Percentage of patients reported very satisfied with overall rehabilitation experience	75%	Percentage of patients who report 'very satisfied'	Local
Quality - Caring and Experience	Percentage of patients who would recommend the service (Friends and Family Test)	75%	Percentage of patients who would recommend the service (Friends and Family Test)	National
Quality - Well led	Expected Date of Discharge is indicated within 8 weeks of assessment	100%	Measures service effectiveness and responsiveness	Local
Quality - Well led	CMRN Data Completeness	Fully Compliant	Measures compliance against UKROC standards	Local
Quality - Well led	Percentage of agency staff: Nursing and Therapy	TBC	Measurement of agency staffing by discipline	Local
Quality - Well led	No. of vacancies: Nursing and Therapy	TBC	Measurement of vacancies by discipline	Local
Quality - Well led	Absence - sickness	TBC	Measurement of sickness	Local
Quality - Well led	Staff - Friends and Family Test (Response Rate)	TBC	Measurement of staff satisfaction. Frequency as per Trust policy	Local
Quality - Well led	Staff - Friends and family Test (Care / Treatment)	TBC	Measurement of staff satisfaction. Frequency as per Trust policy	Local
Quality - Well led	Staff - Friends and Family Test (Place to work)	TBC	Measurement of staff satisfaction. Frequency as per Trust policy	Local
Safety	No. of adverse and near miss incidents investigated and actions taken	TBC	Measures patient and staff safety- Threshold to be set based on 2016/17 data then revised annually	Local
Safety	No. of Patient Falls with minor harm (cuts bruises) during treatment	TBC	Measures patient safety on the Unit- Threshold to be set based on 2016/17 data then revised annually	Local
Safety	No. Patient Falls Causing moderate, major or catastrophic harm during treatment	0	Measures patient safety on the Unit - Threshold to be set based on 2016-17 data then revised annually	Local