National Clinical Audit of Specialist Rehabilitation following major Injury (NCASRI)

Report from Workshop 8th June 2017

Prepared by the NCASRI Team:

Professor Lynne Turner-Stokes
Dr Karen Hoffman
Dr Roxana Vanderstay
Mr Keith Sephton
Ms Heather Williams
Mr Alan Bill
Ms Margaret Kaminska

Version 1.1
Last update: 10.6.2017

Attendance list

Name	Role	MTC network
Sarah Blackburn	Rehab Coordinator	North Yorkshire and Humberside
Rachel Hoggarth	Rehabilitation Leadership Fellow	North Yorkshire and Humberside
Rachel Parsons	Project Lead	Greater Manchester
Emma Denby	Operational Services Manager	Cheshire and Merseyside
Jacqui Isaac	Trauma Therapy Coordinator	Cheshire and Merseyside
Rebekah Phillips	Operational Manager	Cheshire and Merseyside
Hannah Farrell	Clinical Specialist Physiotherapist	Birmingham BC, Hereford and Worcester
Ma. Cyril Ann Gaw	Major Trauma Rehabilitation Coordinator	Central England
Nereo Jesse Salvo	TARN Coordinator	Central England
Rohan Revell	Major Trauma Case Manager	East Midlands
Judith Allanson	Consultant in Rehabilitation Medicine	East of England
Stephen Novak	Consultant in Rehabilitation Medicine	Severn
Annie Thornton	Major Trauma Practitioner	Severn
Davina Richardson	Clinical Service Lead Therapist Neurosciences	North West London
Jessica Rich	Physiotherapist	NELETN
Anna Rose	Rehabilitation Coordinator	NELETN
Alison Shakey	Rehabilitation Coordinator	NELETN
Kerry Staab	PPI Rep	NCASRI and AfterTrauma
Vijay Kolli	Specialist Registrar in Rehabilitation Medicine	South West London and Surrey
Lucy Silvester	Therapy Consultant	South West London and Surrey
Jacqui Wakefield	Consultant Therapist Neurorehabilitation	SELKaM
Emer McGilloway	Consultant in Rehabilitation Medicine	SELKaM
Catherine Sweby	Clinical Specialist Physiotherapist	Sussex
Caroline Hutchings	Consultant in Rehabilitation Medicine	Wessex
Rachel Botell	Consultant in Rehabilitation Medicine	Peninsula
Jude Fewings	Consultant Therapist Neurosurgery	Peninsula
Vivien Seagrove	HQIP Project Manager	HQIP
Mirek Skrypak	Associate Director for Quality and Development	HQIP
Alexis Joannides	Director	IRMA
Tom Lawrence	System Analyst	TARN
Victoria Phillipson	Senior Project Manager	TARN
NCASRI Team		
Lynne Turner-Stokes	Principal Investigator, NCASRI	NCASRI and UKROC
Karen Hoffman	Project Manager, NCASRI	NCASRI
Heather Williams	Senior data analyst	NCASRI and UKROC
Margaret Kaminska	Data entry clerk	NCASRI
Keith Sephton	Senior Data manager and programmer	NCASRI and UKROC

Background and purpose

Lynne Turner Stokes provided an overview of the programme and the purpose of the workshop.

The NCASRI audit is funded by NHS England and commissioned by the Health Quality Improvement Partnership (HQIP) as part of its National Clinical Audit and Patient Outcomes Programme (NCAPOP).

- NCAPOP is a set of centrally-funded national clinical audit projects that collect data on compliance with evidence based standards, providing benchmarked reports on the compliance and performance. Participation is mandatory under the terms of the standard hospital contract
- Contracts to deliver these audits are awarded by tender with funding usually for 3 years in the first instance, with potential to extended for a further 2 years, subject to agreement.
- There is an expectation that, following the initial investment, audits will become embedded in clinical practice going forward.

NCASRI is now coming towards the end of its second year and it is time to consider our proposal for extension into year 4-5. Extension requests must remain in line with the original audit project, and must be deliverable within the financial constraints of the budget (which is reduced in the extension period). The application is due for submission by 27.9.2017, and will be considered by NHSE in November 2017.

The primary purpose of the workshop was therefore to obtain feedback from the MTCs about what had worked well and what not so well, in order to consider how the audit could be extended in year 4-5 in a manner that would be feasible to embed sustainably in routine clinical practice going forward.

This NCASRI audit has identified a number of challenges:

- The first year organisational survey highlighted widely differing practice across the MTC's, and a shortage of input from consultants in Rehabilitation Medicine (RM) - some having little or none.
- We started from a low base of knowledge and data collection - the standard rehabilitation prescription (RP) requiring completion of four tick boxes only providing scant information.
- The specialist RP (SpRP) does not stand alone but builds on the RP by the addition of four standardised tools. These provide more detail but were variably implemented. Half of the MTCs were not yet using any of them.

Prior to this workshop, the NCASRI team undertook a preliminary analysis of the MTC data collected in TARN so far, and a survey of how teams were using their data locally. The findings were briefly presented by Lynne Turner-Stokes and Karen Hoffman. This was followed by general discussion in the morning about what was working well and what not so well, with some suggested solutions.

General feedback from the MTC teams and suggested solutions

Who completes the data?

The BSRM Core standards for Specialist Rehabilitation following trauma recommend that the SpRP tools should be collected by 'an RM consultant or their designated deputy'. From the data analysed to date, it is clear that the majority of the data are collected by the MD teams, even in units where a consultant is available. Some of the teams report feeling under-valued by this requirement.

Prof Turner-Stokes apologised for this. We hoped that the audit would help to highlight examples of good practice and make the case for extra provision of RM consultants to support the MTC multidisciplinary teams. However, it is absolutely critical to make sure that everyone is working together, that every team member feels included and that their contribution is valued. This will be the case going forward.

Lack of consistent data collection in the RP and limitation of the SpRP to a very small group of patients

The RP has developed in many different forms to suit different services / contexts. Whilst this may be appropriate so far as the patient's Rehabilitation Plan is concerned, there is no consistent data collection as part of it, so no opportunity for case ascertainment or comparison between services. The current polarisation of the RP and SpRP was felt to be unhelpful, with minimal information collected for the large majority of patients and then much more detailed information for just a very small number of patients.

We recognise that the RP is not within the scope of this audit, but the teams on the ground are delivering both the RP and the SpRP and would like to make this process as seamless as possible. A suggestion from several quarters has been to expand slightly the information included in the standard RPs, and reduce the level of detail captured for the few, so as to make this more equitable.

Prof Turner-Stokes explained that the original proposal for NCASRI had been more widely based, encompassing rehabilitation services in the level 3 pathway, as well as level 1 and 2 services. The scope was restricted to Level 1 and 2 specialist rehabilitation by NHSE at the scoping workshop, partly due to financial constraints and also because work was already underway through the Clinical Reference Group for Major Trauma to develop a the standard RP further and there was no desire to duplicate this work.

However it was always intended that these two strands of work would come together if the programme continued into Year 4-5, so now is an excellent time to work with Prof Chris Moran's RP Development Group and bring these two strand together

Collection of data at different time points

Collection of data at different time points by different MTCs limits the comparability of data.

Units were asked to collect their data at the 'R point'[1] but there was some confusion about when this is. Some have been collecting data when rehabilitation becomes the main focus of their treatment, even though they still have acute care needs. Others record at the time the patient is ready to transfer to rehabilitation, and others at discharge from the MTC. Some collect data at several of these time points.

Although longitudinal data would be very informative, realistically we cannot expect data at more than one time point, and agreement the optimal time point is essential for the next round.

Lack of resource for data entry and use of different platforms

The lack of extra resource for staff to enter the data has been a challenge for almost all centres. Although the willingness of NCASRI to accept data in a number of different forms is appreciated, it remains a challenge to collate data from all the different sources and is not sustainable after the audit. It was suggested that in future it would be sensible to collate all the MTC data on one system. Even if units collect their data locally on different platforms, if those platforms can upload the data onto to TARN, then TARN would provide a single data source to link with UKROC.

Use of the SpRP tools

Prof Turner-Stokes provided an overview of the SpRP tools and why we collect them.

- The Complex Needs Checklist (**CNC**) is designed as a screening tool to assist clinical teams to identify patients with complex needs who may require referral for further specialist in-patient rehabilitation

[1] The R point is defined in the BSRM Core standards as the point when the patients medical needs no longer require treatment in an MTC or Trauma Unit (i.e. RCS-ET-Medical score 5 or 6) but could be managed in a DGH or rehabilitation unit (RCS-ET-M score 4 or below).

- Patient Categorisation Tool **(PCAT)** details the types and complexity of rehabilitation need in accordance with the NHSE service specification criteria. It is a requirement for admission to Level 1 and 2 services and is often used by those services as part of their pre-admission assessment
- The Rehabilitation Complexity Scale **(RCS-ET)** is a measure of resource requirements (medical, nursing and therapy inputs) to meet the complex needs for rehabilitation. While it correlates with the PCAT and CNC, it describes services element rather than individual patient characteristics. It cannot be used alone to describe category of need
- The Neurological Impairment Set for Trauma **(NIS-Trauma)** details the type and severity of impairment. It is generally acknowledged that the Injury Severity Score recorded by TARN does not capture the range of impairments that are typically the target for rehabilitation. The NIS-Trauma records neurological and musculoskeletal impairments and their impact on function – also co-morbidities.
- The Northwick Park Dependency Score and Care Needs Assessment **(NPDS/NPCNA)** details nursing and care needs and ongoing estimated the costs of care in the community. It is used to demonstrate the cost benefits of rehabilitation – and in this context to help us estimate the cost of the NHS of not providing timely specialist rehabilitation.

Feedback from the MTC teams

The SpRP tools have had mixed reception. Some teams find them useful for clinical decision-making, but the time it takes to complete them can be a barrier to identifying patients with conflict needs. Some duplication of information between the tools was noted – particularly the PCAT and the CNC.

The CNC and RCS-ET

Both of these tools were easily accepted. Most teams reported that they were timely to use and helpful One team (Bristol) is now recording these two tool on all patients with category A-D needs. They have not found this difficult to integrate into practice and report that it helps with clinical decision-making.

It was agreed that these two tools might also be applicable for use in Trauma Units.

The PCAT

The survey demonstrated that many teams liked the PCAT and found the information help in their decision-making. Others were concerned about the validity of the PCAT numerical score and would also like more training.

Prof Turner-Stokes emphasised that the PCAT was not designed to be used as a measurement tool – it is a checklist of the NHSE criteria for Category A and B needs as set out in the Specialist Rehabilitation Service Specification. There are 'self-service' training slides for use of the PCAT on the NCASRI website http://www.kcl.ac.uk/lsm/research/divisions/cicelysaunders/about/rehabilitation/Self-service-slides-for-PCAT.pdf and more face-to-face training can be set up if this would be helpful.

She advised not to focus too much on numbers, as the primary purpose and use of the PCAT data is descriptive. Interestingly, however, recent psychometric analyses (including Rasch analysis) show that it actually works quite well as a single scale numerical scale. Although most patients with category A needs will have PCAT total score of >30, we know that a small number of them have PCAT scores <30 (especially ambulant patients requiring cognitive/behavioural rehabilitation) and hence we are exploring the use of physical and cognitive subscales to capture these. The information is summarised in the UKROC final report which is available on the UKROC website and is in the process of submission for publication. http://www.kcl.ac.uk/lsm/research/divisions/cicelysaunders/research/studies/uk-roc/index.aspx

It was also noted that the CNC was designed as a screening tool to identify which patients to collect the PCAT on. For units who wish to collect the PCAT on all patients, there is no need to collect the CNC as the data can be derived from the PCAT.

The NIS-Trauma
One centre reported that the name 'Neurological Impairment Scale" is off-putting, and wondered if the trauma elements were sufficient. Prof Turner-Stokes advised that the name can be changed if this improves engagement. The neurological elements are well validated and many are relevant even for non-neuro patients (eg motor, pain, emotional, fatigue etc) but the trauma elements are really being used for the first time in this audit, so the tool may be refined and further developed. Karen Hoffman agreed to populate the ICF codes on the trauma elements

The NPDS / NPCNA
Teams recognised the advantage of making the case on for rehabilitation on grounds of cost efficiency, and some have integrated this without difficulty, but others have struggled to find nursing staff who are able to complete the NPDS consistently.

It was noted that we will have quite a large amount of NPDS and NIS data from the first around of the audit, which will be written up in our 3rd year report. It is probably not necessarily to continue to collect these going forward, as the results will probably not be dissimilar to those from this first year. However, if teams do wish to record data on impairment and dependency as part of their rehabilitation prescription or plan, they should be encouraged to use these tools, so that there is a common language for comparison.

Round up of current practice

12 units fed back on their current practice (2 were not yet submitting but were keen to do so):

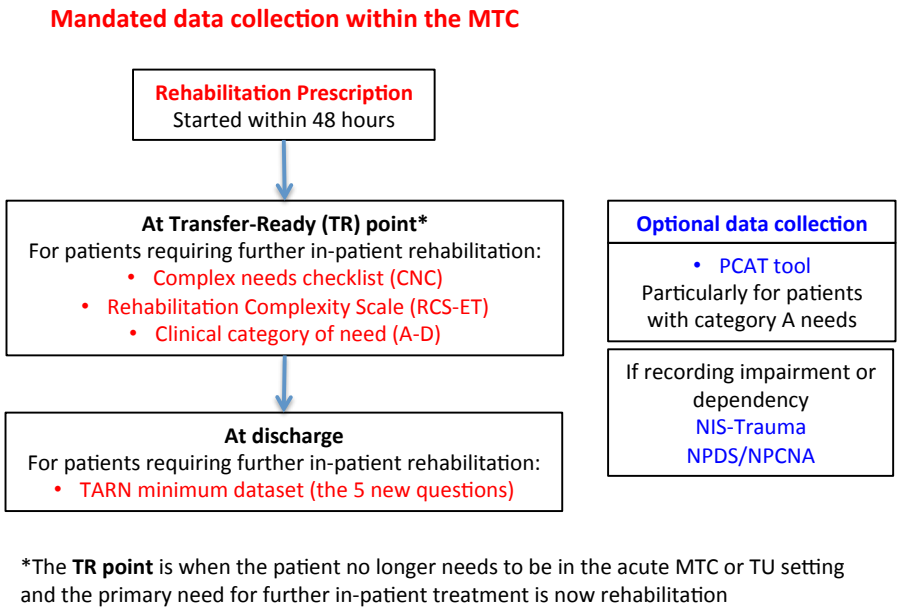
- Nine out of 16 MTCs currently collecting data were using the CNC and RCS-ET. The 7 MTCs that do not use the CNC uses the PCAT as a consultant sees all the patients
- In the majority of MTCs, tools were collected by rehab or trauma coordinators with input from the MD Team. In 8/12 MTCs category A needs were confirmed by an RM consultant.
- Two of the units used the IRMA platform in ORION, nine MTCs used TARN and four collected data on paper
- Most teams were collecting data at the 'Transfer Ready' (TR) point, although two (Birmingham and Cambridge) collected RCS-ET scores at multiple time points. Bristol is currently collecting the RCS-ET and CNC at 72 hours and the category of need (informed by use of the PCAT, although the PCAT is not formally recorded) at discharge. The Bristol team agreed that the TR point is the most useful, and they could change the timing of data collection to fit in with other centres.
- Several teams reported a shortage of specialist rehabilitation beds so that many patients remain in the MTC after the TR point until they are ready to go home. Virtually no patients would therefore have category A needs at discharge. The TR point was therefore agreed to be the most appropriate time point for recording.

Summary and recommendations for the next phase of NCASRI

The discussions at this one-day workshop were both helpful and positive. The consensus was as follows:

- Although it has been challenging to get data collection off the ground, the audit has been useful. Now that they have got going, the MTC teams on the ground would like to see it continue.
- The complete NCASRI toolset collected in this year will be informative, but is too burdensome to continue and may not be capturing all people with complex needs.
- Going forward it would be better to collect a reduced dataset and potentially capture more people.
- The primary point for data capture for NCASRI should be the TR point, if different from discharge
- Teams agreed it would be feasible to collect CNC and RCS-ET for all patients who require further in-patient rehabilitation, alongside clinical categorisation of needs (A, B C or D) at the TR point.
- On this basis, they were willing to continue data collection when the current audit round ends on 31st August – ie starting 1st September 2017
- Although the design of standard RP is not within our remit, it would be helpful if this data collection (RCS-ET, CNC and category of need) could be built in as a mandated requirement for the standard RP as this would embed data collection into routine practice going forward.
- Data should be collated on a single database (TARN) in future as there will be no additional resource to support collation from multiple data sources. Locally-used databases and electronic patient record should provide data in a form that can be uploaded into TARN
- Completion of the other SpRP tools at the TR point should be optional going forward, but is still encouraged in order to provide comparable information, especially patients with very complex (Category A) needs. (The small numbers should not create an excessive data collection burden)
    - Ideally a PCAT should be recorded for patients with category A needs at the TR point, but this may be completed by any experienced member of the rehabilitation / therapy team.
    - If teams wish to record data on impairment and/or dependency, the NIS-Trauma and NPDS/NPCNA should be used as a common language in order to support data comparison.

Figure 1: Proposed new scheme for MTC data collection going forward



*The **TR point** is when the patient no longer needs to be in the acute MTC or TU setting and the primary need for further in-patient treatment is now rehabilitation