



DEBATE PACK

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Acquired brain injury

This pack has been prepared ahead of the debate to be held in the Commons Chamber on Thursday 9 May 2019. The subject for the debate has been selected by the Backbench Business Committee.

The House of Commons Library prepares a briefing in hard copy and/or online for most non-legislative debates in the Chamber and Westminster Hall other than half-hour debates. Debate Packs are produced quickly after the announcement of parliamentary business. They are intended to provide a summary or overview of the issue being debated and identify relevant briefings and useful documents, including press and parliamentary material. More detailed briefing can be prepared for Members on request to the Library.

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1. Acquired Brain Injury

A Backbench Business Debate on Acquired Brain Injury will take place in the Commons Chamber on Thursday 9 May 2019. The debate will be led by Chris Bryant, Sir John Hayes and Liz Twist.

A wide range of issues may be raised during this debate, including the provision of services for treatment and rehabilitation, head injury in sports and brain injury and the criminal justice system.

In September 2018, the All-Party Parliamentary Group on Acquired Brain Injury and the UK Acquired Brain Injury Forum (UKABIF) published a report, [Acquired Brain Injury and Neurorehabilitation, Time for Change](#). This made a number of recommendations relating to neurorehabilitation and other issues. In the application to the Backbench Business Committee for the debate, Mr Bryant (Chair of the APPG on Acquired Brain injury) highlighted the report and the Government reply to this:

There are 1.4 million people living with brain injury in this country. One of the great successes of the past few years has been that we save more lives from road traffic accidents than previously—about 800 more lives a year—but unfortunately we are not able in all instances to give people the quality of life that would benefit them, because there is simply not enough neuro-rehabilitation available around the country. Last autumn, the all party parliamentary group together with the United Kingdom Acquired Brain Injury Forum produced a big report, which John has a copy of, and the Government have formally replied to it, which is very good of them.

[...] One of the most intriguing things about the debate is that, while one's immediate instinct is that this is about health, it is actually about the Ministry of Defence, the Department for Work and Pensions, the Ministry of Housing, Communities and Local Government, the Department for Education, the Ministry of Justice, the Home Office—it affects so many different Departments that it is time we had a proper three-hour debate to go over some of the answers that the Government have come back with and to explore further.¹

A [UKABIF briefing prepared for the debate](#) provides further information about the report and responses to this.

This briefing provides some background information on acquired brain injury and links to further reading.

1.1 Background

Acquired brain injury refers to a brain injury of any cause after birth. This includes traumatic injuries such as following a road traffic accident or a fall, or non-traumatic causes such as stroke, tumours and infection.

The effects of a brain injury can be wide ranging, varied in severity and may be temporary or long term. The brain injury association, [Headway](#), groups these potential effects into three groups:

¹ Backbench Business Committee, [Transcript 26 March 2019](#)

- Physical effects such as fatigue, impaired mobility, weakness/paralysis and speech problems;
- Cognitive effects such as memory problems, impaired reasoning and reducing problem solving ability; and
- Emotional and behavioural effects such as personality changes, depression, anxiety and anger.

More information about these effects is provided in a 2017 Headway leaflet, [The effects of brain injury](#) and on the [Headway website](#).

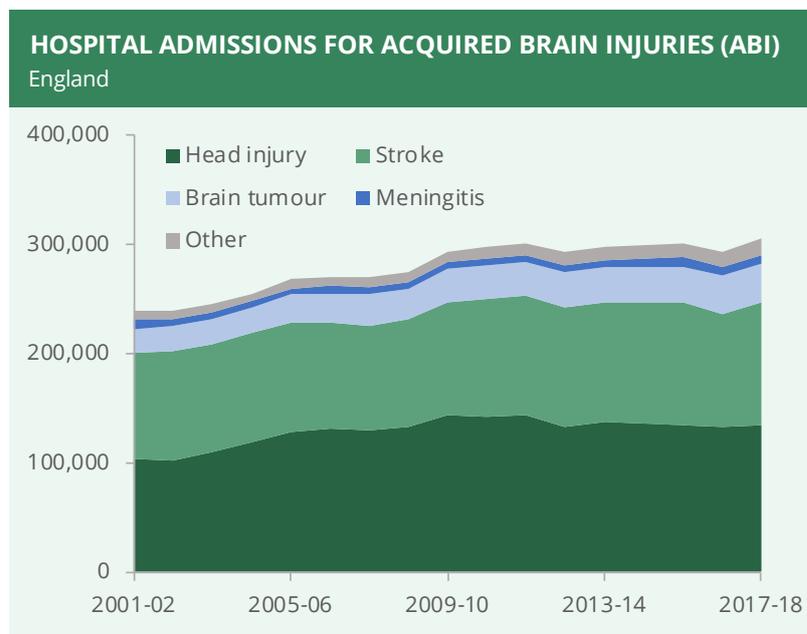
The UK Acquired Brain Injury Forum (UKABIF) provides the following information about the scale and the costs associated with brain injury in the UK:

A report by the Centre for Mental Health stated that 1.3 million people live with the effects of brain injury at a cost to the UK economy of £15 billion per annum, based on premature death, the health and social care required as well as lost work contributions and continuing disability. This cost is the equivalent of 10% of the annual National Health Service (NHS) budget.²

Number of diagnoses of acquired brain injury

The chart below summarises data on hospital admissions in England due to Acquired Brain Injury (ABI). The data uses the ICD-10 codes advised by Headway to identify admission episodes: [ABI Statistics Methodology](#).

Total ABI admissions increased year on year from 2001/02 to 2011/12 when they reached 301,400. Since then numbers have fluctuated between around 293,000 and 301,500, before rising again to the highest recorded level in 2017/18 - 304,800 admissions. Head injury and stroke account for the majority of cases.



Source: NHS Digital [Admitted patient care activity data](#)

² UKABIF, [Government debate on brain injury, 7pm -10pm \(approx\) Monday 18th June 2018, House of Commons chamber](#), June 2018

1.2 Assessment and Treatment

There are a number of causes of ABIs and as a result, there is no one single treatment pathway.

Treatment for major trauma is coordinated through regional trauma networks, centred around major trauma centres for the most serious injuries. Networks involve a triage system for assessing injuries prior to hospitalisation.

The National Institute for Health and Care Excellence (NICE) quality standard on [Head Injury](#) has the following standards related to rapid assessment:

- People attending an emergency department with a head injury have a CT head scan within 1 hour of a risk factor for brain injury being identified;
- People attending an emergency department with a head injury have a CT head scan within 8 hours of the injury if they are taking anticoagulants but have no other risk factors for brain injury.

The NICE clinical guideline, [Head Injury: assessment and early management](#), also provides guidance on assessing head injuries for ABIs.

Although traumatic injuries are one cause of ABIs, injuries from other causes can often be harder to detect. In 2013, Headway, endorsed by the Royal College of General Practitioners, produced a factsheet for GPs on identifying ABIs, including the following guidance on some of the difficulties in diagnosing it:

It can be all too easy to miss a previous ABI as the primary cause of a patient's difficulties. In many cases, people with ABI show no external signs of injury, so there are no visual clues to the condition. For this reason the condition is often referred to as the 'hidden disability'. This is even true in many cases of traumatic brain injury, when the external wounds have healed well.

Symptoms can overlap with other conditions, such as depression, post-traumatic stress disorder (PTSD) and other mental health problems, and if someone has a complex medical history it can be easy to focus on the wrong thing. The patient may also lack insight and awareness of their own problems and fail to report relevant information, therefore complicating matters further.³

1.3 Rehabilitation

The [2014 NICE quality standard on head injury](#) sets out the following rehabilitation standards:

- People who are in hospital with new cognitive, communicative, emotional, behavioural or physical difficulties that continue 72 hours after a traumatic brain injury have an assessment for inpatient rehabilitation.
- Community-based neuro-rehabilitation services provide a range of interventions to help support people (aged 16 and over) with

³ Headway, [Management of acquired brain injury: a guide for GPs](#), 2013

continuing cognitive, communicative, emotional, behavioural or physical difficulties as a result of a traumatic brain injury.⁴

The report by the All-Party Parliamentary Group on Acquired Brain Injury, *Time for Change* (September 2018), highlighted the importance of neurorehabilitation and the use of Rehabilitation Prescriptions. It also highlighted lack of beds and regional variation in access to services:

Neurorehabilitation can avoid or minimise disability and optimise recovery. Early access to specialist and/or community neurorehabilitation are critical components of the ABI care pathway. A Rehabilitation Prescription (RP) documents the individual's neurorehabilitation needs and optimises access to services along the care pathway. Substantial and robust evidence emphatically supports the clinical effectiveness and cost-effectiveness of neurorehabilitation. It is one of the most cost-effective interventions available to the National Health Service (NHS), with positive financial impacts on both health and social care. However, despite these proven benefits, investment in neurorehabilitation, in-patient neurorehabilitation beds and service provision are all inadequate and hugely variable across the United Kingdom (UK). This resource limitation is compounded by the inconsistent and limited use of RPs. These deficiencies reflect a broader neglect of neurorehabilitation. The 2001 Health Select Committee Report 'Head injury: rehabilitation' made over 20 recommendations. While significant progress has been made regarding many of the recommendations relating to acute care, the recommendations regarding neurorehabilitation have not been substantially implemented. This limited progress over 17 years has had significant and societal consequences.⁵

The APPG made the following recommendations relating to neurorehabilitation services:

- Rehabilitation Prescriptions should be available to all individuals with an Acquired Brain Injury on discharge from acute care, held by the individual with copies made available to the general practitioner
- A national review of neurorehabilitation is required to ensure service provision is adequate and consistent throughout the UK
- The Government should collate reliable statistics for the number of individuals presenting at Accident and Emergency Departments with Acquired Brain Injury, and record the numbers that require and receive neurorehabilitation
- There should be a significant increase in neurorehabilitation beds and neurorehabilitation professionals so that every trauma centre has a consultant in rehabilitation medicine, and individuals with an Acquired Brain Injury have access to neurorehabilitation
- Cooperation between key government departments (i.e. the Department of Health and Social Care and the Department for Work and Pensions) is required to review funding for in-patient and community neurorehabilitation services

⁴ NICE, [Quality Standard: Head injury](#), 2014

⁵ All-Party Parliamentary Group on Acquired Brain Injury, *Time for Change* (September 2018), Executive Summary

1.4 Sport and brain injury

Concerns have been raised about the risk of concussion and brain injury while playing sport. Some doctors, health experts and politicians have called for boxing to be banned.⁶ There have also been warnings about the risks of heading in football.⁷

The websites of the [Rugby Football Union](#) and [Rugby Football League](#) both include information on concussion.

In 2015, the Government asked Baroness Grey-Thompson to conduct an independent review into the Duty of Care sport has towards its participants. The [Duty of care in sport](#) report (April 2017) has a chapter on safety, injury and medical issues. This recommends, among other things, that:

- NGBs [national governing bodies] that instruct doctors or medical experts to review concussion protocols should ensure that they are regularly checked to ensure tests remain accurate and are not easily subverted by those wishing to return to sport or field of play early.
- All sports (even those who may not be readily thought susceptible to concussion) need to be aware of concussion protocols and work together to ensure they have something in place and communicate with other organisations.
- All contact sports to consider pre-season concussion awareness courses.
- Consideration should be given to the separation of medical services within a sport's performance department to give a clear line of demarcation to ensure that medical advice cannot be compromised.
- Government should consider how different government departments and agencies can work together on concussion and other medical issues.⁸

1.5 The criminal justice system and brain injury

One of the issues that has been raised both inside and outside Parliament is the estimated high prevalence of brain injury in the young offender population and what can be done in all parts of the criminal justice system to ensure that this is identified and appropriate support and services are provided for those with brain injury.

⁶ For discussion see: "[Mike Towell death prompts renewed calls for boxing ban](#)", Guardian, 1 October 2016; "[Should we ban boxing?](#)", British Medical Journal, 27 January 2016; British Board of Boxing Control website, [Boxing, the facts](#) [accessed 25 April 2019]

⁷ "[Brain injury expert calls for ban on heading in football](#)", BBC Sport, 8 August 2018; "[Football is heading for trouble over brain injuries caused by the ball](#)", Guardian, 30 September 2017; see also "[Concussion may have led to Loris Karius's calamities, says US hospital](#)", Guardian, 4 June 2018

⁸ Baroness Tanni Grey-Thompson, [Duty of Care in Sport: Independent Report to Government](#), April 2017, p25

An October 2016 report of a Commons Justice Select Committee Inquiry, [The treatment of young adults in the criminal justice system](#) provided a specific look at brain injury in young offenders:

Taking head injury as an example, there is far higher prevalence of Acquired Brain Injury—estimated to be between 50-60%—among young prisoners compared to older prisoners. Young adults with traumatic brain injury (TBI) are even less likely to reach full neurological development by their mid-20s. The consequences of TBI include poor memory; reduced concentration capacity; reduced ability to process different streams of information; poor initiation and planning; lack of self-monitoring; decreased awareness of one's own or others' emotional state; and particularly, poor social judgments. This can contribute to behavioural problems, such as conduct disorder, attention problems, increased aggression, and impulse control problems, and mental health problems like anxiety and depression. Perhaps not surprisingly therefore it is associated with earlier onset, more serious, and more frequent offending and those with TBI typically present with especially complex needs and can be particularly challenging to manage. The Centre for Mental Health has estimated that a traumatic brain injury increases the likelihood of crime by at least 50%.⁹

The Committee also highlighted that the experience of the criminal justice system can be particularly challenging for young people with neuro-disabilities, neuro-developmental disorders and mental health conditions and that a change in policy and practice was required to address this. It recommended screening for these conditions, raising awareness and improved support.¹⁰

The Justice Committee held a follow up [one-off evidence session on young adults in the criminal justice system](#) in November 2017.

Following this, in May 2018, the then Parliamentary Under-Secretary of State for Justice, Dr Phillip Lee wrote to the Committee to update them on action being taken. This included the following information about screening and raising awareness on acquired brain injury in offenders:

Acquired brain injury. We are improving identification and support of brain injury through grant funding to the Disabilities Trust. This will pay for a pilot in four English prisons, a Welsh prison and a Welsh Approved Premises. It will develop and test how we understand and meet the needs of those with Acquired Brain Injury (ABI) or Traumatic Brain Injury (TBI). This work includes staff awareness training in relation to brain injuries and training in the administration of a screening measure.

Training court staff in brain injury. In Wales, we are funding Brain Injury Staff Awareness training from The Disabilities Trust. This targets court-based staff, as well as staff from other HMPPS sites across Wales. This will improve awareness at the sentencing level to ensure an individual's risk and needs are appropriately

⁹ Commons Justice Select Committee, [The treatment of young adults in the criminal justice system](#), October 2016

¹⁰ Commons Justice Select Committee, [The treatment of young adults in the criminal justice system](#), October 2016

considered and alternative rehabilitation or treatment pathways are considered. Training events are scheduled for early 2018.¹¹

[The Disabilities Trust](#) provides [further information](#) about its work in prisons and young offender institutions with people with brain injury. This includes screening for individuals with brain injury, training and offering support with education and training. More information is provided in a 2015 report on the [Brain Injury Linkworker service](#). In 2019 the Disabilities Trust published [Making the Link: Female offending and brain injury](#).

In February 2019 Lord Keen, answering an oral question to the Ministry of Justice, stated that a cross-government group with the Department of Health and Social Care, NHS England and the Prison Service had been formed to develop a more strategic picture of acquired brain injury within the criminal justice system.¹²

More information about brain injury and the criminal justice system is provided in the following sources:

- The Disabilities Trust, [Brain injury and offending](#)
- Professor Huw Williams, [Repairing Shattered Lives: Brain Injury and its implications for criminal justice](#), Barrow Cadbury Trust, 2015
- Michael Parsons, [Traumatic brain injury and offending. An economic analysis](#), Centre for Mental Health, 2016

1.6 Welfare benefits

Apart from Industrial Injuries Disablement Benefit – which may be paid to people suffering disablement as a result of an accident at work or an industrial disease – the general position is that particular disabilities or health conditions do not give a person automatic entitlement to benefit. Instead, entitlement to benefits depends on the extent to which a person’s condition affects them and what they can or cannot do.

People with an Acquired Brain Injury and their families may potentially be entitled to a range of benefits, but the two main types of social security benefit likely to be relevant are:

- **“income replacement”** benefits, which cover basic living costs for people whose ability to work is affected by their condition; and
- **“extra costs”** benefits which are intended to help with the additional costs people face as a result of their condition.

Employment and Support Allowance (ESA) is an income replacement benefit which is intended to cover the basic living costs of people who have a “limited capability for work” because of illness or disability. This means that the person’s capability for work is limited by their physical or mental condition, and the limitation is such that it is not

¹¹ Commons Justice Committee, [Response from Minister of State for Justice, relating to evidence session on young adults in the youth custodial estate, dated 21 May 2018](#).

¹² [Prisoners: Acquired Brain Injuries, HL Deb 12 February 2019 c1743](#)

reasonable to require them to work. This is determined by the Work Capability Assessment (WCA), which looks at both physical and mental activities. The activities for the physical assessment include, for example, standing and sitting, reaching, and manual dexterity. The mean-tested version of Employment and Support Allowance (income-related ESA) is one of the benefits being replaced by **Universal Credit**. The Work Capability Assessment is also used to determine which, if any, work-related requirements UC claimants are subject to, and access to the additional Limited Capability for Work-Related Activity Element in UC.

As part of the WCA process, the evidence submitted by the claimant is considered by a Healthcare Professional (HP) employed by MAXIMUS, the contracted assessment provider. In most cases claimants will also be asked to attend a face to face meeting.

The HP should consider all the available evidence and exercise clinical judgement to reach an opinion on the nature and severity of the effects of the claimant's health condition. They should also take full account of factors such as pain, fatigue, stress and of the possible variability of the condition. For example, if the claimant can perform a particular activity only by incurring a considerable degree of pain, they will be classed as being incapable of performing that activity. The HP should also consider the effects of the condition on the claimant for the majority of the time – their opinion should not be based on a “snapshot” of the claimant's condition on the day of the assessment.

The HCP produces a report for the DWP recommending whether the claimant meets the conditions for ESA and, if so, which group they should be placed in, but the decision on whether to award benefit is ultimately one for a DWP Decision Maker.¹³

Personal Independence Payment (PIP) is the “extra costs” benefit for people who have daily living and/or mobility needs as a result of a disability or health condition. It is replacing **Disability Living Allowance (DLA)** for people of working age. DLA remains the extra-costs benefit for children with care and/or mobility needs. **Attendance Allowance** is the extra-costs benefit for people with care needs which emerge after they reach the age of 65. Unlike PIP and DLA, Attendance Allowance has no mobility component.

As with ESA, eligibility for PIP does not depend upon the person being diagnosed as having a particular health condition or disability, but on how their health condition or disability affects what they can and cannot do, as determined by the PIP assessment. The assessment for PIP looks at an individual's ability to carry out a series of key everyday activities. The assessment considers the impact of a claimant's health condition or impairment on their functional ability rather than focusing on a particular diagnosis. For information on the activities considered in

¹³ Detailed information can be found in the DWP's [Work Capability Assessment handbook for healthcare professionals](#), last updated 11 June 2018. A shorter overview is given in the Department's [A guide to Employment and Support Allowance – The Work Capability Assessment](#), ESA214, 7 July 2016.

the assessment, and how the assessment is carried out, see the DWP's [PIP assessment guide](#).¹⁴ Assessments are undertaken by Health Professionals employed by one of the contracted PIP assessment providers (Atos or Capita, depending on the region), but as with ESA decisions on entitlement to benefit are made by DWP Decision Makers (referred to as "Case Managers" where the decision is in relation to PIP).

The DWP guidance states that the Healthcare Professional should explore all the PIP activity areas for daily living and mobility, focusing on the activities most likely to be affected by the claimant's condition. The HP should invite the claimant to talk through all the activities they carry out on most days, and explore how long it takes the claimant to carry out a task and whether they experience any symptoms such as pain or fatigue. As with the WCA, PIP assessors should also consider how a person's condition fluctuates over time rather than taking a "snapshot" view of their condition on a particular day at a particular time.

A person "regularly and substantially" caring for someone getting the PIP daily living component, Attendance Allowance or the middle or highest rate DLA care component may be entitled to **Carer's Allowance** and/or the **carer element in Universal Credit**.

The Department for Work and Pensions does not hold data on the number of ESA or PIP claimants with ABI.¹⁵ Statistics on the number of Universal Credit claimants with an ABI are "not readily available" and to provide them would "incur disproportionate cost."¹⁶

Comments and criticisms

The All-Party Parliamentary Group on Acquired Brain Injury's September 2018 [Time for change](#) report observed that an individual with an ABI may not be able to work in the short or long-term, and that the loss of income is likely to have an immediate impact on their quality of life, at a time when they are most vulnerable. It added however that the welfare benefits system is "complex, with detailed application processes, and can be protracted."¹⁷ For people with an ABI, navigating the complex welfare benefits system can be a difficult challenge:

Individuals with ABI frequently have cognitive problems which makes the application process extremely challenging, from understanding the information required, through to communicating the answers. Often the assessors have inadequate knowledge and understanding of ABI, and lack empathy with both the individual and their family.¹⁸

A focus group with brain injury survivors conducted in 2015 by Thompsons Solicitors and the brain injury charity Headway found that:

¹⁴ Last updated 7 February 2019

¹⁵ The Department's systems record the number of people whose primary medical condition is a disease of the nervous system, but they do not show how many within this group have an ABI; PQ 138404, 3 May 2018

¹⁶ PQ 138405, 3 May 2018

¹⁷ p36

¹⁸ Ibid. p38

- 93% of people found the benefits assessment process difficult and/or unsatisfactory
- Over 90% agreed that benefit assessors did not have good insight into the challenges, symptoms and impact of ABI. Assessors had little knowledge of the issues
- Only 1 in 4 thought they or their loved ones were receiving adequate levels of welfare benefit to meet their needs
- Over 90% agreed that benefit application forms were not a good measure of an ABI individual's needs and they focussed on physical illness, neglecting cognitive issues¹⁹

A separate report published by Headway in September 2018, [Right First Time](#), calls for "urgent changes to disability assessments to reduce the number of vulnerable people forced to go through stressful and often unnecessary appeals processes." Specifically, Headway argues:

1. Assessments should be conducted by people with expert knowledge of complex conditions such as brain injury. In our survey, only 29% of ESA claimants felt their assessor understood brain injury.
2. Audio or visual recording of the face-to-face assessment should be offered as standard to all applicants. They should not have to make special arrangements or provide their own recording equipment for this.
3. A new transparent system must be put in place to reassure applicants that medical and other evidence has been taken into account.

In its 2018 [Time for change](#) report, the All-Party Parliamentary Group on ABI makes three recommendations in relation to the welfare benefits system:

4. All benefits assessors should be trained to understand the problems that affect individuals with an Acquired Brain Injury
5. Re-assessment for welfare benefits for people with Acquired Brain Injury should only take place every five years
6. A brain injury expert should be on the consultation panel when changes in the welfare system are proposed²⁰

1.7 Support for children and young people with acquired brain injuries – schools in England

Special educational needs (SEN) provision

Background on the current arrangements for supporting children with special educational needs in schools in England can be found in a separate briefing paper:

- [Special Educational Needs: support in England](#), updated 8 February 2019.

¹⁹ Thompsons Solicitors, [Welfare benefits and acquired brain injury infographic](#)

²⁰ Ibid. p36

As this sets out, the type of support that children and young people with SEN receive may vary widely, as the types of SEN that they may have are very different. However, two broad levels of support are in place - SEN support, and Education, Health and Care Plans:

SEN support - support given to a child or young person in their pre-school, school or college. In schools, it replaces the previously existing 'School Action' and 'School Action Plus' systems. For children of compulsory school age the type of support provided might include extra help from a teacher, help communicating with other children, or support with physical or personal care difficulties.

Education, Health and Care Plans - for children and young people aged up to 25 who need more support than is available through SEN support. They aim to provide more substantial help for children and young people through a unified approach that reaches across education, health care, and social care needs.

Parents can ask their local authority to carry out an assessment if they think their child needs an EHC Plan. A request can also be made by anyone at the child's school, a doctor, a health visitor, or a nursery worker.

Pupils with medical conditions and/or disabilities – schools' duties

Under S100 of the *Children and Families Act 2014*, as amended, maintained and academy schools in England must make arrangements to support pupils with medical conditions. There is [DfE guidance](#) (December 2015) on schools' duties in this area. Parts of this guidance are statutory, and parts are non-statutory; it covers areas such as working with parents, carers and other health and social care professionals, and drawing up individual healthcare plans.

Part 6 of the *Equality Act 2010* requires schools to provide reasonable adjustments for disabled pupils, and to avoid discrimination. The Equality and Human Rights Commission (EHRC) has published [technical guidance](#) (July 2014) setting out schools' responsibilities in relation to the 2010 Act, and [separate guidance](#) (April 2015) on the practical implementation of the reasonable adjustments duty.

Sources of information and support on acquired brain injury and education:

- *Children's Trust/ Brain Injury Hub* web briefing, '[Returning to education after ABL: an introduction](#)', June 2018.
- *Headway* factsheet, '[Returning to education after brain injury](#)', 2016.
- [Health Conditions in Schools Alliance website](#).
- *United Kingdom Acquired Brain Injury Forum* website section, '[Signpost education resources for professionals](#)'.

2. News items

Telegraph

Brain charity argues for 'temporary concussion substitutions' in football after Jan Vertonghen head injury

1 May 2019

<https://www.telegraph.co.uk/football/2019/05/01/brain-charity-argues-temporary-concussion-substitutions-football/>

Guardian

Nearly 65% of prisoners at women's jail 'show signs of brain injury'

6 February 2019

<https://www.theguardian.com/society/2019/feb/06/nearly-65-of-prisoners-at-womens-jail-show-signs-of-brain-injury>

Independent

Quarter of prisoners have suffered traumatic brain injury, study suggests

17 January 2019

<https://www.independent.co.uk/news/uk/home-news/prisoners-brain-injury-scotland-inmates-study-university-glasgow-a8733106.html>

BBC News Online

Better concussion protocols needed in sport, say MPs

26 November 2018

<https://www.bbc.co.uk/sport/46350379>

BBC News Online

Brain injuries increase dementia risk, study finds

11 April 2018

<https://www.bbc.co.uk/news/health-43711627>

3. Press releases

Headway

Football's concussion protocols 'need urgent review'

1 May 2019

Headway has called for football's authorities to urgently review concussion protocols within the sport in order to assist medical staff in the assessment of players following head injuries.

The call comes after the latest in a long line of incidents that have called into question the sport's commitment to tackle this important issue. Tottenham Hotspur defender Jan Vertonghen suffered a clash of heads in a collision with teammate Toby Alderweireld in their side's Champions League semi-final first-leg match against Ajax.

After being assessed on the pitch for five minutes, the player briefly returned to the match before quickly being removed permanently after appearing to stagger. He then had to be helped from the pitch, with the player later stating that he had fainted.

Luke Griggs, spokesperson for Headway – the brain injury association, said:

It is hugely disappointing that we are once again talking about concussion rather than the game itself.

Concussion is notoriously difficult to diagnose. The symptoms may be hidden and require the individual to be honest about how they're feeling, while they can also be delayed in their presentation.

Assessing a player for three minutes – or even five, as was the case with Jan Vertonghen – does not allow for medical staff to make a reliable diagnosis, particularly when this is conducted on the pitch under the gaze of tens of thousands of fans eager for the game to resume.

The pressure on club medical staff is enormous and unfair, particularly in such high-stakes games such as a Champions League semi-final.

We believe the time has come for football to introduce temporary concussion substitutions that would allow for longer off-pitch assessments to be conducted.

In addition, independent doctors with expertise in concussion and head injuries should make the ultimate decision as to whether or not a player is fit to continue.

Not every head injury will result in a concussion. But allowing players to continue while showing clear signs of discomfort following a head injury is contrary to the 'if in doubt, sit it out' principle at the heart of all effective concussion protocols.

UK Acquired Brain Injury Forum

NEW REHABILITATION PRESCRIPTION – RP2019 NOW AVAILABLE

March 2019

A new [Rehabilitation Prescription \(RP2019\)](#), the tool that documents the rehabilitation needs of the individual with Acquired Brain Injury (ABI), is now available, with versions available for adults and children.

Commenting on RP2019, Professor Chris Moran, National Clinical Director for Trauma to NHS England, and Professor of Orthopaedic Trauma Surgery at Nottingham University Hospital said:

Neurorehabilitation is a key component of the major trauma network; an essential part of good trauma care and good patient outcomes. Rehabilitation needs should be assessed shortly after a patient is admitted to the major trauma centre, delivered during the inpatient phase, and continued in a trauma unit or in the local community. This new RP details the neurorehabilitation needs of both children and adults, and in order to maintain the continuity of rehabilitation, a copy should be given to both the patient and/or family as well as their GP.

Professor Michael Barnes, ABI Alliance Chair said:

The Acquired Brain Injury Alliance is a collaborative venture between charities, professional groups and industry coalitions working in the field of ABI. We are supporting the availability of this revised version of the RP to emphasise its key role in ensuring patients access neurorehabilitation services following discharge. However, the RP has no value if the individual with an ABI and their GP don't receive a copy. And if the individual and the GP don't know what rehabilitation is required then no access to services can be planned or implemented.

The report produced in September 2018 by the All-Party Parliamentary Group on Acquired Brain Injury (APPG on ABI) entitled 'Acquired Brain Injury and Neurorehabilitation – Time for Change' outlined the critical role of neurorehabilitation in the ABI care pathway and the need for RPs for all brain injury survivors following discharge from acute care¹.

RP2019 stipulates that a rehabilitation assessment should take place within 48-72 hours of the patient's admission and has to be completed for all major trauma patients who need rehabilitation at discharge². The RP must contain core items and be developed with the involvement of the individual and/or their family/carers, and administered by a specialist health care professional in rehabilitation.

RP2019 should be completed by health care professionals after a multidisciplinary team assessment and signed off by senior staff members, at a minimum a consultant or specialist trainee in rehabilitation medicine, Band-7 specialist rehabilitation clinician or major trauma coordinator. It can be provided as a single document for both the patient and professionals, or as two separate documents to be given at the point of discharge.

The ABI Alliance supports the use of the RP for every individual, both children, young people and adults with an ABI, on discharge from hospital, with a copy sent to their GP. This will then provide a useful

resource for the GP to work with the individual and facilitate access to rehabilitation services in the community, maximising the individual's health outcomes.

<https://www.ukabif.org.uk/wp-content/uploads/2019/03/Background-information-for-the-media-Rehabilitation-Prescription-2019.docx>

Disabilities Trust

People with acquired brain injury need rehab prescriptions, says parliamentary group

15 March 2019

Children and adults who have an acquired brain injury (ABI) should receive a rehabilitation prescription, which details their neurorehabilitation needs, before they leave acute care.

The report highlights the impact of ABI across all sectors of society

This is one of the recommendations in a report produced by the all-party parliamentary group on acquired brain Injury, entitled [A Time For Change](#).

It states that 1.3 million people in the UK live with ABI, with a cost to the economy of £15 billion per annum, and calls for joined up thinking across departments to tackle the issue.

The report also outlines the critical role of neurorehabilitation in the ABI care pathway, and identifies the impact of the condition on individuals, families and the wider community.

Physiotherapist Susan Pattison, the director of a private practice that specialises in ABI, attended the report's launch at an ABI Alliance event, held in Manchester last month.

1.3 million people in the UK live with ABI, with a cost to the economy of £15 billion per annum

She told *Frontline*:

This report cleverly collates and combines the impact of ABI across all sectors of our communities. It talks about neurorehabilitation, education, the criminal justice system, the benefits system and sports related concussion.

We all know neuro rehab beds are underfunded, but this report looks at the problem holistically. It points out that it is the investment in acute care that has led to the shortage of beds, both in the public and private sectors.

And it highlights the national shortfall and geographical gaps across our communities, in terms of access to neuro rehabilitation, and the burden of care and finances across all departments and sectors of society.

This report cleverly collates and combines the impact of ABI across all sectors of our communities

The report highlights the long-term impact ABI can have on an individual and explains how it can influence an individual's thinking processes and cause problems with concentration, memory, impulsivity and fatigue.

As a result, it recommends that information and training about ABI should be made available to staff working in the welfare and benefits system, the police, courts, probation and prison services.

And it suggest the government should ensure collaborative research is undertaken to evaluate and improve practical assessment tools, develop objective diagnostic markers and gain a deeper understanding of the recovery process and long-term risks of sport-related concussion.

Raising physio awareness

Ms Pattison, a member of CSP's north west regional network, added that physiotherapists, working in a variety of specialities, also needed to be more aware of the long-term impact of ABI.

You don't have to be a neurological practitioner to come across a head injury, and because ABI is a long-term condition physiotherapists are bound to come across people who have it,

she said.

As physios we are taught to screen patients and ask specific questions to flag up things, but we don't routinely ask: "Have you had a blow on the head that's caused loss of consciousness?"

If we learnt to ask that question we could be so much more informed as to whether we have a brain injured patient in front of us

New major trauma rehab prescription

Since the report's publication, NHS England has announced its development of [a new major trauma rehabilitation prescription](#), which is due to launch in April.

Their new guidance stipulates that rehab assessments should take place within 48-72 hours of a patient's admission to major trauma, and that all major trauma patients who require rehab after discharge should receive a completed prescription.

The Disabilities Trust

The Disabilities Trust launch 'Making the Link' report

6 February 2019

On 6th February, we launched the results of our report, [Making the Link: Female Offending and Brain Injury](#), the first study of its kind into brain injury in female offenders.

The study, funded by the [Barrow Cadbury Trust](#) and [The Pilgrim Trust](#), was carried out from 2016 to 2018, with an accompanying [independent evaluation](#) by Royal Holloway, University of London. The

findings highlight the need for a support pathway to help manage the health, cognitive and behavioural issues associated with brain injury, which may impact on likelihood of re-offending.

The launch, hosted by Victoria Prentis MP took place with MPs, Ministers, Charity Representatives and Trustees in attendance.

Our research found that of 173 women within HMP/YOI Drake Hall, who were screened using the Brain Injury Screening Index tool, 64% reported a history indicative of brain injury, and of those, almost all (96%) reported a history indicative of traumatic brain injury (TBI). From the women supported through the service, 62% reported they had sustained their brain injury through domestic violence.

It is widely acknowledged that TBI is over-represented in prison populations, with the likelihood of increased risk of violence, earlier age of first incarceration, a greater number of convictions, re-conviction, mental health problems and a greater number of attempts at suicide.

The needs of women in prison with TBI are likely to be complex, and the lack of understanding and identification of a brain injury may result in a higher risk of custody and re-offending. Therefore, the study introduced a Brain Injury Linkworker Service in HMP/YOI Drake Hall to provide specialist support to women with a history of acquired and traumatic brain injury.

The Brain Injury Linkworker aimed to develop a sustainable pathway of support for rehabilitation and help prisoners to manage the transition between custody and the community.

From the women supported through the service, there were 196 reports of severe blows to the head and distressingly, 62% of 100 women reported they had sustained their brain injury through domestic violence.

Nearly half (47%) of the women had been in an adult prison five or more times and 33% sustained their first injury prior to their first offence.

The trauma in the lives of the women with TBI is evident in the accounts provided by interview participants. Some of the accounts and case studies presented in the independent evaluation written by Royal Holloway, University London are distressing to read.

The independent evaluation also showed a female Linkworker was sensitive to the gender-specific needs of those being supported. The women who were seen by the Linkworker experienced improved mood and self-esteem, and enhanced confidence and positivity; key factors that have been previously identified as being essential for a woman to engage in rehabilitative programmes.

The Linkworker service also offered practical guidance for staff working with women with a brain injury, and alleviated pressure from other service provisions (e.g. mental health) with the conclusion that a Brain Injury Linkworker service provides a strong framework which will benefit offenders and prisons to identify and manage brain injury.

As a result of these findings The Disabilities Trust calls for:

- The inclusion of brain injury screening as a routine part of the induction assessment on entry to prison or probation services
- All prison and probation staff to receive basic brain injury awareness training
- The provision of brain injury support; similar to the Brain Injury Linkworker (BIL), in prisons and probation settings
- Assurance that brain injury support would be aligned with gender-informed practice
- Further research to be conducted to examine the potential effect of brain injury on re-offending behaviour, how effective neurorehabilitation can contribute towards the reduction of recidivism and the role of early intervention approaches.

Georgina Nayler, Director of The Pilgrim Trust said:

The Pilgrim Trust was pleased to part fund this project and we have been struck by the positive impact the Brain Injury Linkworker has had on the women supported within the prison. Such screening and support should be available to all women in the criminal justice system. This report demonstrates that such understanding and support would improve the women's mental and physical health and assist them to lead fulfilling lives outside prison.

Irene Sobowale, Chief Executive of The Disabilities Trust said:

The Disabilities Trust is delighted to launch this research, which builds on over five years of research into male offenders and brain injury. For the first time in the UK, we have considered the specific needs and experiences of female offenders, who are some of the most vulnerable in the criminal justice system.

The personalised service which we have developed, supports women dealing with the impact of their brain injuries, and independent evaluation from the Royal Holloway University London agrees that our Linkworker service within HMP & YO1 Drake Hall recognised the gender specific needs of women.

There is much more work to be done to ensure that women with a brain injury are provided with effective support to ensure that they can engage in rehabilitation programmes and reduce the likelihood of reoffending. The Disabilities Trust looks forward to working with partners and Government to achieve this.

UK Acquired Brain Injury Forum

Time For Change – APPG On ABI Launch Report On Acquired Brain Injury And Neurorehabilitation

10 October 2018

Acquired Brain Injury is an invisible epidemic, and we need to ensure that the neurorehabilitation services required following a brain injury are 'fit for purpose' throughout the UK

said Chris Bryant MP and Chair of the All-Party Parliamentary Group on Acquired Brain Injury (APPG on ABI) speaking today in London at the launch of a report 'Time for Change: Acquired Brain Injury and Neurorehabilitation'.

Brain Injury Survivors, charities, clinicians, campaigners, academics and MPs attended the launch of the report, where a short film was played showing the cause and effect of acquired brain injuries.

There are more than 1.3 million people living with the effects of brain injury at a cost to the UK economy of £15 billion per annum or 10% of the National Health Service (NHS) budget. The excellent advances in emergency and acute medicine mean that many more children, young people and adults now survive with an ABI, however, many of these individuals require early and continued access to neurorehabilitation to optimise all aspects of their physical, cognitive, behavioural and psychosocial recovery, and to maximise their long-term potential.

Neurorehabilitation is one of the most cost-effective interventions available on the NHS, but there are large variations in the provision and access to neurorehabilitation services across the UK.

The report outlines the critical role of neurorehabilitation in the ABI care pathway, and the need for Rehabilitation Prescriptions for all brain injury survivors following discharge from acute care so they know what neurorehabilitation they need. The report reviews the implications for children and young people with ABI when most of their neurorehabilitation takes place in the education system. The high incidence of ABI amongst offenders is discussed, as is the impact of neurorehabilitation on behavioural change and reoffending. The current issues in sport-related concussion are outlined as well as the need for an improved welfare system that is easily accessible.

The report summarises the key issues and makes several recommendations. Chris Bryant concluded:

ABI impacts on many government departments so a task force is required to address the issues and recommendations as a matter of urgency. The APPG on ABI intends to unite all the departments involved in order to drive change for brain injury survivors.

Copies of the report can be obtained from: www.ukabif.org.uk/campaigns/appg-report

4. Parliamentary material

Debate

Commons debate: Acquired Brain Injury

HC Deb 18 June 2018 | Vol 643 c132-

<http://bit.ly/2u9wFZc>

Member's debate contribution

[Department for Education Estimates]

Chris Bryant: It is strange that but a couple of handfuls of Members are here to discuss one of the largest budgets that the Government dispose of. We never analyse the expenditure very closely as it goes through Parliament; personally, I feel that a new system of assessing expenditure—more like a proper budgetary process in a local authority, frankly—is long overdue.

I will speak primarily about acquired brain injury, which may not come as a surprise to many Members. I know that people think that it looks as if I have had a brain injury of my own of late—it looks far more dramatic from behind than it is on the inside, but I am enormously grateful to people who have commented.

I want to talk about the issue because all too often an acquired brain injury, which might have come about through a road traffic accident, carbon monoxide poisoning, a stroke or a whole series of other means, may not be visible to the naked eye when we meet somebody. I have said this before in the Chamber, and it is true: the person standing in front of us in the queue, who is being difficult and seems drunk, might have a brain injury. All our judgmental attitudes may say more about us than about the person standing in front of us.

When somebody is being assessed by the Department for Work and Pensions for benefits, it is really important that the assessor has a full understanding of brain injury, for a multitude of reasons. First, such judgmental attitudes might be of no assistance whatever; and secondly, because the person's condition may vary—not only across time, but from day to day or at different times of the day.

One of the most common symptoms of an acquired brain injury, even a relatively mild one that may have followed concussion, is chronic fatigue. I do not just mean feeling tired, as we might from day to day in the normal course of things, but real debilitating fatigue that means that we simply cannot get out of bed—not through laziness, but through utter fatigue at the core of our being. The Department for

Work and Pensions has found it very difficult to cope with assessing somebody in that situation without resorting to language of, “Pull your socks up, chap!”

I know that the Minister is keen to see whether there are ways for us to work this out better, and I, along with the all-party parliamentary group on acquired brain injury, am really keen to make sure that every single assessor has some understanding, at least, of acquired brain injury—and, if they are not sure, the ability to refer the individual to another person.

There is another element to the issue. Fatigue is one of the most common elements of an acquired brain injury, so someone with one needs to harness all the energy they do have to strengthen their brain and recuperate. That requires a superhuman effort. I have spoken to individuals who have been through major road traffic accidents. They know that all the stuff they do with their doctors and clinicians—all the neuro-rehabilitation—is about how they strengthen their brain. But the benefits system is so complicated that it makes them feel like a number rather than a person; they find that they are using their energy just to deal with that, rather than making themselves better.

There could be a real advantage if there were a grace period of four or five years for people who have had a brain injury, so that once they had their first assessment they would know they would not have another for a set period. This is not about spending money; it is simply about enabling people to resuscitate and revitalise their own brains.

There is an additional problem which is known as the frontal lobe paradox. People may present extremely well and do well in tests, but some of the other elements of their executive function simply do not work as well as they might. That is why it is so important for us to have a system that can respond to individual needs. I hope very much that in the coming months we will be able to develop the system further, and that Ministers will work onside, to ensure that we can address those needs.

HC Deb 26 February 2019 | Vol 655 cc260-2

<http://bit.ly/2Ezp7W4>

PQs

[Armed Forces Covenant](#)

Asked by: Chris Bryant

The acute care for armed forces personnel who have had acquired brain injuries in the course of their duties is second to none—no one would doubt that—but the anxiety is that when they leave the forces, or sometimes even before they enter the forces, an acquired brain injury will go unnoticed and therefore untreated and uncared for, which is why so many veterans end up homeless and living on the street. What are we going to do about that?

Answered by: Mr Ellwood | Department: Defence

I pay tribute to the hon. Gentleman for the personal interest that he takes in this issue. He is absolutely right: people need signposts so that they know where to go. We are working far more closely with NHS England and the devolved Administrations to understand where the complex treatment services are, and to ensure that when people make the transition, they are handed across to the civilian agency that will look after them.

HC Deb 25 March 2019 | Vol 657 c13

[*Prisoners: Acquired Brain Injuries*](#)

Lord Ramsbotham

To ask Her Majesty's Government, in the light of the findings of the Disabilities Trust and Royal Holloway University that 65% of women in HM Prison Drake Hall had suffered from an acquired brain injury, what plans they have to make assessment for such injuries compulsory for all prisoners on reception into prison.

Lord Ramsbotham (CB)

My Lords, I beg leave to ask the Question standing in my name on the Order Paper, and declare an interest as chairman of the Criminal Justice and Acquired Brain Injury Interest Group.

The Advocate-General for Scotland (Lord Keen of Elie) (Con)

My Lords, all children and young people within the secure estate are screened for brain injury through the comprehensive health assessment tool. If an adult prisoner presents with a significant brain injury, a specialist neurological referral is made. We have formed a cross-government group to develop a more strategic picture of ABI within the criminal justice system.

Lord Ramsbotham

My Lords, I thank the Minister for that somewhat disappointing reply. This is not new; indeed, I have been campaigning for assessment of head injuries for 20 years. In addition to the horrifying figures for women prisoners that the Disabilities Trust has just produced, it has proved that 40% of males and 47% of young offenders are suffering from acquired brain injury. The point about an assessment is that, if you know which part of the head has been hit or damaged, you can predict behavioural outcomes. Unfortunately, the Prime Minister dropped the prisons part of the Prisons and Courts Bill, in which we hoped to have made the assessment of head injuries compulsory. I ask the Minister whether he will make it so.

Lord Keen of Elie

My Lords, the NHS England prison health care national standards service specification requires providers to screen individuals where it is suspected that they may have an acquired brain injury. Clearly, we want to take this further in light of the recent report from the Disabilities

Trust. We have now formed a cross-government group with the Department of Health and Social Care, NHS England and the Prison Service to develop a more strategic picture of acquired brain injury within the criminal justice system. We hope to be able to report to the group chaired by the noble Lord by the end of March.

Baroness Burt of Solihull (LD)

My Lords, I am very heartened by the Minister's response. This shocking finding explains the possible source of many difficult and counterproductive behaviours one sees in the prison population, which can seriously hamper the ability of prisoners to cope inside and outside prison and of professionals to help them. The brain injury screening index provided by the trust is freely available, and its use and effectiveness among prisoners at Drake Hall is tremendously encouraging. Will the Minister agree to add his voice to the Disabilities Trust's demand that all prisons should adopt it?

Lord Keen of Elie

Clearly, we are reviewing this matter with a degree of urgency, and to that extent I add my voice. There is an issue about the extent to which we can apply particular test criteria in the context of prisoners. These cannot be over-complex because of the nature of the people we are dealing with, so this has to be a matter for further consideration. However, we are looking not just at those already in prison but those who come into contact with the criminal justice system. It is equally important that they, too, should, where possible, be assessed for the sort of vulnerabilities referred to by the noble Baroness.

Baroness Corston (Lab)

My Lords, as I understand this survey, 62% of the women reported that their brain injury was sustained as a result of domestic violence, so these women are not only domestic violence survivors, they are brain-damaged and are locked up for ridiculously short periods. Does that not beg the question of whether they should be there at all?

Lord Keen of Elie

I cannot say that it begs the question of whether they should be there at all, given that the nature of their offences may vary quite widely. But clearly, the findings of the Disabilities Trust are extremely disturbing and give cause for concern. That is why we have made them the subject of a review.

Baroness Finlay of Llandaff (CB)

My Lords, I declare my interest as chair of the National Mental Capacity Forum. Do the Government recognise that many people have had head injuries in their pre-offending behaviour? They are in touch with social workers, yet poor social work training does not include functional assessment of them. Ordinary assessments of capacity do not pick up the functional impairment that results in their later offending behaviour.

Lord Keen of Elie

I am not in a position to say what the scope of social work training is with regard to that point, but I quite accept the observation made by the noble Baroness. However, where it is anticipated that someone will be subject to imprisonment, or where they have come into contact with the criminal justice system, NHS England has commissioned liaison and diversion services aimed at identifying those who are vulnerable. It is anticipated that by 2020-21, that service will cover the whole of England.

[...]

HL Deb 12 February 2019 | Vol 795 c1742

[Acquired Brain Injury](#)

Asked by: Bim Afolami

What steps the Government is taking to support charities and other organisations working on treating acquired brain injury.

Answered by: The Minister for Care (Caroline Dinenage)

|Department: Health and Social Care

Everyone who has an acquired brain injury deserves to receive the best possible care and rehabilitative service. To ensure that, the NHS long-term plan included £4.5 billion of new investment to fund primary and community health services over the next five years.

Bim Afolami

I thank the Minister for that answer. The NHS has a good strategy on community-based care. On acquired brain injury, will the Minister advise me and Headway Hertfordshire, a brilliant local organisation, on how we can be more proactively involved with the strategy and attract more funding from local clinical commissioning groups? Will she meet me and the organisation to discuss this matter further?

Caroline Dinenage

I am delighted that my hon. Friend mentions Headway, which is a fantastic organisation that does great work. I meet it regularly in my own constituency and I would be more than happy to do so with him. The partnership boards of local integrated care systems, which will plan and shape those services, will include the voice of voluntary services and the voluntary sector in their area. His local Headway branch would be well advised to engage with that group.

Seema Malhotra (Feltham and Heston) (Lab/Co-op)

Some 1.3 million people are living with traumatic brain injury and related disabilities. Brain injury can be caused by excessive alcohol consumption, particularly among young people. What support will the Government be giving to local health services to increase the use of technology, particularly using creative industry developments, that can help rehabilitation for those with brain injuries?

Caroline Dinenage

There are several points here. On local community services, as the hon. Lady heard, we are putting an extra £4.5 billion into community and local health services. Through the National Institute for Health Research, we fund brain injury research into how technology and other innovations can be used to better support people.

HC Deb 19 February 2019 | PQ 909308 | 654 cc1317-8

[Brain: Injuries](#)

Asked by: Bryant, Chris

To ask the Secretary of State for Education, what estimate he has made of the number of incidents of concussion in schools in each of the last five years.

To ask the Secretary of State for Education, what the requirements for training teachers how to (a) identify and (b) treat acquired brain injury are.

Answering member: Nadhim Zahawi | Department: Department for Education

It is important that children with medical conditions, such as acquired brain injury, are supported to receive a full education.

To be awarded qualified teacher status, trainees must meet the Teachers' Standards, which include a requirement that they adapt teaching to meet the strengths and needs of all pupils. The performance of all existing teachers in maintained schools must be assessed every year against the Teachers' Standards. It is the responsibility of school leaders to determine the training needs of their staff, within their approach to school improvement, professional development and performance management.

Under Section 100 of the Children and Families Act 2014, governing boards are required to make arrangements to support pupils with medical conditions and to have regard to statutory guidance. The guidance is available at <https://www.gov.uk/government/publications/supporting-pupils-at-school-with-medical-conditions--3>, and covers a range of areas including staff training. Staff training is critical in enabling school staff to provide the support needed to pupils with medical conditions. The statutory guidance is clear that governing boards should ensure that any member of school staff providing support to a pupil with medical needs has received suitable training. It also states that training should be sufficient to ensure that staff are competent and have confidence in their ability to support pupils with medical conditions, and to fulfil the requirements as set out in individual healthcare plans.

The information requested on number of incidents of concussion in schools is not held centrally.

HC Deb 11 October 2018 | PQ 176033; PQ 176032

[Brain: Injuries](#)**Asked by: Bryant, Chris**

To ask the Secretary of State for Health and Social Care, what estimate he has made of the annual cost to the public purse of people with an acquired brain injury.

Answering member: Steve Brine | Department: Department of Health and Social Care

These data are not available in the format requested and no estimate has been made.

Reference costs are the mandatory collection of costs data from all National Health Service trusts and NHS foundation trusts. Whilst there is a very wide coverage of services delivered across the NHS collected in reference costs, the diagnosis and treatment of acquired and traumatic brain injuries are excluded.

This is as per table 39 of the national cost collection guidance which can be found at the following link:

improvement.nhs.uk/resources/approved-costing-guidance-collections/

HC Deb 11 October 2018 | PQ 176030

[Brain: Injuries](#)**Asked by: Bryant, Chris**

To ask the Secretary of State for Health and Social Care, how many rehabilitation prescriptions have been issued by the NHS in each year of the last five years.

Answering member: Caroline Dinenege | Department: Department of Health and Social Care

The information requested is not held centrally.

NHS England commissions specialised rehabilitation services for patients with the most complex levels of need. Teams within trauma units assess and develop a rehabilitation prescription for patients with Acquired Brain Injury and other injuries.

In 2015, NHS England published 'The Principles and Expectations for Good Adult Rehabilitation' to support commissioners on delivering rehabilitation care locally, and describes what good rehabilitation looks like and offers a national consensus on the services people should expect.

It includes 10 'principles and expectations' that were designed by people who use rehabilitation services, carers, healthcare professionals, commissioners, strategic clinical networks and national clinical directors from NHS England.

Furthermore, in 2016, NHS England published further rehabilitation commissioning guidance covering both adults and children, setting a

commissioning model, evidence base for the economic benefits of delivering high quality rehabilitation services.

HC Deb 06 September 2018 | PQ 169133

[Brain: Injuries](#)

Asked by: Bryant, Chris

To ask the Secretary of State for Health and Social Care, what the average cost is to his Department of treating an acquired brain injury.

To ask the Secretary of State for Health and Social Care, what information his Department holds on the number of traumatic brain injuries that have happened in each NHS trust area in the last 12 months.

To ask the Secretary of State for Health and Social Care, what information his Department holds on the number of traumatic brain injuries that have happened in each year of the last five years.

Answering member: Stephen Barclay | Department: Department of Health and Social Care

A count of finished consultant episodes (FCEs) with a primary or secondary diagnosis of traumatic brain injury is shown in the following table for the last five years in which data is currently available.

Year	Primary diagnosis	Primary or secondary diagnosis
2012-13	28,733	35,288
2013-14	31,724	39,051
2014-15	35,048	43,440
2015-16	38,744	48,662
2016-17	42,224	53,974

Source: Hospital Episode Statistics, NHS Digital

FCE activity for traumatic brain injuries, by National Health Service trusts, is displayed in the attached table owing to its size, and reports on 2016-17 which is the latest available data.

An FCE is a continuous period of admitted patient care under one consultant within one healthcare provider. FCEs are counted against the year in which they end. Figures do not represent the number of different patients, as a person may have more than one episode of care within the same stay in hospital or in different stays in the same year.

Information surrounding the average cost of treating an acquired brain injury is not collected centrally.

HC Deb 06 September 2018 | PQ 169132; PQ 169131; PQ 160130

5. Useful links

All-Party Parliamentary Group on Acquired Brain Injury Report –
Acquired brain injury and neurorehabilitation: Time for Change
September 2018

https://www.ukabif.org.uk/wp-content/uploads/2018/10/1533_40pp_APPG-on-ABI_Report_Time-for-Change_2018_AW_SINGLES_WEB.pdf

All-Party Parliamentary Group on Acquired Brain Injury

<https://www.ukabif.org.uk/campaigns/all-party-parliamentary-group-on-acquired-brain-injury/>

The UK Acquired Brain Injury Forum

<https://www.ukabif.org.uk/>

Headway – the brain injury association

<https://www.headway.org.uk/>

Brain Injury Rehabilitation Trust (BIRT)

<https://www.thedtgroup.org/brain-injury>

Child Brain Injury Trust

<https://childbraininjurytrust.org.uk/>

Children’s Trust for children with brain injury – Brain Injury Hub

<https://www.braininjuryhub.co.uk/>

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