



Acquired Brain Injury. A Perspective from Northern Ireland

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Community Brain Injury Service

South Eastern Health and Social Services
Trust.



Overview

- Brain Injury Services in NI
- South Eastern Trust Community Brain Injury Team
- Service Improvement Project



Northern Ireland

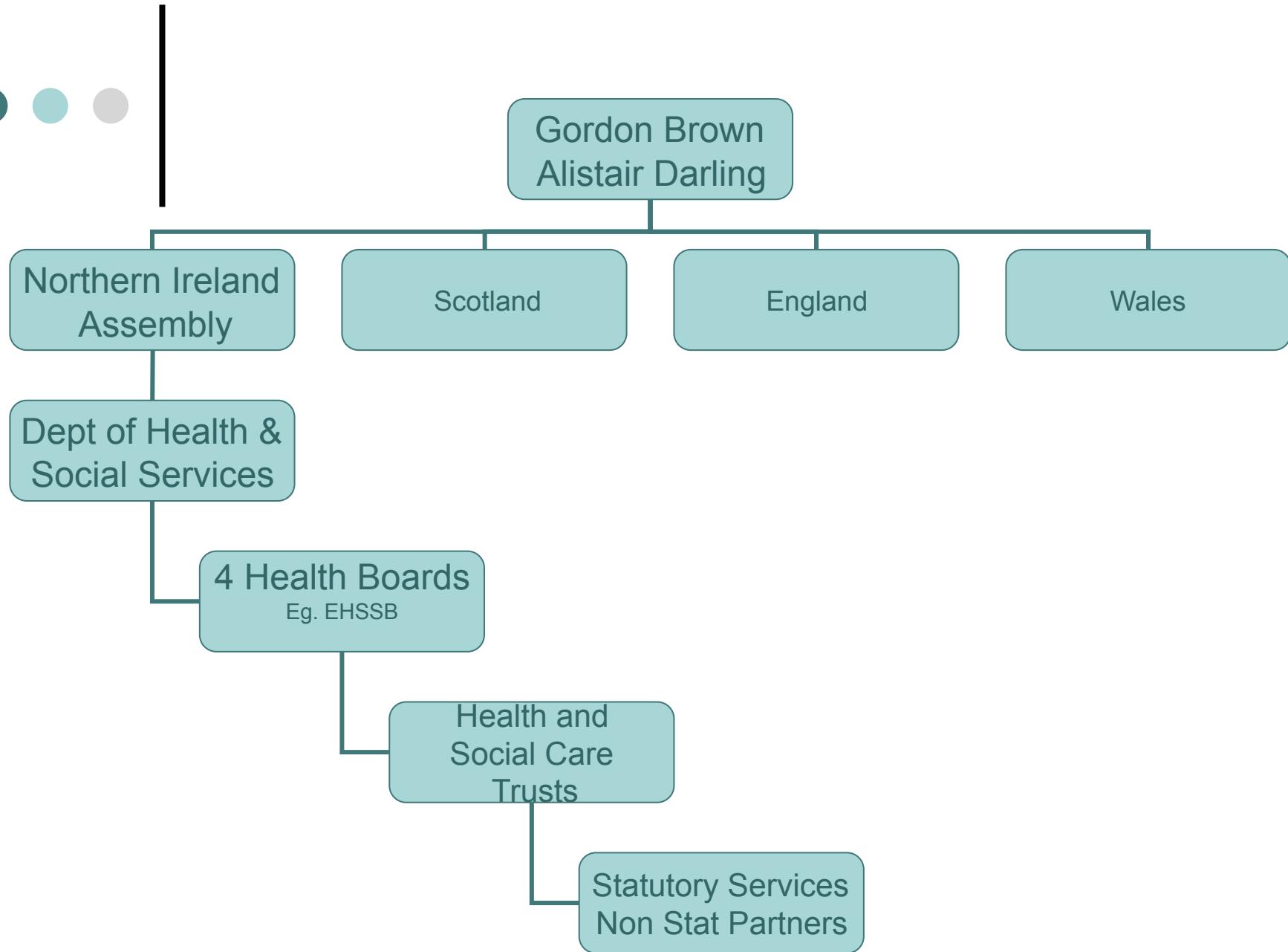


- We're part of the UK
- We use £ Sterling
- Queen Elizabeth II is our Monarch
- Gordon Brown is our Prime Minister
- We drive on the left side



Demographics

- Population 1.7 million
- Stable population base
- Dept. Health Social Services and Public Safety
- Four Area Health and Social Services Boards
- Regional Medical Services Consortium
- Mixed regional and local commissioning





Epidemiology of A B I

- Stroke. <65y.o. 20/100000. N.I. ~ 300
- S A H. ~8500/yr. N.I. ~ 200
- Head Injury. ~275/100000. N.I. ~ 4000
- Mod-severe. 25/100000. N.I. ~ 260



Background Documentation

- Royal College Surgeons England. Working Party on Management of Patients with Head Injuries. June 1999.
- **Royal College of Physicians / BSRM. Rehabilitation following acquired brain injury. National clinical guidelines. 2003.**
- National Service Framework for Long-term Conditions. March 2005.



These reference....

- Principles and organisation of services
- Transfer to rehabilitation
- Timing, intensity and duration of intervention
- Discharge planning
- Continuing care and support
- Carers and families
- Vocational rehabilitation



Principles and organisation of services

- access to specialist neurological rehabilitation services.
- acute management - medium term rehabilitation - long term support - life long
- meet published standards, and comprise the following:
 - A coordinated interdisciplinary team of all the relevant clinical disciplines.
 - Staff with specialist expertise in the management of ABI including a consultant specialist in Rehabilitation Medicine.



Transfer to Rehabilitation

- Access to rehab team
- Coma – ABI Unit – interdisciplinary team
- Post acute rehab – as soon as medically fit



Timing, intensity and duration of treatment.

- Following acute ABI patients should:
 - Be transferred as soon as possible to a rehabilitation programme of appropriate intensity to meet their needs.
 - Receive as much therapy as they need, can be given and find tolerable.
 - Be given as much opportunity as possible to practise skills outside formal therapy sessions.
- need for life-long contact to meet the changing clinical, social and psychological needs of patients and carers.
- formal therapy to a guided and supported resumption of chosen activities over months and years.



Discharge Planning

- Inpatient rehabilitation should continue while the patient requires the facilities, skills and therapeutic intensity of a specialist rehabilitation unit in order to make progress or while the hospital environment is needed in order to maintain safety.
- transferred back to the community once any specialist rehabilitation and support needed can be continued in that environment without delay.



Continuing care and support

- long term access to an individual or team with experience in management of ABI.
- Care services should be provided by skilled workers trained in the needs of ABI patients
- Patients with complex needs after ABI should have joint assessment by health and social services, with ongoing review and re-assessment
- Access to regional services is needed to supplement local service provision.



Carers and families

- Rehabilitation services should be alert to the likely strain on families/carers and, in particular the needs of children in the family
- Patients and their families/carers should be considered with regard to treatment and care options and should be involved in planning of the patient's specific rehabilitation programme, negotiating appropriate goals, and in decisions regarding their care.



Carers and families

- Families of patients with ABI should be offered timely:
 - Information and education about ABI, and local and national services and support groups.
 - Referral to social services regarding their own needs.
 - Assistance with the benefits system.
 - Support and counselling, which should be available long-term, provided by professionals experienced in ABI management.



Carers and families

And where appropriate:

- The opportunity to learn skills, techniques and routine necessary to maintain rehabilitation gains.
- Information about the process of compensation for personal injury and approved sources of information concerning legal assistance.



NI Brain Injury Service

- Acute Hospitals
- Regional Acquired Brain Injury Unit (RABIU)
- Community Brain Injury Services
- Thompson House Hospital
- Maine
- Spruce House
- Day centres
- Non statutory service providers / partners
- Partners – CEDAR, HEADWAY, RECONNECT, Local facilities eg leisure centres, colleges



Didn't happen over night



- A lot of people kept chipping away



20+ Years a coming

- 1982. Medical Rehabilitation. Report of a Working Party.
- 1991. Sloan Report.
- 1994. Business Case for R.R.U. submitted to Management Executive.
- 1996. Social Services Inspectorate. Symposium and Workshop on TBI.
- 1998. RMSC Report on ABI Rehab.



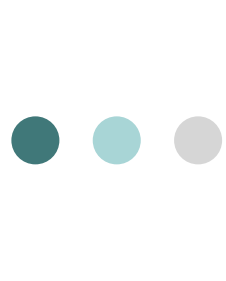
Regional Strategy. 1997-2002.

- Dept. should undertake to resolve with Boards the provision of Rehabilitation services for persons with T B I.
- Development of locally sensitive hospital and community services and establish a Regional Rehabilitation Unit.



Priorities for Action 2001/2002

- Boards and Trusts should finalise a Business Case for a Regional TBI Unit by December 2001.
- Agreement that Greenpark should lead development of Business Case.
- Sept. 2001 Outline Case submitted
- Dec. 2001 Capital funding announced.



Inpatient Rehabilitation Services

- Regional Acquired Brain Injury Unit
- Thompson House
- Maine Villa

- Spruce House



Regional Acquired Brain Injury Unit.

- Opened May 2006.
- 25 Beds
- Flexibility of accommodation
- Integrated outpatient service
- Early transfer from acute units
- Working relationships with other providers
- Interdisciplinary team structure



Thompson House Hospital

- South Eastern Trust
- Young disabled unit
- Slow stream neuro-rehabilitation and respite
- 6-8 Brain injury rehab beds.
- Low level consciousness patients
- Shares base with community brain injury team



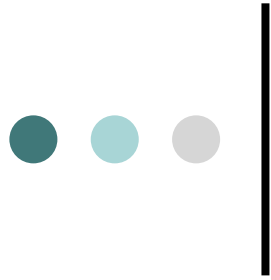
Maine Villa

- Stand alone within psychiatric unit
- Locked facility
- 10-12 beds
- Challenging behaviour
- No female patients
- Linked to Mourne project



Spruce House

- New build on acute hospital site
- Slow stream rehabilitation and respite
- Limited therapy input
- 6-8 brain injury beds
- Links to community team
- Potential step down facility



Outpatient/Community Services

- RABIU
- Mourne Project
(Maine Day Centre)
- EHSSB
 - South Eastern CBIT
 - N & W Belfast CBIT
 - S & E Belfast CBIT
- NHSSB CABIRS.
- SHSSB. CBIT
- WHSSB. CBIT



Vocational Rehabilitation

CEDAR Foundation.

- Vocational and pre-vocational rehabilitation services in each of N.I. Area Health Boards

Reconnect.

- Provision of services for persons in Greater Belfast Area.



Support Organisations

- Headway STAR Project
- Headway Belfast.
 - Social Reintegration and Family Support Services.
- Headway Ballymena.
- Headway Londonderry
- Headway EnnisRone
- Headway Southern Region.
- CBIT Support Groups



Down Lisburn
Community Brain Injury Team
(part of South Eastern Trust)



- 1997 - Community Brain Injury Service
 - Regional Strategy
 - Moffat paper
 - Existing staffing
 - Part time
 - Interdisciplinary team model – Clin Neuropsych, Clin Psych, OT, Physio, SLT, Social Work, *Nursing, Rehab Assistants (3)*
 - Benchmarking exercises – eg. Toronto Brain Injury Network, Anagram
 - Partnerships - eg. Cedar Foundation, Headway STAR
 - Database

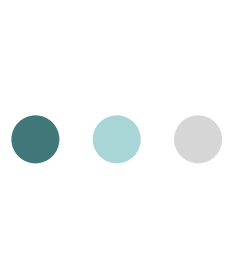


- CARF x 2
- Chartermark
- Public Servant of the Year Team Award
- ISO
- Publications
- Conferences



Referral Criteria

- 16 - 65
- acquired brain injury with non progressive condition
- live within DLT geographical area



Sources of Referral

	2004	2005
RVH	4	6
FGH	1	1
JCRC	3	3
Other Hospital	17	15
Community	20	15
Psychiatry	3	1
TOTAL	48	41



Demographics

○ Diagnosis

- TBI 59%
- CVA/SAH 29%
- Other ABI 13%

○ Gender

- male 61%
- female 39%

○ Age

- 16 - 20 6%
- 21 - 34 19%
- 35+ 75%



Services provided – wherever appropriate for service user

- Screening – usually home
- Assessment / Joint goal setting
- Rehabilitation – individual /group
- Fast Track Service
- Outreach
- Education
- Advice
- Counselling
- Support Groups – generic/female carers, floating support
- Pre vocational – Headway Star
- Vocational - Cedar



2005/2006



AP / Damian Dovarganes



Down Lisburn Trust Community Brain
Injury Team

Better Access to Brain Injury
Rehabilitation
Service Improvement Project
2006



Background to project

- Problem with waiting lists and flow through the service
- Processes not optimal



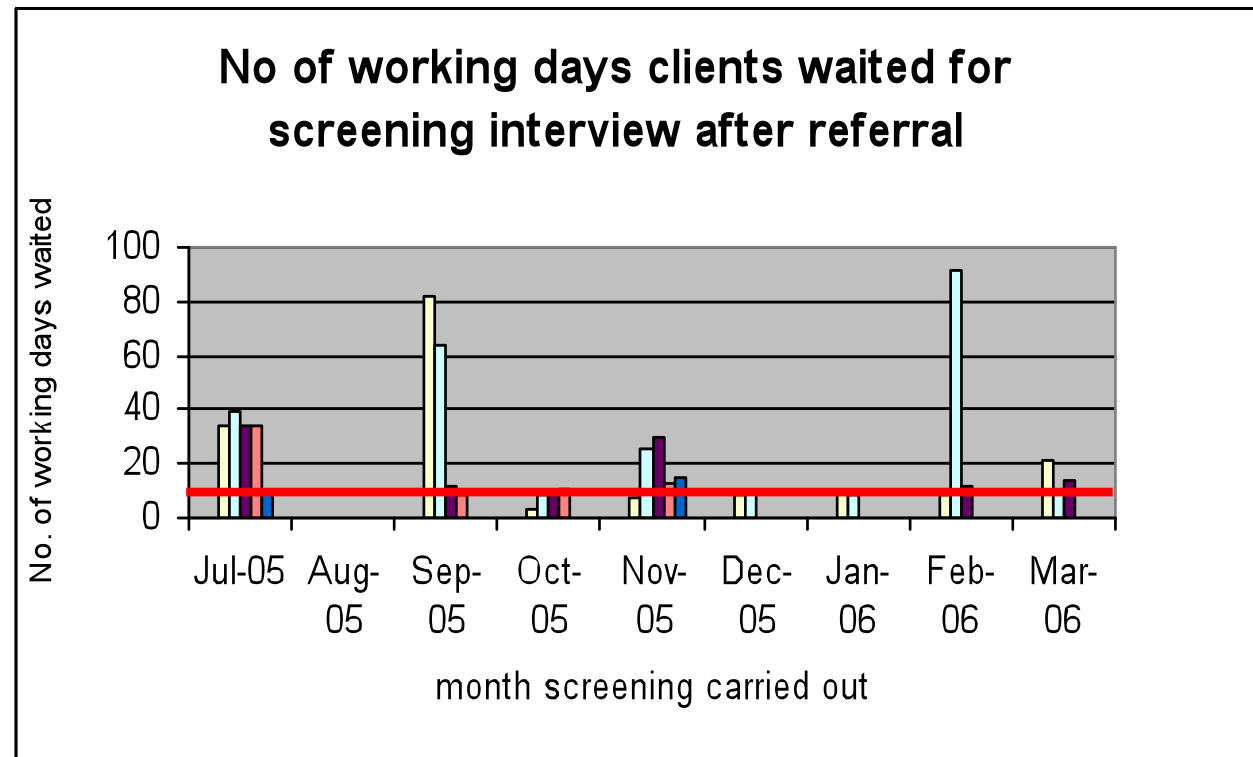
Aim of project

- To improve access to the Community Brain Injury Service
- **Objectives:**
 - To reduce waiting time from referral to first face-to-face contact **from 5 weeks to 10 days.**
 - To reduce waiting time from first face-to-face contact to start of intervention **from 51 weeks to 12 weeks.**
 - To reduce waiting time **from 170 weeks to a maximum of 52 weeks**
 - To achieve a high level of client and carer satisfaction with quality of information given on entry to the service.



Objective 1:

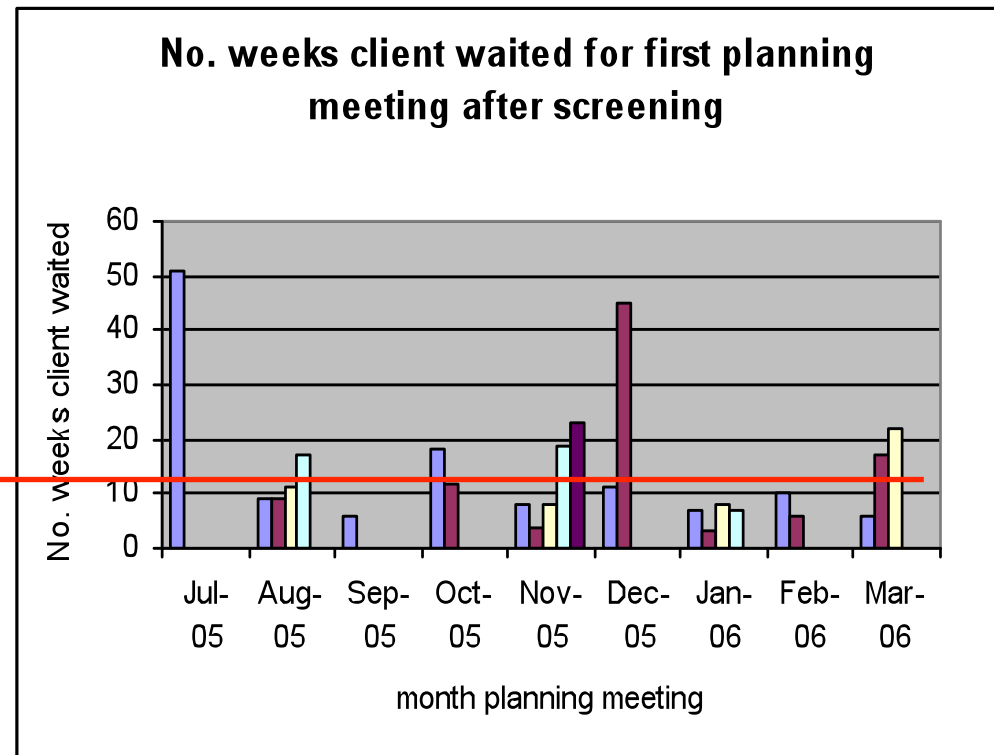
New referrals are seen within 10 days.





Objective 2:

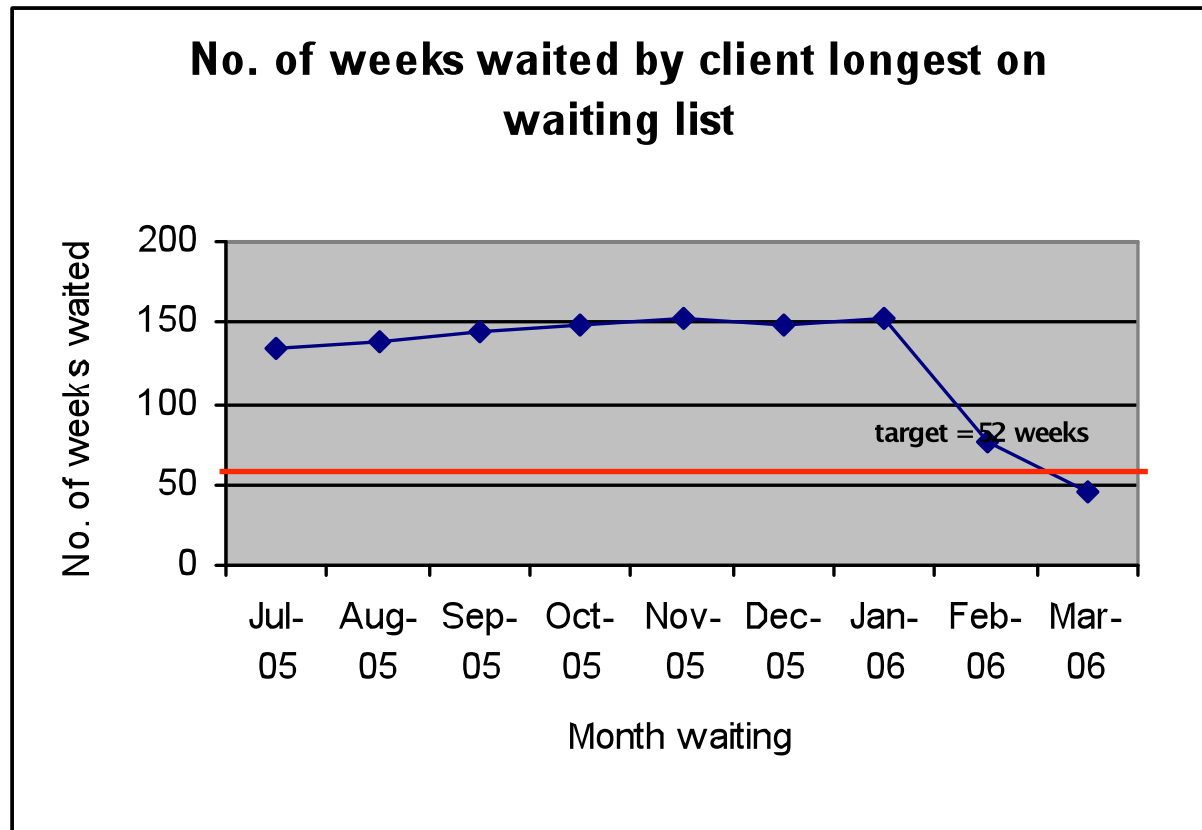
Clients are planned within 12 weeks of screening





Objective 3:

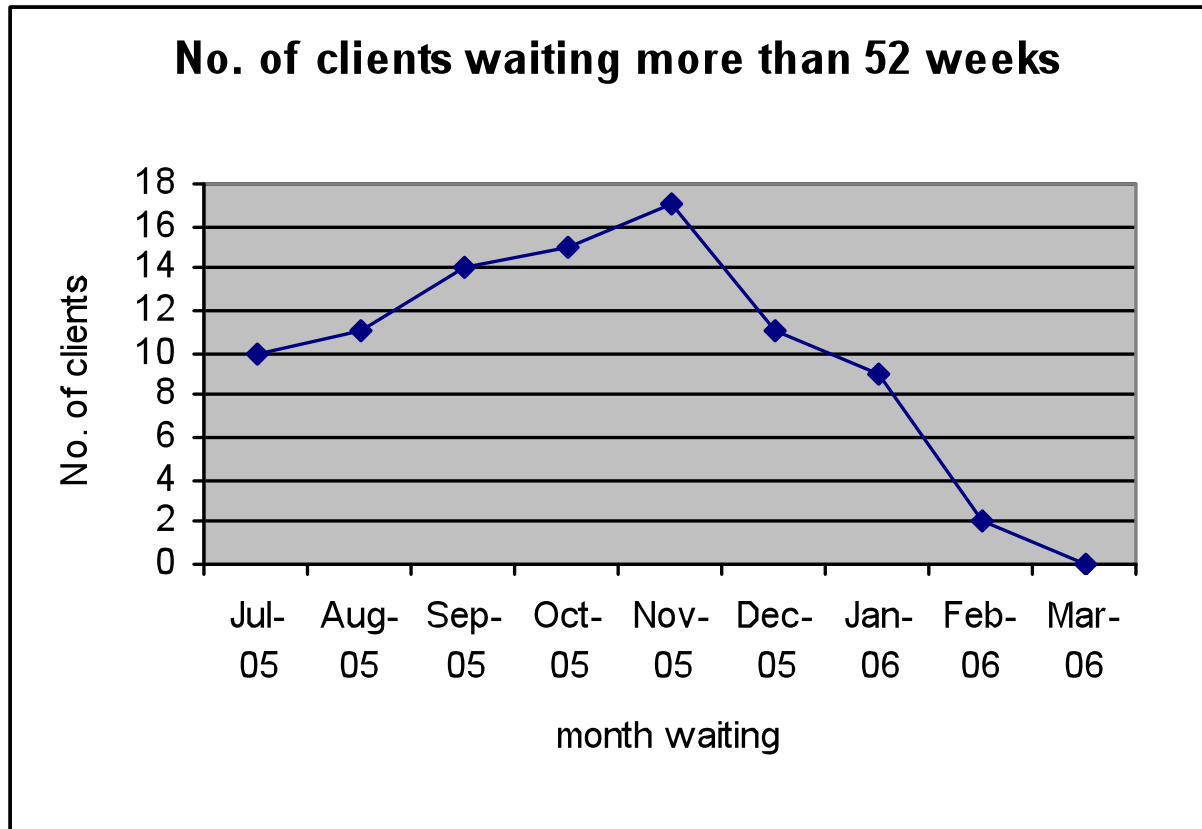
Length of time waiting is below 52 weeks





Longest wait reduced to 46 weeks (1 client)
Next longest wait is 5 weeks

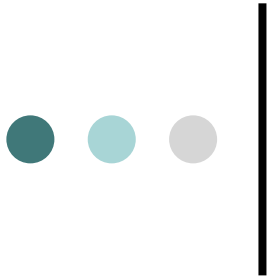
Reduction from 170 weeks to 5 weeks





How..

- Overcoming inertia
- Streamlining referral process
- Segmented time - screening, assessment
- Waiting list validation/management



- Information - letters, folders, reception staff
- Streamlining CBIS - 3 options of service
- Fast track service - specific, intensive
- DNA/CNA procedure



- Professional service users
- Regular, short project meetings
- Additional hours
- Representation at higher level in Trust



Challenges

- Thompson House renovations
- Project Manager left post
- Social worker leaving post
- Team working relationships
- Time commitment
- Service user satisfaction
- New Trust Community Stroke Team
- RPA



Lessons learned

- Process mapping - lengthy but necessary!
- Demand and capacity - effective planning
- Medical/Neuro assessment informs access to service
- Waiting list review/validation - service process



Lessons learned....

- Working groups - effective problem solving
- Innovative practice doesn't necessarily fit the service eg. partial booking
- Discharge policy - a 'must have'
- Keep it simple!



Spread and Sustainability

Short term:

- ➔ stringent processes within service
- ➔ renewed motivational drive

- ➔ Withdrawal of additional 6 hours per week which had met demands of administration and data collection



Spread and Sustainability

Long term:

- ➔ Threat to service model due to RPA
- ➔ Down Lisburn Trust CBIS will inform service delivery within RPA arrangements



The future.....

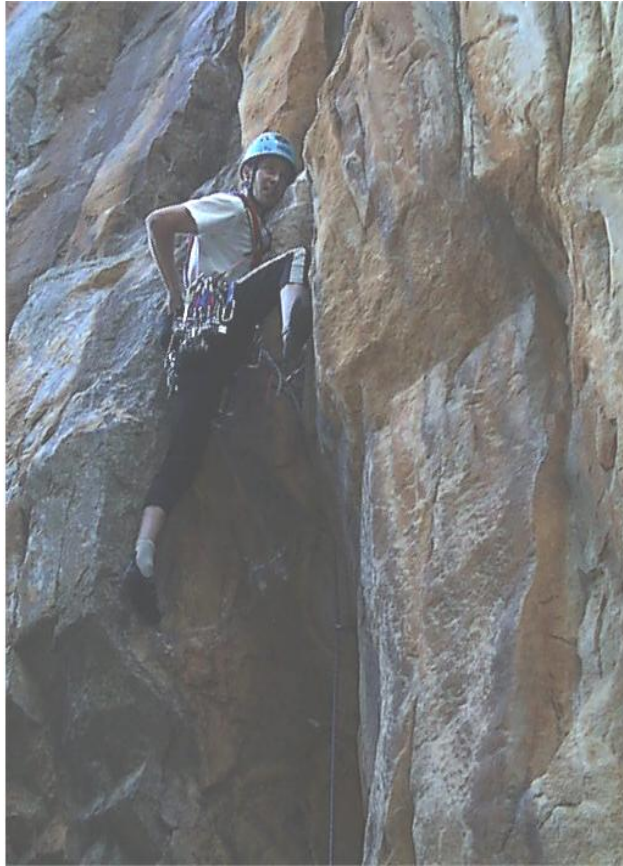


Future ...is here!

- Continue with Service Improvement
- Promote service model within Public Administration arrangements
- Service user consultation
- Address bottleneck after planning stage
- Liaise with Trust Community Stroke Team
- Develop communication further with Regional ABI Unit



Regional Challenges



- We're still getting there!



Unresolved Issues

- Minor Brain Injury
- Patients managed within DGH
- Children with ABI
- Transition services
- Step down units
- Community care
- Long term neuro - behavioural management



Future challenges

- Review of Brain Injury Services (NI) 2008
- Review of Public Administration - ongoing
- Comprehensive Spending Review 2008
- Links with RABIU
- Reduction in number of Trusts
- Locality Based Commissioning
- Service network development
- European expansion



European matters.

- Increase in size of European Union
- Accession states / economic migration
- Language
- Culture
- No family network
- Longer term placement
- Long term support

