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Lifelong Learning Programme

Leonardo da Vinci

Northumberland Head Injuries Service: Combined Health and Social Care

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Community Rehabilitation in Neurology Training Programme

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Presented educational materials were developed in 2008-2010 with support from European Union funds as a part of the Leonardo da Vinci project titled: Community Rehabilitation in Neurology Training Programme

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Aim of presentation

- Explain why there is a need for Community Brain Injury Services
- Describe The Northumberland Head Injuries Service
- Describe how Health and Social Services have come together to help form the service
- Use case study to outline the benefits of this joined up approach

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Northumberland: Where we are

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Northumberland: Information

- 6th largest county in England
- Northumberland has more castles than any other county in England (probably due to wars with Scotland)
- The most northerly town is Berwick upon Tweed has changed hands between Scotland and England 14 times.

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Northumberland: information

- Population of 300,000
- Large rural area has the lowest population density in England (62 people per square kilometre)
- 25% of the county is protected from development as it is part the Northumberland National Park – area of outstanding landscape
- The Northumberland Coast is designated an Area of Outstanding Beauty

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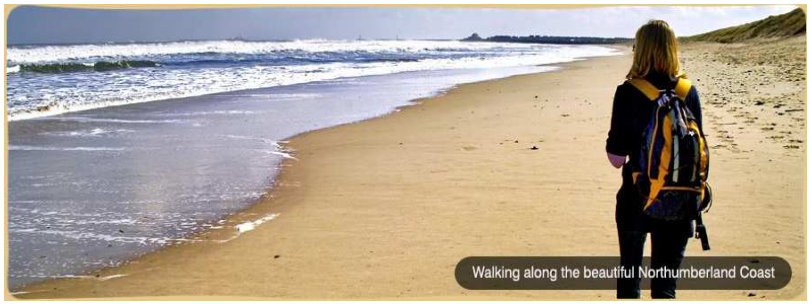
Northumberland: Photos



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What is Northumberland Head Injuries Service?

- NHIS provides a community based neuro-rehabilitation service
- NHIS set up and co-ordinate care packages for those clients who need formal care
- Multi-disciplinary team approach
- Goal directed rehabilitation
- Co-ordinated health and social care
- Partnership with private, voluntary sector, education & employment service

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Why is there a need for Community Brain Injury Services?

- National Services Framework Quality Requirement 5 Community Rehab and Support recommends: ongoing access to comprehensive rehab/advice/support
- Rehabilitation is a slow process – rehab gains can be made many years post injury long after hospital discharge
- Survivors do not view successful rehab in terms of how well they did in hospital
- Survivors view successful rehab as
  - Getting back to work
  - Assimilating back into family life
  - Partaking in previous social roles and activities

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Who do we serve?

- People who have sustained a traumatic brain injury
- Northumberland residents
- Aged between 18 to 65
- Referrals who are under 18 are care managed by Social Services Children's Services
- Referrals who are over 65 have access to assessment

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What is the scope of the service?

Between April 1st 2009 & March 31st 2010:

- 129 active cases
- 45 new referrals during that period
- 16 discharged

We serve:

- People with mild injuries who need support and reassurance
- People with severe injuries who need 24 hr care

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Who can refer clients?

- Direct by Hospitals
- GPs
- Social Work Teams
- Other care agencies/providers
- Self referrals

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The Team: Part Time and Full Time Staff

- Care Managers (fulfil the role of social workers)
- Clinical Psychologist
- Consultant in Rehab Medicine (2 sessions)
- Speech Therapist (2 sessions)
- Occupational Therapist
- Neuro-Physiotherapist
- Rehab Assistants
- Medical Sec/Administrator

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What are benefits of a joined up health and social care team?

- Holistic Multi Disciplinary approach (Social Model)
- Clients are seen by health and social care professionals that are specialist
- Reduced waiting times
- Efficient use of resources (by providing specialist knowledge we can often reduce the need for paid formal care)
- NHIS has access to Health and Social care budgets to provide or purchase care and rehabilitation for the client

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Case study: Christina

- Road traffic accident while living in Germany age 36
- Hospital based rehab in Germany
- Returned to Northumberland for ongoing care from her mother
- Christina had rented out her house in the South of England while she was in Germany and planned to move south when she was well enough to live on her own.

Christina: Care manager/Social Work support

- Referred to NHIS by GP
- Risk assessment by care manager to decide priority of referral/ ensure she met the criteria (within 2 working days of referral)
- Initial Assessment took place within 2 weeks of the referral
- Post injury needs identified: fatigue, balance, psychological adjustment, emotional labile, double vision, social isolation, word finding, anxiety, low confidence, left side weakness, short term memory, financial, shoulder and back pain

Christina: Care manager/Social Work support

The care manager organised:

- Internal referrals to OT, Physio, SLT, Consultant in rehab medicine & Psychologist
- External referrals: Vocational Rehabilitation service, Welfare benefits assessment & Driving Assessment service
- Small package of care 2 hours per week to help her re-learn how to use public transport
- Regular reviews involving Christina and the professionals involved in her care/rehab

Christina: Clinical Neuropsychology intervention

- Low mood
- Low confidence and some social anxiety, especially regarding word finding difficulties
- Cognitive problems (memory and concentration)
- Adjustment issues, e.g. living at home with mother, loss of valued social roles (e.g. job, friendships etc).

Christina: Clinical Neuropsychology intervention

- Psycho-education re nature of clinical depression, advice on self care, medication.
- Cognitive behavioural interventions to improve mood and confidence
- Normalising psychological symptoms associated with anxiety
- Neuropsychological assessment showed mild verbal learning deficits and slowed information processing
- Supportive counselling

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Occupational Therapy intervention

Home and community visits to:

- Assess of Christina's present level of functioning
- Risk assess the home environment
- Risk assess when in the community
- Discuss and establish Christina's goals and expectations

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Occupational Therapy intervention

Strategies identified

- Safe transfers established within home, bathroom and stairs
- Dressing programme developed to increase independence
- Pain and Fatigue management in relation to home and community activities
- Support to access community facilities
- Build confidence and self esteem

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Outcomes achieved by joint health and social care approach

18 months post injury Christina was discharged

- Christina moved to her old home in the south of England
- She had already achieved full time employment in Northumberland and arranged a transfer to an office in the south of England

36 months post injury - referred herself back to the service

- Christina was struggling with anxiety, isolation, fatigue and she was not using her compensatory strategies.
- She returned to Northumberland

Present time

- Christina has her own flat
- she has reduced her hours at work
- And she calls NHIS for help and support as required

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Thank You