INPA | Independent Neurorehabilitation Providers Alliance

INFLUENCE SUPPORT COLLABORATE CONNECT

The Independent Neurorehabilitation Providers Alliance (INPA) Membership Standards

INPA was established by a group of independent neurorehabilitation providers to ensure that neurorehabilitation is delivered in quality environments by trained and experienced staff thereby providing and ensuring a minimum standard of care from those who are members.

In order to join INPA, members have to comply with standards related to provision of service. These standards were last reviewed in 2025 to ensure that they are comprehensive and relevant. There are currently seven membership categories as below;

- ☐ **In Patient Full Membership**
- ☐ **In Patient Associate Membership**
- ☐ **Community On-Site Membership**
- ☐ **Community Domiciliary Membership**
- ☐ **Community On-Site Associate Membership**
- ☐ **Community Domiciliary Associate Membership**
- ☐ **Partner Membership**

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Membership Definitions

INPA is not a regulatory body; therefore all members must be registered with an appropriate body.

The Care Quality Commission (CQC), Health Inspectorate Wales (HIW) and the Care Inspectorate Scotland (HIS) regulate inpatient and care facilities throughout the UK ensuring they comply with their standards for quality and safety. It is therefore assumed that the criteria for membership of INPA do not need to include categories already covered under CQC/HIW/HIS.

The definition of a separate facility will be based on the appropriate national regulatory body e.g. CQC/HIW/HIS but INPA will retain some flexibility.

Independent community therapy providers that are not covered by CQC regulations must be registered with HCPC as their regulatory body.

In Patient Full Membership

In Patient Full Membership is for organisations offering neurorehabilitation with one or more services. Rates vary according to the number of beds and services provided. All services must have completed at least one full year of operation.

In Patient Associate Membership

Associate Membership is proposed for services that do not meet all the standards for Full Membership. It is also the category for members who have not yet completed one full year of operation as they are unable to provide the appropriate level of evidence required. Companies may therefore have some services that meet all criteria for Full Membership and others that would be approved as Associate Membership.

Community On-Site Membership

This category applies to Community neurorehabilitation services operating from a physical building and offering multidisciplinary neurorehabilitation
These companies offer a variety of disciplines across a range of therapies.

Community Domiciliary Membership

This category applies to a Community neurorehabilitation company or individual operating in the client's own environment. This applies to an individual therapist/group of therapists offering one or more disciplines.

Community On-Site Associate Membership

This applies to Community neurorehabilitation services operating from a physical building and offering multidisciplinary neurorehabilitation who do not meet all the standards or who have not yet completed one full year of operation.

Community Domiciliary Associate Membership

This applies to a company or individual operating in the client's own environment offering one or more disciplines who do not meet all the standards or who have not yet completed one full year of operation.

Partner Membership

Partners are defined as suppliers of goods and services to neurorehabilitation providers, for example companies providing moving and handling, neurotechnology, communication technology, orthotic or wheelchair equipment.

Standards for Membership

For the purposes of Membership, standards are generic and reflect best practice for a neurorehabilitation provider. The British Society of Physical and Rehabilitation Medicine (BSPRM) has published standards for rehabilitation services and these form the basis of INPA's inpatient standards. In addition, knowledge of the Commission on the Accreditation of Rehabilitation Facilities (CARF) was drawn upon with regards evidence required to support a provider's application and approve membership.
The BSPRM standards for staffing levels were not included as these are very much based on an acute care model which is not applicable to the majority of INPA members.

Community standards are drawn from the 2021 BSRM "Standards for Specialist Rehabilitation in Community Dwelling Adults – update of 2002 standards (Summary as at 1 March 2021)" and "A New Community Rehabilitation and Reablement Model" published by NHS England 2023.

Ensuring Compliance with Standards

INPA has set standards for each category (inpatient, community on-site and community domiciliary). For all categories, the standards look to ensure that neurorehabilitation is provided in an appropriate environment by skilled professionals and that there is a clear pathway from the point of referral to discharge. The pathway should be delivered by an appropriate multidisciplinary team and be person centred throughout.

Prospective members will be provided with a copy of the specific standards template for the category that applies to them. This will clearly outline each standard and give examples of the type of evidence that will be required to show compliance but in broad terms for each category the standards cover:

Environment
Examples of Standards:
The service primarily provides a neurorehabilitation service.
The service has appropriate equipment and resources for therapy.
Inpatient and on-site services have appropriate treatment spaces for therapy.
The general environment supports the individual and promotes independence.

Examples of Evidence:
Statistics showing numbers of neurorehabilitation referrals/admissions.
Clear information on website and marketing materials stating neurorehabilitation services.
Pictures/virtual tour on website showing general environment and therapy treatment areas.

Staffing

Examples of Standards:

The service is led by a senior clinical rehabilitation professional with extensive experience.
Staffing levels allow for face to face and non-direct activities.
Staffs demonstrate relevant knowledge and experience.
Staffs maintain skills and knowledge through regular training.
Staffs participate in regular clinical supervision and appraisal.

Examples of Evidence:

Biography of senior clinical lead available on website and/or provided at INPA assessment.
Information provided on staffs experience
Training records/CPD records
Evidence of knowledge being shared e.g. training of other colleagues
Supervision/appraisal documentation
Policies/procedures relating to training/supervision/appraisal.

Pathway and structure

Examples of Standards:

The service has a clear pathway from referral to discharge.
There is a clear process for managing new referrals.
An holistic assessment involves all relevant disciplines from the team.
Assessment results in an individual rehabilitation plan.
All key decision making meetings are undertaken by the multidisciplinary team in conjunction with the individual and their family/carer.
Rehabilitation is structured and measured by the setting and achieving of goals which are reviewed regularly.
Inpatient/bedded facilities, demonstrate that rehabilitation is provided as a 24hr process.

Examples of Evidence:

How to refer clearly stated on website/promotional materials.
Policy/procedure outlining management of referral.
Written outline of rehabilitation process available for services users with timings of goals/reviews/discharge meetings.
Clear documentation in the individual's case notes.
Documented goal setting with the individual.

Regular progress review meetings

Discharge management
Discharge commences at the start of the rehabilitation pathway.
Discharge is planned with the MDT, individual, family members and relevant 3rd parties such as social services of commissioner.
Assessment of the discharge destination, equipment requirements and care needs are considered as part of discharge.
Discharge meetings are documented and actions assigned to staff to ensure a smooth process.
Referrals to ongoing care and therapy services are made.
Discharge report provided.

Examples of Evidence:
Minutes of discharge meetings, including attendees.
Copy of action plans arising from meeting.
Home visit report.
Copy of discharge report.

Outcomes
The service uses outcomes appropriate to the service to measure progress.
There is a clear review process of patient progress.
Data is recorded on a regular basis and used to improve individual outcomes as well as the service.
The service submits outcomes to UKROC if appropriate.
The service collects feedback from service users and uses it to improve the service.
Clinical audit is completed on a regular basis and used to improve the service.

Examples of Evidence:
Outcome measures recorded in case notes.
Annual outcomes report.
Audit schedule and results report including recommendations and actions to implement changes.
UKROC reports.