Health and Social Care Board

Public Health Agency

Regional Acquired Brain Injury Implementation Group (RABIIG)

Acquired Brain Injury Adult Community Care Pathway

Contents

1.0 Introduction

The Regional Acquired Brain Injury Implementation Group has been established to take forward the DHPSSPS ABI Action Plan 2009/10-2010/11 (2009). The Action Plan was developed in response to the recommendations outlined in the Independent Review of ABI Services set up by the Minister for Health (2008).

The Action Plan includes specific recommendations in relation to:

- Service Redesign (supporting people to achieve their full potential through enhanced service commissioning and provision)
- Quality Improvement & Performance Management
- Improved support for Individuals, Carers and Families
- Effective Engagement and Partnership Working

The themes and actions are delivered by a series of workstreams as follows:

- Adult Community Services
- Inpatient Rehabilitation
- Children's Services
- Communication and Information
- Performance Management and Quality Improvement

One of the key outcomes required of the Adult Community Workstream was to develop a regional standardised ABI Community Care Pathway for Adults. This document has been produced by the Adult Community Services Workstream chaired by Garry Hyde.

1.1 Definition of Acquired Brain Injury (ABI)

Acquired Brain Injury (ABI) is defined as an injury to the brain caused by an identifiable event such as trauma, hypoxia, metabolic disorders or infection. The term does not include brain injuries that are congenital or induced by birth trauma. It also does not include progressive brain disorders and those that are acquired over time due to alcohol and drug misuse.

Those accessing care through Acquired Brain Injury Services will have an injury as outlined above. However, it is recognised that clinical judgement will be required for a number of people with exceptional, complex presentations to be cared for on a 'case by case' basis in partnership with other services. This will require Trusts, as outlined in Recommendation 2 of the Service Standards and Quality Indicators document, to develop joint care protocols with Stroke, Mental Health, Addictions, Forensic and Core Disability Services. These protocols must include escalation arrangements for when agreement cannot be reached regarding the most appropriate service intervention(s).

While stroke is classified as an acquired brain injury, separate standards/guidelines and services have been developed for stroke survivors

and are therefore not dealt with in this document. In the case of children with stroke, care will be provided through the Children's ABI Pathway as no children's stroke services are currently available.

The majority of ABI patients suffer a Traumatic Brain Injury (TBI) and within this group the larger number will have received a mild or moderate injury that does not require inpatient treatment or rehabilitation. Standards are included for such groups of individuals.

1.2 Objectives of the Care Pathway

A care pathway provides the client and professionals with a summary of the key aspects of care that should be considered for ABI patients. The following pathway is designed to facilitate the smooth transition of clients through the stages of rehabilitation after inpatient care. It is recognised that the implementation of the different phases of the pathway will depend upon the way services are organised locally. The primary aim of this pathway is to improve the continuity and co-ordination of care across the various disciplines and sectors who are involved, clarifying expectations for service users.

This pathway will operate collaboratively to provide safe and effective services with both the ABI Inpatient Care Pathway and the ABI Children and Young People's Pathway within the framework of RABIIG Brain Injury Service Standards and Quality Indicators.

Specific objectives include:

- To provide a resource that offers clients a summary of the key aspects of adult community, statutory and independent services for people with ABI.
- To provide a streamlined approach to the management of referrals and to ensure clients and their families receive the most appropriate service/ intervention at the appropriate time.
- To facilitate the provision of high quality, timely and effective assessment and rehabilitation to meet the needs of the client with acquired brain injury.
- To involve the client, families and carers in a collaborative approach to rehabilitation and support thereafter.
- To standardise the process of referral across all Community Brain Injury Teams within Trusts across Northern Ireland.
- To clarify the roles and remit of the Community Brain injury Teams and improve the interfaces between them, inpatient units and other supporting services to the families.
- To clarify other adult community services focused on Acquired Brain Injury and how these are accessed
- To ensure the content of the pathway is grounded in evidence based practice, regarding the use of individual assessment strategies and the delivery of interventions and treatments.
- To encompass a process of continuous service improvement.

1.3 Guiding Principles – What Patients and Families Can Expect

- A person centred pathway, which focuses on improving access, timely assessment and individually tailored interventions.
- To be able to access individually appropriate tailored information, communication and support for clients with brain injuries and their families.
- Access to specialist ABI multidisciplinary and multi-agency working to ensure the development of a co-ordinated and integrated care pathway.
- Equitable access to voluntary and independent sector services available in their communities.
- Referral access points that offer equitable service provision.
- Improved access to information about available services in statutory, voluntary and independent sectors.
- Client and family involvement central to rehabilitation goal planning and decision making.
- A written Rehabilitation Plan, agreed with the Community Brain Injury Team, client and their family.

1.4 Scope of the Care Pathway

- The following pathway will use Traumatic Brain Injury (TBI) as a paradigm, given that it is the most prevalent condition, with reference to other forms of ABI as appropriate. This pathway reflects the management of adults with ABI in community settings. It does not address the specific needs of either children or adolescents.
- This pathway recognises the long term nature of TBI and the changing needs of clients over time. The care pathway takes account of, and, highlights service provision for clients and their families in both statutory and non-statutory environments. This is reflected in the diagrams to follow.
- This is an Adult Community Services pathway beginning normally at age 18 years. However Adult ABI community teams will work closely with colleagues in Children's Community Disability services in respect of children from the age of 16 years who have an ABI to offer both a seamless transition to Adults Services and also to offer specialist advice on the management and support of ABI if this is required.

1.5 The Model

The regional care pathway incorporates local and regional considerations and takes into account the five legacy Care Pathways in current use across the Health and Social Care Trusts and non statutory service providers in Northern Ireland. The model reflects possible availability of adult community based ABI resources and does follow the quality requirements recognised through the National Service Framework for Long Term Conditions. This framework recognises person centred needs for:

- Community rehabilitation and support
- Vocational rehabilitation
- Specialist accommodation and equipment
- Personal care/respite

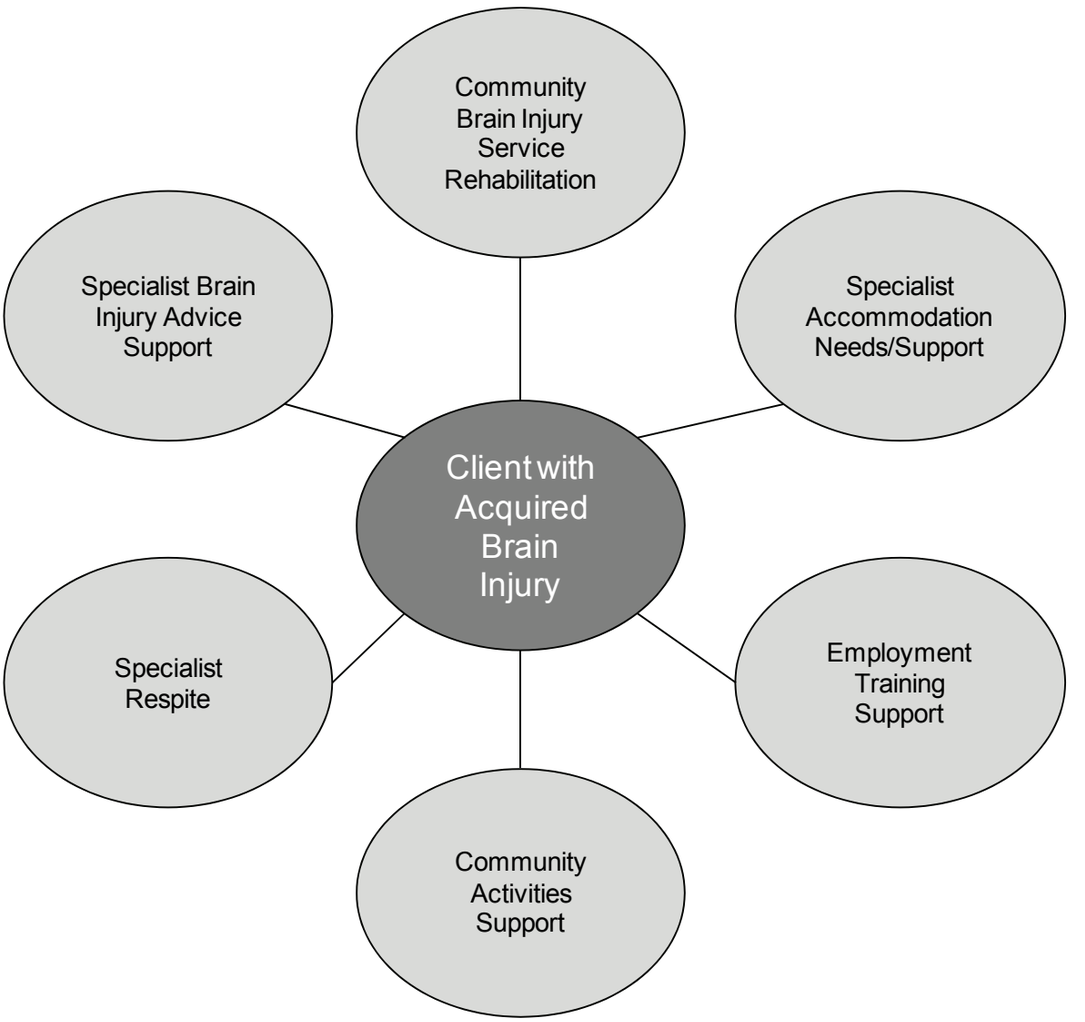


Figure 1: The Adult Community Acquired Brain Injury Model

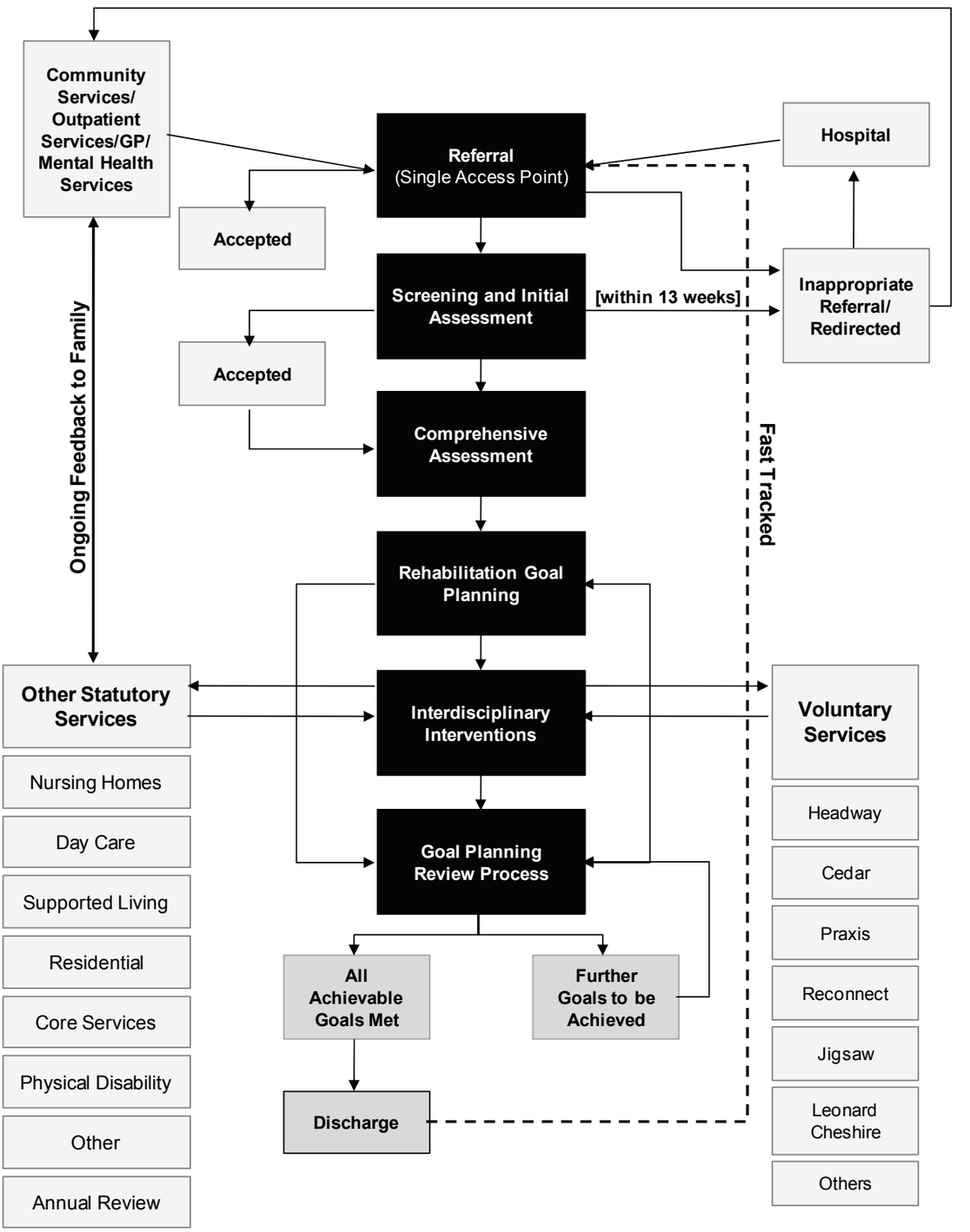
Although the voluntary sector provision is embedded in the Adult Community ABI Model, it is important to note that a referral from the single point of access (Community Brain Injury Teams) is not always required and therefore not the only route to access these services in some instances. Service funding is committed by the Health and Social Care Board according to the strategic direction set by the DHSSPS. Most statutory services have a recurrent core basis for delivery. Some voluntary sector organisations additionally attract separate and match funding from other sources including the European Social Fund delivered through the Department of Social Development. These invariably have socio-vocational targets additionally set with organisations. A supplementary pathway outlines the access route and availability of services for adults with Acquired Brain Injury provided by the voluntary sector.

2. 0 The Care Pathway

2.1 There are six main phases to the adult community care pathway provided through both statutory and non statutory services. These are shown in Figure 2, Page 6, as follows:

2.1.1. Initial referral − recognition and identification
2.1.2. Screening and initial assessment − triage and recommendations
2.1.3. Comprehensive assessment
2.1.4. Rehabilitation goal planning
2.1.5. Interdisciplinary interventions
2.1.6. Rehabilitation goal plan review process and discharge planning

Figure 2: The Community Brain Injury Team Care Pathway



2.1 Referral

The statutory Community Brain Injury Service will accept referrals from any healthcare professional, including those from GPs, professionals working in outpatient services, professionals working in Specialist ABI Units, Acute hospitals, etc (see Appendix I for details of each Trust Community Brain Injury Team, its remit and functions).

After discharge from hospital by adults, Community Brain Injury Teams will assume clinical lead responsibility for the delivery of ongoing rehabilitation goals and management.

Referrals will be accepted on a written standardised referral form through a single access point within the team. If information is not adequate on receipt of the referral from, the referral will not be accepted and further information will be requested from the referring agent.

Discharge/transition reports from Inpatient Units are sent to the client's GP and other health professionals and are available to the client and with their consent, their family/carers within 10 working days of discharge. This report should contain information regarding:

- Nature/history of injury
- Assessment results
- Progress made
- Interventions provided
- Current needs
- Key contacts
- Responsible services/professionals for future care/therapy.

On the discharge of a patient from inpatient rehabilitation, there will be clear and agreed processes in place for the handover of care to community services.

Appropriate administration systems for receipt, recording and processing and monitoring of referrals will be established by each Team. If the referral meets service criteria, an acknowledgment letter will be issued to the referring agent and a letter to the client for an appointment for the screening assessment.

The referral service criteria is as follows. The client:

- lives within the Trust catchment area;
- has an acquired brain injury noted within the common definition and where this injury is the primary issue;
- suffers from deficits in cognitive function;
- has the potential to engage fully in goal directed rehabilitation;
- will achieve benefits from the service that cannot be provided elsewhere.

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2.2 Screening and Initial Assessment

All clients referred will be seen for initial assessment/treatment within 13 weeks.

Procedure for Waiting Time Management

The DHSSPS sets standards for response times within Acquired Brain Injury Services. The current standard is:

Community Brain Injury Teams should ensure a 13 week maximum waiting time from referral to assessment and commencement of specialist treatment:

i. Following receipt of appropriate referral on appropriate referral form the date of the referral will be placed on the 13 week monitoring sheet.

ii. The referral will be discussed at the community brain injury service multidisciplinary team meeting.

iii. Clients are removed from the 13 week monitoring sheet when the first appointment is attended.

iv. If the client fails to attend the assessment appointment without notifying team in advance, their wait time is reset according to the Integrated Elective Care Access Protocol which sets out standards for 'reasonable offers' to clients if appointments are cancelled.

v. When the case is taken off the 13 week monitoring sheet, the client file will be moved to the open/active section of the filing cabinet.

vi. Where clients fail to attend two consecutive appointments and do not notify the service the case will be closed and a letter sent to the referrer advising of same.

vii. For those people for whom the service is not appropriate a letter will be sent.

The screening assessment will be completed by professionals within the team to ascertain the appropriateness for further CBIT work, including therapeutic interventions, goal planning and other interdisciplinary interventions. The screening assessment will be carried out by trained staff from the core interdisciplinary team which include:-

- Clinical Neuropsychologist
- Speech and Language Therapist
- Nurse
- Occupational Therapist
- Physiotherapist
- Social Worker
- Rehabilitation Assistant

It is noted however that not all core teams will have the same professional composition. In addition, dependent on local commissioning arrangements, Community Teams may also have agreed access sessionally to specialist Rehabilitation Medicine outreach activity in the community.

The screening assessment can be carried out in the person's own home and an appropriate carer can be present. The assessment will be reported back to the Team and feedback will outline:

- appropriateness of the referral
- need for further assessment
- necessity for onward referral
- an initial rehabilitation goal plan, as agreed with the client and carer/family

Clients who have been previously known to the team may not require a full re-assessment.

Mild Traumatic Brain Injury (MTBI)

For those clients who are suspected of having sustained a Mild Traumatic Brain Injury (MTBI) referral should be made to the CBIT, even if the period of loss of consciousness has been minimal, or, especially in the case of the elderly, there has been a serious fall with no loss of consciousness but there is a suspicion that a MTBI may have occurred.

A member of the CBIT will meet with the client to provide information and education regarding the common symptoms that can occur after concussion (physical, emotional and cognitive).

It is expected that education and information will be sufficient in the vast majority of cases to allow recovery to proceed and to prevent complications (especially psychological) due to the misinterpretation of symptoms. Follow-up to ensure that recovery is progressing as expected can be carried out face-to-face or by telephone.

Should the symptoms not resolve, or should it become apparent that there are more difficulties than first reported, a member of the CBIT staff will carry out a screening cognitive assessment.

If there is evidence that the difficulties are simply slow to resolve further education/advice can be offered.

Evidence or reduced cognitive function may result in the client being advised that comprehensive assessment is warranted. The case will be discussed by the Team and the appropriate assessments arranged. The case will then be managed as any other using an interdisciplinary approach.

2.3 Comprehensive Assessment

Acquired Brain Injury is a multi-faceted disability which requires an inter-disciplinary approach, including assessment of both health care and social care needs.

A comprehensive assessment will be completed as necessary. Each professional involved will conduct an individual assessment appropriate to the client's needs, using a standardised professional assessment tool.

The need to undertake further assessments will be reviewed by the team at regular team meetings and communicated to the client and their carer/family. Where specialised assessment is required an appropriate referral will be made by the team at that time

Following completion of this work the outcomes of the comprehensive assessment will be fed back to the client and carer/family and the rehabilitation plan including goal planning next steps will be discussed

The team will ensure timely and appropriate communication with the client and family at all times during the process.

2.4 Rehabilitation Goal Planning

Rehabilitation is a client-centred, goal-driven process based on the premise that all individuals are entitled to have as full and meaningful a life as possible following an acquired brain injury. It is important to understand the long term nature of acquired brain injury and the changing needs of clients over time.

The starting point for rehabilitation goal planning should be the client, and they should be given as much choice and control of the services they receive as possible. Each client will have a rehabilitation goal plan that is:

- Led by professionals specialised in brain injury
- Goal directed
- Tailored to meet the needs of each client and their families/carers
- Involve the client, families/carers
- Reflect their needs within the community
- Delivered on a one-to-one or group basis

Rehabilitation goal plans are set to reflect the agreed needs of the client and will be recorded and a copy of the rehabilitation goal plan will be provided to the client, GP and other key professionals.

Each client will have a named key worker within the team whose role it is to take the lead in the plan and liaise with the client's carers/family.

A review date for rehabilitation goal planning will be agreed and recorded on the plan. Referrals/links will be made where appropriate to other statutory,

and, community and voluntary organisations, as part of the goal/rehabilitation goal plan (see Figure 2: The Community Brain Injury Team Care Pathway on Page 6 and Section 3, Page 14, for a list of all ABI Support Organisations.

Community Brain Injury Teams should have strong links to external services including ABI Support Organisations and the following:

- Benefits, Allowances etc
- Housing, Aids and Adaptations
- Disability Employment Advisers/Job Centres
- Citizens Advice Bureau and Benefits Advice Workers
- Information about Disability Access Programmes
- Local Support Groups
- Advocacy Groups

2.5 Interdisciplinary Interventions

Service interventions for clients will be based on the comprehensive assessment carried out and the agreed goal plans devised with the client and carer/family. Interventions provided by Community Brain Injury Teams include comprehensive assessment and treatment of:

- Cognitive, behavioural, emotional and psychological function
- Capacity and issues of risk management
- Communication difficulties – verbal, non-verbal and written
- Swallowing difficulties
- Activities of daily living
- Functional difficulties
- Vocational and educational issues
- Activity in social and leisure activities
- Social issues through engagement with family and friends
- Physical difficulties a including stamina and fatigue
- Health issues
- Carer needs – psychological, financial and social
- Carer training and education

Rehabilitation is provided on a one-to-one or group basis in the client's home or in the community. It may require intensive inputs on a committed basis eg. by rehabilitation training coaches in the Adapt Programme in the Northern Health and Social Care Trust.

Intervention records will reflect the frequency and intensity of the level of service required at any given time. Professionals carrying out interventions will record these on an ongoing basis on case records sheets.

Arrangements will be in place between CBITs and Outpatient Services (regional and local) to allow clients to be referred for additional therapy

designed to work in concert with the interdisciplinary community rehabilitation process.

There are a range of external agencies who work in partnership with statutory agencies to deliver services to meet the client's individual needs. Please refer to Section 4, Page 18, for details of ABI Support Organisations.

All carers will be offered a carer's assessment, as well as information and support.

Interventions will be carried out in a timely manner and reflect the wishes of the client and their carer/family at all times.

The rehabilitation goal plan will remain flexible to meet the changing needs of the client and their carer/family as recovery occurs.

2.6 Goal Planning Review Process

Rehabilitation goal plans will be reviewed with the named key worker and the client and their carer/family at least 6 monthly**.** A formal review will take place within an agreed timeframe, depending on the rehabilitation goal plan, and according to the client's needs. The review meeting will be an opportunity to reflect upon the rehabilitation goal plan agreed and to assess the client's progress. The meeting will discuss next steps as follows:

- Continue current rehabilitation goal plan
- Devise a new plan
- Revise interventions
- Plan for discharge

The review meeting will be recorded and a next review meeting (6-12 months) will be agreed with the client and their carer/family.

Teams will take cognisance of the changing requirements of clients and their need to reassess services at any point in time.

2.7 Discharge Policy

Community Brain Injury Team(s) will have a clear discharge policy which will be clearly communicated to the client and their carer/family. Discharge will be completed for the following reasons:

- Rehabilitation goals/service interventions completed
- Service refusal/lack of engagement
- Client transfers to another Trust area
- Service no longer meets the needs of the client
- Client not compliant with the requirements of the rehabilitation plan

Discharge will be planned in conjunction with other services being provided to the client ie statutory support services and those delivered by community and voluntary/independent sector organisations.

Discharge plans will be written and the plan will be given to the client/carer/ family, and a copy sent to the GP and other relevant professionals, who may initiate re-referral if required.

Clients will be offered information about re-entry to ABI services, should their needs require it.

2.8 Statutory Community Service Provision

Community Brain Injury Teams can offer a range of community services to clients, depending upon specified needs, including the following:

- Residential Placements
- Nursing Home Placements
- Direct Payments, where appropriate
- Floating support schemes
- Vocational employment
- Peer/Group Support
- Day Care placements
- Information and advice to Employers
- Rehabilitation Day Care
- Early Intervention Service (Northern Health and Social Care Trust)

3.0 Acquired Brain Injury Non Statutory Pathway

3.1 This section identifies the core elements of support available to patients with ABI and their families across Northern Ireland, reflected in Figure 2 on Page 6, and below in Figure 3: Acquired Brain Injury Non Statutory Pathway.

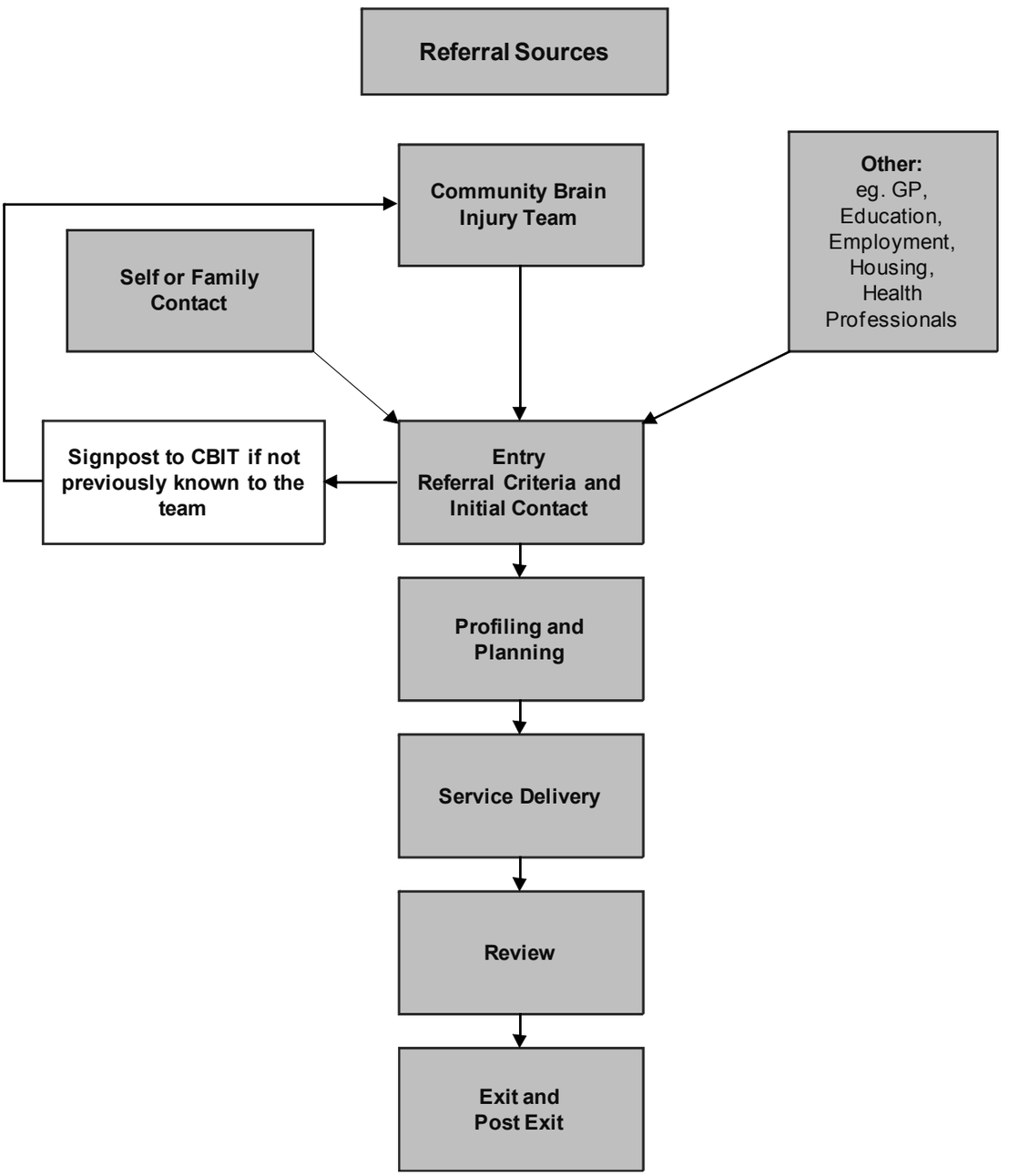


Figure 3: Acquired Brain Injury Non Statutory Pathway

There are five main phases to the adult community care pathway provided through non statutory services. These are illustrated in Figure 3 on Page 14 as follows:

- Entry to the service (Referral and Initial Contact).
- Profiling and Planning (Presentation of services and identification of need. Referral and signposting as appropriate to CBIT and/or other service providers).
- Service delivery.
- Review (ongoing monitoring and review to ensure relevance of the service being provided and ensure needs are being met)
- Exit and Post Exit Monitoring (leaving the service and ongoing contact arrangements).

3.2 Entry

The voluntary sector will provide services in accordance with referral criteria specific to each organisation. This ensures that they meet the needs of those who will benefit from the service they provide. An overview of these organisations is provided in Section 4, Page 18.

Access may primarily be through the CBITs. In these instances it is recognised that the CBIT has clinical lead responsibility for the delivery of ongoing rehabilitation/management and the voluntary sector provider will work in partnership with the CBIT to provide a holistic rehabilitation response.

However individuals may be signposted to the voluntary sector from a number of other sources, particularly when they do not require specialist rehabilitation from the CBITs.

These will include referrals from healthcare professionals, including those from GPs, professionals working in outpatient services, professionals working in Specialist ABI Units, the education, employment and housing sectors. Organisations respond to family and self referral. (See Appendix II: Acquired Brain Injury Voluntary and Community Sector Organisations).

In line with good practice, the referral process should request key information to allow the service provider to plan a person-centred service and manage risk in relation to the activities/support being provided.

Furthermore when responding to a self-referral in particular, it will be important to ascertain if there is currently any input from other professionals to avoid duplication and where possible to ensure the individual has had access to the CBIT and if not to signpost them to this resource.

Appropriate administration systems for receipt, recording and processing and monitoring of referrals should be established by each provider.

3.3 Profiling and Planning

Services should communicate what a service user can expect in terms of how quickly their referral will be responded to and if they have a waiting list system, how this will be managed.

In order to meet good practice standards, services should aim to ensure that there is a 13 week maximum waiting time from referral to planning and commencement of service delivery.

Profiling is an opportunity for the service provider to communicate what they can provide and to give the individual an opportunity to make an informed decision about the service. The provider will ensure timely and appropriate communication with the service users and family at all times during the process.

All services should be person-centred and needs led, giving choice and control to the individual. If the nature of the service is to provide a person specific service that requires an individual plan this should include clear information on the following:

- SMART goals (Specific, Measurable, Achievable, Realistic, Timebound)
- Clear understanding of who will take responsibility for doing what
- When goals can be expected to be completed
- When the plan will be reviewed
- Risk management of any activities planned

3.4 Service Delivery

Each service provider will have a service specification detailing what a service user can expect to receive from that organisation. They will then aim to deliver on these expectations to the best possible standard.

The service that can be expected by an individual will be clearly agreed in advance and communicated to all who need to be aware of this, including any other agencies with whom the individual is involved and has given permission to share information.

3.5 Review

Services provided will be reviewed in line with the agreement made with the service user at entry and reflecting the nature of the service being provided. This is to ensure the individual and their family are continuing to receive a service that best meets their needs which can be adapted to meet changing requirements. It will also be an opportunity to devise new goals or to plan for progression as appropriate.

3.6 Exit

Where a service is time-limited or there is reason for the service to end, the process for this should be communicated clearly to the service user at entry. This should also be a planned process involving others as appropriate (eg. family member, advocate, health professional).

If the organisation has a code of conduct and adherence to this is a condition of being able to receive services, this should be clearly explained at the outset as should a clear process for how this will be managed including how the individual will be supported in the process.

It is also important to agree any need for further signposting or opportunity for follow-up contact and seeking the service user's agreement in this.

4.0 Community Services

The following section identifies core elements of support available to people living with ABI and their families across NI, and is reflected in Figure 3 on Page 14.

There are specialist organisations such as Headway that have their origins in offering specialist support, advice and social networks to people with acquired brain injuries and their families. Key functions of such organisations include:

- ABI knowledge
- Advocacy
- Social support , community based activities
- Social reintegration
- Physical therapies
- Carer/family support, including counselling and practical support
- Respite – what it is and how it is delivered

Such groups are accessed through self referral, membership and access details are supplied by both inpatient and statutory community services. These services have limited resources which are supplemented by some Trusts, through fund raising or by individual donations. Headway in Northern Ireland has an affiliation to the larger UK based charity.

4.1 Community Accommodation Options

- Specialist Residential /Nursing Home Accommodation
- Supported Living Options
- Domiciliary Care
- Direct Payments
- Floating Support

After specialist inpatient rehabilitation progression to community placement the normal pathway is currently dependent on local trust and voluntary sector capacity and specialised ability to support individual needs.

At present specialist needs do emerge in terms of challenging behaviour or of specialist physical nursing needs which do challenge generic nursing and accommodation services in their ability to respond to need.

Acquired Brain Injury services are therefore required to avail of the process of Extra Contractual Referrals ie. sending individuals out of area for a more suitable placement. For example, some clients with ABI and challenging behaviours have often had to be placed through ECR. These are often at very high cost eg approximately £150,000 per individual. At present in Northern Ireland there is a lack of specialist behavioural community accommodation.

Across Northern Ireland options for acquired brain injury accommodation and support are at different stages of development. These are areas of adult community resource that have a partial presence in all five Health and Social Care Trusts across the region. Some individual nursing homes and residential facilities have offered placement to people with brain injuries who are unable to return to live at home, developing specialist skills in this area with support from Community CBITs but often requiring top-up funding to support placements. Providers such as Cedar Foundation and Praxis have also developed specialist accommodation options including specific facilities and more independent supported tenancies. They also work closely with Trust Community Brain Injury Teams to ensure appropriate supports and staff skill sets are available to support the specialised needs of these individuals. These also can be higher cost nursing placements

More recently Supported Living options are a growing service provision and choice for people with brain injuries where both personal care and housing support needs are often met through joined up provision delivered through the same organisation such as Leonard Cheshire or Cedar Foundation. Such support through Health and Social Care and Supporting People funding are provided to people with brain injuries to allow them to live independent lives in their own communities. Supporting People funding is provided through the Northern Ireland Housing Executive. Such cross departmental support for complex needs is a positive way forward in supporting individuals to have more integrated lives in their own communities.

In addition, domiciliary care supports are available to people who return to live at home with their own families or on their own. Such individual packages of care and personal support are determined on a needs assessed basis and vary widely depending on need and availability of resource to meet that need. The ending of the Independent Living Fund which previously match-funded support for more complex needs will have a detrimental effect on such support packages. At this stage it is unclear how such support will be replaced.

Some people opt to take a Direct Payment instead of receiving care from the statutory or voluntary sector to meet their assessed needs. This allows them individual flexibility to design and model the care they need. The Centre for Independent Living offers a support service to those opting for this process of care delivery

Floating Support services which specifically address the housing support needs of people with brain injuries is now also widely available across Northern Ireland through providers such as Cedar Foundation, Leonard Cheshire. Supporting People as noted above is the funding source for this support. Referral is often through Community Brain Injury Services, although not the only access route.

Access to all of these specialised community accommodation/support options is usually by referral from or co-ordination by the statutory community brain injury service who continue to offer support and advice to service users or

through physical disability services. The Community Brain Injury Services also liaise with commissioners to request and monitor ECRs and specialist placements when these are required because of specialised need.

4.2 Vocational Employment/Community Support

- Vocational Rehabilitation (employability skills and preparation for work)
- Support to access education and training
- Work opportunities in the community – supported pathways
- Volunteering − support
- Opportunities for community based rehabilitation support

Cedar Foundation and Reconnect in Belfast are two of the main providers of these specialist pre-vocational and vocational training services. Cedar vocational rehabilitation has a presence in all Trust areas. Services include detailed profiling of needs and support to engage in vocational, social and education opportunities for individual service users. Funding sources include DEL, European Social Fund and also Health and Social Care. These services aim to meet the more holistic needs of individuals with a brain injury. These programmes are generally accessed through referral from community brain injury services in each Trust area.

Included in vocational rehabilitation is the consideration of other options such as further training through Further Education colleges and training organisations, 'tasters' of other work environments and development of supports to assist individuals to return to employment or a voluntary role. This would include involvement if necessary of the Disablement Advisory Service which may assist in addressing access/support issues at work.

Volunteering has become a positive option in opening opportunities to people with brain injuries for whom sustaining paid work is not currently viable.

Most statutory day services provided to people with physical disability are also accessed by people with acquired brain injuries. These are available in most Trust areas. Some have specific programmes developed for people with acquired brain injuries eg. community integration/access staff who can also work with people with acquired brain injuries rather than use a more traditional centre-based day support model. Independent sector services such as JIGSAW in Belfast /North Down offer community support and integration to 145 individuals a week, focussing on local and community services, resources and leisure facilities. Headway Belfast, Newry and Ballymena also offer day services including art and drama, IT support and Peer Support meetings.

The NI Traumatic Brain Injury Forum also exists and represents service users, carers and professionals with the aim of educating, informing and campaigning for better services, promoting best practice in Brain Injury Services, facilitating the exchange of information and raising awareness of the needs of people with Brain Injury and their carers.

5.0 Appendices

Appendix I: Trust Community Brain Injury Team Profiles

Appendix II: Acquired Brain Injury Voluntary and Community Sector Organisations

Appendix I: Trust Community Brain Injury Team Profiles*

Trust Community Brain Injury Team Profile	
Name of Team:	Community Brain Injury Team North and West Sector, Belfast Health and Social Care Trust
Address:	Grove Wellbeing Centre 120 York Road Belfast BT15 3HF
Geographical Coverage:	North and West Belfast
Contact Details:	Team Lead: Dr Robert Rauch, Consultant Neuropsychologist Tel: 028 9063 6810 Email: robert.rauch@belfasttrust.hscni.net

Staff Team Profile:

WTE	Post
1.0	Co-ordinator/Consultant Neuropsychologist
1.0	Clinical Specialist Occupational Therapist
0.5	Clinical Specialist Speech and Language Therapist
0.5	Physiotherapist
1.0	Social Worker
1.0	Associate Rehabilitation Practitioner

Service Provision Description:

Interdisciplinary, community based, holistic, goal directed and time-limited rehabilitation service for people from 18 years of age with acquired brain injury which is non-degenerative.

* *Please note that Trust Staff Profiles were correct at time of publication*

Trust Community Brain Injury Team Profile		
Name of Team:	Community Brain Injury Team Belfast Health and Social Care Trust	
Address:	Administration Building Knockbracken Healthcare Park Saintfield Road Belfast BT8 8BH	
Geographical Coverage:	South and East Belfast	
Contact Details:	Team Lead: Dr Marie Goss Tel: 028 9096 0085/9091 6892	
Staff Team Profile:		
	WTE	**Post**
	0.30 0.65 0.5 1.0 0.3 0.4 0.3 1.0	Clinical Psychologist Clinical Psychologist Clinical Psychologist Senior Practitioner Social worker Speech and Language therapist Physiotherapist Occupational Therapist Occupational therapist
Service Provision Description: Interdisciplinary, community based, holistic, goal directed and time-limited rehabilitation service for people from 18 years of age with acquired brain injury which is non-degenerative.		

Trust Community Brain Injury Team Profile	
Name of Service:	The Mourne Project
Address:	Mourne Project Knockbracken Healthcare Park Saintfield Road Belfast BT8 8BH
Geographical Coverage:	Belfast Health and Social Care Trust South Eastern Health and Social Care Trust
Contact Details:	Manager: Mrs Patricia Kirk Tel: 028 9056 6789 Email: patricia.kirk@belfasttrust.hscni.net Clinical Lead: Dr Marie Goss Tel: 028 9096 0085 Email: marie.goss@belfasttrust.hscni.net

Staff Team Profile:

WTE	Post
1.0	Service Manager
0.2	Clinical Lead/Neuropsychologist
1.0	Senior Day Care Worker
2.0	Day Care Worker
0.2	Occupational Therapist
1.0	Psychology Assistant

Service Provision Description:

Established in 2005 as a specialist skills day support unit, to provide a service to the four Community Brain Injury Teams within Belfast and South Eastern Trusts, Mourne provides support for male and female adults in the community who have significant neurobehavioural dysfunction following acquired brain injury or brain disease. Clients may additionally display sensory, physical and physical impairments.

The service provides day support and training opportunities for a small group of approximately 15 people with very complex needs who require a high level of staff support. Clients attend on a sessional basis ie. morning or afternoon and the frequency of attendance is dependent upon individual need.

Trust Community Brain Injury Team Profile
Referrals are generally received from the respective Community Brain Injury Team and Mourne staff work collaboratively with the team throughout the client's attendance. Each client has an individual structured programme of social, recreational and therapeutic activities as based on their needs and capabilities. Whilst some activities are unit based we also encourage and support clients to enable engagement within the local community. This range of activities provide staff with an opportunity to carry out in-depth assessments of the individual. Regular client case review meetings are held at least twice yearly and more often in response to client need. We give clients, their carers, relatives and referral agents sufficient information to enable them to make decisions about treatment, rehabilitation, care, discharge planning, equipment and ongoing care.

Trust Community Brain Injury Team Profile	
Name of Team:	Northern Trust Brain Injury Service
Address:	Ballymena North Business and Recreation Centre 120 Cushendall Road Ballymena BT43 6HB
Geographical Coverage:	Northern Health and Social Care Trust area
Contact Details:	Team Lead: Dr Rosemary Macartney, Consultant Clinical Neuropsychologist/Brain Injury Services Manager Email: rosemary.macartney@northerntrust.hscni.net Tel: 028 2563 2035

Staff Team Profile:

WTE	Post
1.0	Consultant Clinical Neuropsychologist/Manager
1.0	Clinical Neuropsychologist
0.6	Clinical Psychologist
0.85	Speech and Language Therapist
1.0	Clinical Psychologist
1.0	Occupational Therapist
1.0	Nurse
1.0	Carer Therapist
0.8	Physiotherapist
1.0	Adapt Service Manager
2.0	Psychology Assistant
3.64	Rehabilitation Training Coach (one post in vacancy control)
0.5	Physiotherapist (in vacancy control)
1.0	Team Administrator/Personal Secretary
1.0	Clerical Assistant

Service Provision Description:

The Northern Trust Brain Injury Service (NTBIS) provides assessment, treatment and management for those with non-progressive acquired brain injury caused by a definable event such as trauma (a blow to the head), hypoxia (loss of oxygen to the brain) or infection (encephalitis/meningitis). It excludes all progressive brain disorders and those that are acquired over time due to alcohol and drug misuse. While stroke is defined as an acquired brain injury, separate standards and services are available for this group and so it is not dealt with by the NTBIS.

Trust Community Brain Injury Team Profile
The service focuses on dealing with the range of deficits caused by brain injury and aims to reduce these difficulties, allowing the injured person to reintegrate into family, social, education and work situations. The service is available to adults (18+ years) however those who have acquired their brain injury at a younger age will be accepted after their 17th birthday to allow for transitional planning from Children's Services. Older adults are accepted by the service and a dedicated Older Adult Service is provided by a Clinical Psychologist with expertise in assessment and treatment of this client group. The NTBIS is interdisciplinary and provides holistic assessment and therapy that can be delivered within one of its centres or within the client's home. An Early Intervention Service is delivered which provides assessment for those still in hospital and follow-up visits after discharge. In addition, a follow-up service for mild traumatic brain injury is provided following attendance at Accident & Emergency or Short Stay Wards. The NTBIS Adapt Service provides rehabilitation both in the community and at a number of bases including Moneymore, Ballymena and Whitehead. The NTBIS Carer Service is available to all carers of clients known to the service. It provides education, therapy and support through one-to-one input, therapeutic groups or through workshops. Unless specifically requested by the client, the NTBIS involves carers and families in their care and treatment.

Trust Community Brain Injury Team Profile		
Name of Team:	Western Trust Community Brain Injury Service	
Address:	Northern Sector:	Community Brain Injury Unit Foyle Disability Resource Centre Glen Road Londonderry BT48 0BX
	Southern Sector:	Drumcoo Centre Enniskillen BT74 6AY
Geographical Coverage:	Western Health and Social Care Trust area	
Contact Details:	Team Lead: Dr Shane McCarney, Consultant Clinical Psychologist	
Staff Team Profile:		
	WTE	**Post**
	1.0	Consultant Clinical Psychologist – Northern and Southern sectors of Trust
	0.5	Specialist Neuro Occupational Therapist – Northern Sector
	0.8	Specialist Neuro Occupational Therapist – Southern Sector
	1.0	Social Worker (with care management responsibility) – Northern Sector
	1.0	Social Worker (with care management responsibility) – Northern Sector
	1.0	Social Worker (with care management responsibility) – Northern Sector
	1.0	Neuro Physiotherapist
	0.5	Clinical Psychologist - Northern sector (appointed and commencing in December 2011 following completion of training)

Service Provision Description:

- The Western Trust Community Brain Injury Service is organised into 2 locality-based teams in Enniskillen and Derry. The service provides a rehabilitation service including assessment, treatment and training to adults with an acquired brain injury, their families and carers.
- The service considers adults with an acquired non-progressive brain injury, following an identifiable neurological event where there are significant cognitive,

Trust Community Brain Injury Team Profile
emotional and/or behavioural sequelae in addition to any physical or medical issues. • The team prioritises the needs of those with early brain injury and those judged to be at high risk as most benefit is likely to be gained. Clients must be able to achieve benefits from Community Brain Injury Service not achievable elsewhere. • Older adults with Acquired Brain Injury can be assessed and advice and information provided to carers and generic services. • Co-working of cases across services will be considered if this has the potential to be of benefit and meet the client's needs. • Referral may not be accepted due to ongoing problems (eg. drug/alcohol abuse, mental health problems, ongoing medical concerns) which can reduce the potential to benefit fully from the service. • Referrals will be accepted from any source. The referral must be discussed and agreed with the person involved. Referrals from professionals must be made in writing either by letter or on the referral form. • Referrals, where possible, should provide information on the nature and cause of the persons brain injury, relevant medical details such as secondary complications of injury, surgical interventions and results of brain imaging scans. Demographic details of the person, their family, social or work issues, physical, cognitive, behavioural or emotional difficulties should also be provided. • Referrals will be acknowledged within 10 working days of receipt. New referrals are discussed at the weekly team meeting and if appropriate will be allocated for initial screening assessment within 28 days of allocation. • Reduction of the range of decrements in health, functioning and disability caused by brain injury are reduced, and family, social, educational and vocational reintegration are promoted. • This is a specialist resource to other services offering advice, consultancy and specialist training on the complex nature of brain injury to those who have acquired a brain injury and their family and carers. • Links are established with other agencies including relevant voluntary and statutory organisations, and Education facilities.

Trust Community Brain Injury Team Profile	
Name of Team:	South Eastern Trust Community Brain Injury Team
Address:	Thompson House Hospital, Lisburn Ards Community Hospital, Newtownards
Geographical Coverage:	Population 336,000 covering Lisburn, Downpatrick, Bangor, Newtownards, and the Ards Peninsula
Contact Details: **Down and Lisburn Sector Thompson House** **North Down & Ards Sector**	 No Clinical Lead. Whole service is operationally managed by Mr Maurice Devine Tel: 028 9263 3189 Team Lead: Dr Dario Barsalini, Clinical Co-ordinator North Down and Ards Sector Tel: 028 9151 1192 Mobile: 075 2589 9172

Staff Team Profile:

WTE	Post
0.33	Operational Manager
0.25	Clinical Coordinator
1.25	Consultant Neuropsychologist
0.6	Clinical Psychologist
0.7	Speech & language Therapist
1.0	Social Work Practitioner
0.8	Rehabilitation Nurse
0.5	Senior Physiotherapist
1.43	Senior Occupational Therapists
0.5	Social Work Practitioner
1.8	Rehabilitation Assistants
1.0	Psychology Assistant

Service Provision Description:

Total Clinical Staff (not including Operational Manager & Clinical Co-ordinator) = 9.58 WTE. This does not include Administration staff of 1.3 Band 3

The South Eastern Trust is split between two legacy sites (Down & Lisburn and Ulster Community & Hospital Trust). The team is an interdisciplinary/multidisciplinary team offering client centred, goal orientated rehabilitation to individuals, carers and their families. The team is operationally managed by a service manager and North Down & Ards sector has a Clinical Co-ordinator whilst Down & Lisburn sector is waiting to appoint a new clinical co-ordinator. The service offers episodic episodes

Trust Community Brain Injury Team Profile
of brain injury rehabilitation, although episodes of care can last anything from 6 months to 3-4 years. Each referral is comprehensively assessed before acceptance on to the service and progress towards the achievement of collaboratively agreed rehabilitation goals is monitored through various processes including a key worker system, regular reviews and weekly clinical team meetings involving all the multidisciplinary staff. Vocational rehabilitation and social reintegration whilst maximising independence and psychological well being are key features of the service. Acquired Brain injury is often a life long chronic health condition and the service South Eastern Trust Community Brain Injury Team delivers reflects this fact. People over the age of 65 years are currently accepted on a case by case basis. The team will work collaboratively with services providing input to children aged 16-18 years who have an acquired brain injury with the aim of making transition from children's into adult services as seamless as possible. The team works collaboratively with both the independent sector and other statutory services serving individuals, carers, and families who have suffered acquired brain injury.

Trust Community Brain Injury Team Profile	
Name of Team:	Southern Trust Acquired Brain Injury Rehabilitation Team
Address:	Edenderry House 18-22 Gilford Road Portadown Craigavon BT63 5ED
Geographical Coverage:	Southern Health and Social Care Trust area
Contact Details:	Team Lead: Dr Ivor Crothers, Consultant Neuropsychologist Lead Specialist for Physical & Sensory Disabilities ABIRT Service Manager Tel: 028 3839 8350 Fax: 028 3833 3255 Email: ivor.crothers@southerntrust.hscni.net

Staff Team Profile:

WTE	Post
1.0	Consultant Neuropsychologist
1.0	Clinical Psychologist
1.0	Occupational Therapist
0.8	Occupational Therapist
0.55	Physiotherapist
0.55	Speech and Language therapist
0.6	Senior Social Worker
0.5	Early Intervention Officer

Service Provision Description:

The team provide a specialist community based interdisciplinary assessment and rehabilitation service for adults and their families affected by acquired brain injury (mild, moderate, and severe). The team covers the geographical area of the Southern Trust and provides systemic goal directed interventions designed to address the cognitive, physical, emotional, and behavioural consequences of brain injury. The aim is to maximise the individual's potential for meaningful family, social, and vocational activity by minimising and/or managing the impact of their injury on their everyday functioning. Interventions are designed to be person-centred, time-limited and directed by clinical need.

Appendix II: Acquired Brain Injury Voluntary and Community Sector Organisations

Name of Organisation	Description of Services	Contact Information	Service Locality
Headway	Headway operates a network of groups and branches across the UK and Channel Islands. They offer a wide range of services, including brain injury rehabilitation programmes, carer support, social re-integration, community outreach and respite care. The services available will vary, depending on local needs and resources.	Website: www.headway.org.uk	Regional See website for details
Headway Newry	Social and recreational activities for brain injury survivors and their carers and families. Respite care. Advocacy. Information services.	Abbey Yard Newry BT34 2EG Tel: 028 3083 3728 Email: info@headwaynewry.org Website: www.headwaynewry.org	Newry and Mourne and Banbridge Council areas and also accepts members from Armagh and Dungannon Councils
Headway Belfast	Counselling, education and practical support. Social reintegration, Therapies, day service.	Tel: 028 9047 1222 Email: info@headwayni.org Website: www.headwayni.org	Belfast and South Eastern Health and Social Care Trust areas
Northern Ireland Traumatic Brain Injury Forum	A forum of service users, carers and professionals with the aim of educating, informing and campaigning for better services. Promoting best practice in Brain Injury Services.	Email: angela.thompson@reconnect-abi.com	Regional membership

Name of Organisation	Description of Services	Contact Information	Service Locality
	Facilitating the exchange of information and raising awareness of the needs of people with Brain Injury and their carers.		
Cedar Foundation	**Accommodation Services:** provision of Living Options that include accommodation designed to meet the individual needs of people who have brain injury, physical disability, sensory impairment and for people with learning disability. Services include Supported Living in independent apartments, registered residential homes providing 24 hour care and housing support services. **Vocational Services:** Specialist support for people with Brain Injury to access training, employment and volunteering options.	The Cedar Foundation 31 Ulsterville Avenue Belfast BT9 7AS Tel: 028 9066 6188 Fax: 028 9068 2400 Website: www.cedar-foundation.org Email: bis@cedar-foundation.org	Regional See website for details
Leonard Cheshire	**Accommodation Services:** including tenancy-based supported living, registered care homes and specialist acquired brain injury rehabilitation services. **Personalised Care and Support**	Leonard Cheshire Disability Northern Ireland Unit 5 Boucher Plaza Boucher Road Belfast BT12 6HR Tel: 028 9024 6247 Fax: 028 9024 6395	See website for details

Name of Organisation	Description of Services	Contact Information	Service Locality
	Services: including registered care in people's own homes. **Social, Education and Leisure Services:** including day support, community outreach services, respite support and Park House.	Website: www.lcdisabilty.org Email: northernirelandoffice@lcdisability.org	
Praxis	Providing excellence and innovation in care and support to children and adults affected by mental ill health, learning disability, acquired brain injury or dementia	Praxis Care 25-31 Lisburn Road Belfast BT9 7AA Tel: 028 9023 4555 Fax: 028 9024 5535 Website: www.praxisprovides.com Email: info@praxiscare.org.uk	See website for details
Reconnect	Reconnect works in support of adults with acquired brain injury, enabling them to achieve their maximum potential through structured programmes based on the individuals and their personal goals.	1 Lisnabreeny Road East Castlereagh Belfast BT6 9SS Tel: 028 9079 0551 Fax: 028 9079 1026 Website: www.reconnect-abi.com Email: info@reconnect-abi.com	Belfast Health and Social Care Trust area
JIGSAW	The organisation provides adults with disabilities with a range of activities to participate in and operates from local community settings, eg. leisure centres, church buildings etc. The friendly and fully	Jigsaw NI 28 Townsend Street Belfast BT13 2ES Tel: 028 9031 9054 Website: www.jigsawni.org.uk	Belfast and South Eastern Health and Social Care Trust areas

Name of Organisation	Description of Services	Contact Information	Service Locality
	qualified staff ensure members enjoy and benefit from their chosen activity. The service is designed to improve the lifestyles of adults with disabilities, give ownership and encourage community involvement at all levels, while improving the health and well being of members.		

6.0 References

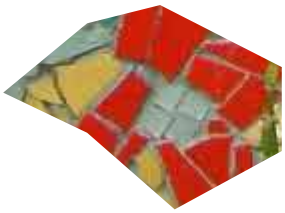
Brain Injury: Service Standards and Quality Indicators, Regional Acquired Brain Injury Implementation Group, 2010

Regional Acquired Brain Injury Action Plan, DHSSPS, 2010

Community Brain Injury team Service Pathway, South Eastern Trust

Gold Standard Care Pathway for People with an Acquired Brain Injury in Sussex, West Sussex Acquired Brain Injury Network and Forum, 2007










This Service Standards and Quality Indicators and Pathways pack was produced by the Health and Social Care Board's Regional Acquired Brain Injury Implementation Group in partnership with parents and carers.

The Regional Acquired Brain Injury Implementation Group would like to extend their thanks for the artwork produced by clients from the Child Brain Injury Trust, Headway Belfast, Headway Newry and Reconnect. Their excellent contributions are much admired and appreciated by everyone involved in producing this resource.

Please ask if you need this information in alternative formats: Large print, computer disk, Braille, audio tape or translation. Please contact the Health and Social Care Board on 028 2532 1206.

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Acquired Brain Injury Adult Community Care Pathway