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DEBATE PACK

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By Bukky Balogun
John Woodhouse
Tom Powell
Robert Long
Jacqueline Beard
Steven Kennedy
Dr Rachael Harker
Nikki Sutherland

Acquired brain injury

This pack has been prepared ahead of the debate to be held in Westminster Hall on Thursday 6 February 2020. The debate will be opened by Chris Bryant MP. The issue has been subject to debates in the last Parliament, for example on 9 May 2019 and 2 July 2019.

Contents

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.

1. Acquired Brain Injury

A debate on acquired brain injury (ABI) will take place in Westminster Hall on Thursday 6 February 2020. The debate will be led by Chris Bryant.

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. ABI has been discussed in previous Parliamentary debates; Acquired Brain Injury (HC Deb, 9 May 2019) and Acquired Brain Injury (HC Dec, 2 July 2019).

Responding to the debate on 2 July 2019, the Minister noted that she would follow up with fellow Ministers on outstanding actions from the 9 May debate, discuss progress of a 2014 audit of regional trauma networks and neuro-rehabilitation provision for children with NHS England, and seek a response from ministerial colleagues on the injury cost recovery scheme. [1]

The UK Acquired Brain Injury Forum (UKABIF) is a charity which aims to promote better understanding of ABI. In September 2018, in conjunction with the All-Party Parliamentary Group (APPG) on Acquired Brain Injury, UKABIF published a report; Acquired Brain Injury and Neurorehabilitation, Time for Change,, making a number of recommendations relating to neurorehabilitation and other issues.[2] The debate may consider what progress has been made since the publication of this report. The Government published its response to the report in February 2019, highlighting its existing work on ABI and outlining further plans to improve support for individuals with ABI.[3] The UKABIF and APPG have published an update ahead of Thursday's debate, outlining a number of measures it would like to see implemented in 2020:

- Children, young people and adults who have an Acquired Brain Injury require early access to adequate and consistent neurorehabilitation services - a mandated approach is needed across the board whether it be a major trauma centre, hospital, or community service.
- More neurorehabilitation health professionals (physiotherapists, occupational therapists, speech and language therapists, nurses, neuropsychologists, educational psychologists) are needed to deliver services.
- Rehabilitation prescriptions documenting support needed to maximise recovery must be mandated across all services and should be updateable so progress can be monitored and integrated with all health and social care systems.
- Criminal justice procedures, practices and policies need to be reformed to take into account the needs of individuals.

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1 Acquired Brain Injury, HC Deb, Hansard, 2 July 2019
2 Acquired Brain Injury and Neurorehabilitation, Time for Change, APPG on Acquired Brain Injury and UK Acquired Brain Injury Forum, Sep 2018
3 DHSC APPG ABI Response, February 2019[3] DHSC APPG ABI Response, February 2019

- Best Practice Guidelines must be approved and followed for Children and Young people returning to education after an acquired brain injury.
- Shared responsibility and cooperation between key government departments is needed including the Department of Health and Social Care, the Department for Work and Pensions, the Department of Education, the Department for Digital, Culture, Media and Sport and the Ministries of Justice and Defence.
- A national plan is needed to articulate societal benefit, raise awareness of this hidden disability, and model pathways and contracts for service planners and commissioners[4]

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:

- 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 APPG and UKABIF report; Acquired Brain Injury and Neurorehabilitation, Time for Change., 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 states that 1.3 million people live with the effects of brain injury at a cost to the UK economy of £15 billion per annum, a figure that is equivalent to 10% of the annual National Health Service (NHS) budget. This includes the costs of premature death, health and social care, lost work contributions and continuing disability. International comparisons suggest a similar scale of impact, at least for TBI [traumatic brain injury].[5]

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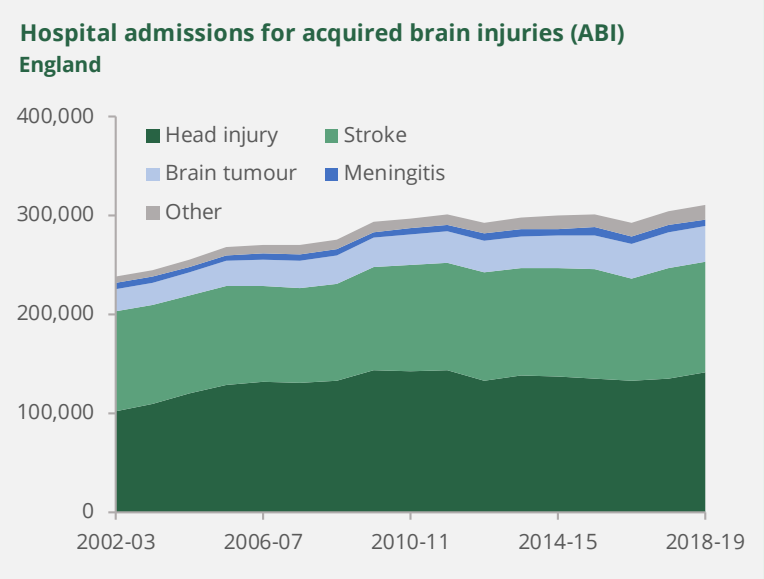
4 UKABIF/ APPG on Acquired Brain Injury Briefing Update, UKABIF and APPG on Acquired Brain Injury, 31 Jan 2020

5 Acquired Brain Injury and Neurorehabilitation, Time for Change, APPG on Acquired Brain Injury and UK Acquired Brain Injury Forum, Sep 2018

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 2002/03 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 2018/19 - 310,750 admissions. Head injury and stroke account for the majority of cases: 46% of ABIs in 2018/19 were diagnosed as head injuries and 36% stroke.



Source: NHS Digital Admitted patient care activity data

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.[6]

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 continuing cognitive, communicative, emotional, behavioural or physical difficulties as a result of a traumatic brain injury.[7]

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

6 Headway, Management of acquired brain injury: a guide for GPs, 2013
7 NICE, Quality Standard: Head injury, 2014

> 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.[8]

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

The Government response to the APPG report was published in February 2019. As well providing responses to the APPG's recommendations, and setting out relevant guidance and policy background, the Government response highlighted the important role of clinical audits in measuring performance and driving improvement. Responding to a debate on ABI in May 2019, the then Under-Secretary of State for Health and Social Care, Seema Kennedy, noted progress in reported rehabilitation prescription completion rates:

> The "National Clinical Audit of Specialist Rehabilitation for Adults Patients with Complex Needs Following Major Injury", published in 2016, found that on average 81% of patients had a record of a rehabilitation prescription. The audit recommended that MTCs take action to improve compliance. The audit report appears to have had a significant impact. The latest data, from the last quarter of 2018, from the trauma and audit research network shows that the national average rose to a 95% completion rate for RPs. This is good news. NHS England has worked with patients, clinicians and charities to improve the RP design and set new standards for communication and involvement of patients, families and carers. It is hoped that the

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

> new RP will support the development of a rehabilitation dashboard to monitor the performance of the system. Audits play an important role in helping services to improve. The report also recommended that all organisations within a trauma network work together to review capacity.[9]

The final report of the National Clinical Audit of Specialist Rehabilitation following Major Injury (NCASRI) was published in April 2019. The NCASRI project identified a number of shortfalls, for example, the authors estimated that only 40% of those who need specialist rehabilitation access these services. The NCARSI recommendations included that trauma centres should ensure that standards for rehabilitation provision and availability are met, and that commissioners should consider opportunities for development of specialist rehabilitation capacity, both for in-patient and community-based services. Responding to a Westminster Hall debate on ABI in July 2019, the Minister said she would discuss with NHS England what actions it is taking following the audit and in particular, would "impress on it the importance of bed provision."[10]

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.[11] There have also been warnings about the risks of heading in football.[12]

The websites of the Rugby Football Union and Rugby Football League both include information on concussion. The Football Association has published Concussion Guidelines (August 2019).

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.

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9 HC Deb, Acquired Brain Injury, 9 May 2019 c729

10 HC Deb, Acquired Brain Injury, 2 July 2019 c465WH

11 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 30 January 2020]

12 "Can heading a football lead to dementia? The evidence is growing", Guardian, 16 January 2020; "Calls for ban on young players heading footballs as brain-injury expert says under 18s are in danger", Telegraph, 21 October 2019; "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; "Concussion may have led to Loris Karius's calamities, says US hospital", Guardian, 4 June 2018; "Concussion in sport: What can be learned from the NFL?", BBC Sport, 24 December 2019

- 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.[13]

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.

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%.[14]

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

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13 Baroness Tanni Grey-Thompson, *Duty of Care in Sport: Independent Report to Government*, April 2017, p25

14 Commons Justice Select Committee, The treatment of young adults in the criminal justice system, October 2016

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.[15]

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 screening and raising staff awareness of acquired brain injury in offenders through training:

> **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 considered and alternative rehabilitation or treatment pathways are considered. Training events are scheduled for early 2018.[16]

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. The Trust's publications include:

- Brain injury and offending briefing
- Brain Injury Linkworker report 2016
- Making the Link: Female offending and brain injury, 2019
- The Impact of Brain Injury and Domestic Abuse: A Further Analysis, 2019

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.[17]

In October 2019 HM Prisons and Probation Service published a summary of evidence about traumatic brain injury in the prison population, with information about how to better help people with TBI.[18]

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15 Commons Justice Select Committee, The treatment of young adults in the criminal justice system, October 2016

16 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

17 Prisoners: Acquired Brain Injuries, HL Deb 12 February 2019 c1743

18 Gov.uk, Guidance: Traumatic brain injury in the prison population, 3 October 2019

The Sentencing Council, in 2019, consulted on a draft guideline, Overarching Principles: Sentencing Offenders with Mental Health Conditions or Disorders. It provides guidance to sentencers when sentencing offenders with mental health conditions or disorders including ABI.

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

- Professor Huw Williams, Repairing Shattered Lives: Brain Injury and its implications for criminal justice, Barrow Cadbury Trust, 2015
- Michael Parsonage, 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 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.[19]

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 the assessment, and how the assessment is carried out, see the DWP's PIP assessment guide.[20] 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

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19 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.

20 Last updated 7 February 2019

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.[21] Statistics on the number of Universal Credit claimants with an ABI are "not readily available" and to provide them would "incur disproportionate cost."[22]

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."[23] 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.[24]

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

- 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 issues[25]

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21 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
22 PQ 138405, 3 May 2018
23 p36
24 Ibid. p38
25 Thompsons Solicitors, Welfare benefits and acquired brain injury infographic

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 proposed[26]

The default position is that all recipients of incapacity or disability benefits are reassessed periodically to determine whether they continue to satisfy the conditions for benefit. Since September 2017 however, some ESA and Universal Credit claimants with the most severe health conditions and disabilities have been exempt from repeat Work Capability Assessments. Claimants meet the "severe conditions criteria" if they have been assessed as having a "limited capability for work-related activity"; have a severe, lifelong disability, illness or health condition; and are unlikely to ever be able to move into work. Personal Independence Payment claimants receiving the highest level of support and whose needs are unlikely to improve may only have a "light touch" review every ten years, under rules introduced in 2018. PIP claimants over State Pension age are also now exempt from reassessment, unless they report a change in their needs. Further information can be found in Commons Library briefing CBP-7820, ESA and PIP reassessments.

The Conservative Party's 2019 General Election manifesto also stated that, as part of efforts to "empower and support disabled people", a Conservative Government would-

> …reduce the number of reassessments a disabled person must go through when a significant change in condition is unlikely – because you should not have to provide repeated proof of your disability in order to receive support.[27]

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26 Ibid. p36
27 Conservative and Unionist Party Manifesto 2019, p17

On 27 January 2020, the Minister for Disabled People, Health and Work, Justin Tomlinson, said that the Government was exploring the manifesto commitment "to ensure a minimum award review duration for PIP awards."[28]

In March 2019, the then Secretary of State for Work and Pensions, Amber Rudd, announced that her Department had launched a "Health Transformation Programme" to develop a new, integrated service, supported by a single digital system, for Personal Independence Payment and Work Capability Assessments, from 2021.[29] The integrated service is intended to provide "a more joined up experience" for claimants, but the two assessments will remain separate. However, she also announced plans to test the feasibility of a single assessment covering to determine eligibility for both ESA/UC and PIP. A Commons written answer on 17 January 2020 said that the DWP remains "committed to delivering the new single, integrated assessment service for health assessments across PIP, ESA and UC."[30]

1.7 Support in 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 17 December 2019.

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

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28 HC Deb 27 January 2020 c17

29 Health and Disability Announcement: Written Statement HCWS1376, 5 March 2019; see also End to unnecessary benefit reassessments for disabled pensioners, DWP press release, 5 March 2019

30 PQ 1766 [on Social Security Benefits: Medical Examinations]

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 ABI: 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

Nursing Times

Bid to develop advance nurses to meet brain injury care demand

16 October 2019

https://www.nursingtimes.net/news/education/bid-to-develop-advance-nurses-to-meet-brain-injury-care-demand-16-10-2019/

Community Care

Spotting the signs of acquired brain injury (ABI) in adults: top tips

23 August 2019

https://www.communitycare.co.uk/2019/08/23/spotting-signs-acquired-brain-injury-abi-adults-top-tips/

Chartered Society of Physiotherapy

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

15 March 2019

https://www.csp.org.uk/news/2019-03-15-people-acquired-brain-injury-need-rehab-prescriptions-says-parliamentary-group

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

Brain injuries increase dementia risk, study finds

11 April 2018

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

3. Press releases

University of East Anglia

£1 million project launch to monitor ex-footballers for early signs of dementia

7 January 2020

Researchers at the University of East Anglia are crowd-funding a new project to test former professional football players for early signs of dementia.

Recent research from the University of Glasgow has shown that retired male players are around five times more likely to suffer from Alzheimer's disease compared with the average person.

But little is known about exactly when players start to show signs of the disease and even less about the effects in women as the majority of research has focussed on men.

The UEA research team will use cutting-edge technology to test for early signs of dementia in men and women, that are identifiable long before any memory problems or other noticeable symptoms become apparent.

The University has launched a £1 million fundraising goal for this research, at least 10 per cent of which they hope will be crowd-funded.

Lead researcher Dr Michael Grey, from UEA's School of Health Sciences, said:

> We now know that there is much higher risk of dementia in former professional footballers, and we think this is related to repetitive heading of the ball. We do not know if this extends to the amateur level.
>
> So there will be many footballers out there who are understandably very worried about their futures.
>
> We will be working with former professional players to investigate and track their brain health over time.
>
> We hope to follow these footballers for the rest of their lives.
>
> This is the first time that this type of research has been done,

he added.

Former players in the Eastern region will be the first to take part in the SCORES project (Screening Cognitive Outcomes after Repetitive head impact Exposure in Sport) – before the study is rolled out nationally later this year.

The research team are looking for former professional players to take part.

Former Norwich City Football Club striker Iwan Roberts, who played more than 600 games for club and country, is already backing the project.

He said:

> I played football for 20 years professionally, and headed many balls over that period. I want to see whether there is anything I should be concerned about in the foreseeable future.
>
> It's always important to improve and make things better. The game has improved, balls are lighter, but the modern-day player will still be at risk of this type of illness.
>
> We don't know how young children cope with heading the ball. I personally think that [heading the ball] should be banned from a certain age.
>
> The research they are doing here will help everybody,

he added.

The project is among a number of pieces of work in the Concussion Action Programme, a research group within UEA Health and Social Care Partners.

UK Acquired Brain Injury Forum

RECOVERY PROSPECTS OF BRAIN INJURED PATIENTS JEOPARDISED BY CHRONIC LACK OF RESOURCES

28 January 2020

Majority of solicitors say there are a lack of suitably qualified brain injury case managers in the UK

The recovery prospects of brain injured patients are being jeopardised by a chronic lack of resources - while the majority of solicitors say there are not enough suitably qualified brain injury case managers in the UK.

The research, by brain injury rehabilitation charity Calvert Reconnections and barristers Exchange Chambers, examines the effectiveness of the brain injury recovery process through a series of in-depth interviews with the country's most senior brain injury lawyers.

164 brain injury solicitors took part in the 8-week study with 71% saying that the NHS is unable to provide effective support for brain injured patients. 97% believe there are a lack of residential-based brain injury rehabilitation units in the UK.

Referring to the lack of faith in NHS brain injury care, Bill Braithwaite QC, expert advisor to Calvert Reconnections and Head of Exchange Chambers said:

> I'm not at all surprised. Acute care is often very good but subsequent rehabilitation can be hit and miss, doubtless because of shortage of money. That is why the private and charitable sectors are so important.

The research addresses a number of points in relation to case managers, with 61% of solicitors saying that there are not enough suitably qualified brain injury case managers in the UK.

> This is surprising because it has been a growing profession since it started in the UK in the 1990s,

said Bill Braithwaite QC.

> However, perhaps it is the suitably qualified phrase that is the stumbling block. Sometimes it seems as though people put themselves forward when they do not have the training or experience for the job.

In other case manager findings:

- 37% of solicitors say they regularly disagree with the other side on the most appropriate case manager.
- In the majority (70%) of cases, insurers, defence solicitors and insurers talk to each other before instructing a case manager.
- The majority (66%) of solicitors say case managers work closely with treating professionals, family members and third parties.
- The majority (70%) of solicitors believe case managers set specific rehabilitation goals.
- The majority (80%) of case managers only accept instructions within their field of expertise.

The report found that patients' recovery from brain injury is often delayed by lack of cooperation amongst lawyers.

In brain injury cases over the last 12 months, 68% of lawyers have been unable reach agreement with the other side on the injured person's basic rehabilitation needs, therefore stalling the recovery process.

Added Bill Braithwaite QC:

> This research suggests that in many cases, lawyers often cannot agree on the most obvious recommendations as a starting point.
>
> Delay is hugely damaging to anyone who has suffered a brain injury. Sensible dialogue on both sides would improve the problem as rehabilitation will only work at its best if both sides enter into it voluntarily.

The report also points to the positive role outdoor activities can play in brain injury rehabilitation. Walking is viewed as the most effective activity, followed by fishing, gardening, horse riding, cycling, water sports and orienteering.

Continued Bill Braithwaite QC:

> There is considerable medical support for the notion that outdoor activity is helpful in brain injury rehabilitation. The challenge moving forward is to incorporate outdoor activities into rehabilitation plans wherever appropriate.

Calvert Reconnections is the UK's first intensive acquired brain injury (ABI) rehabilitation centre combining traditional interdisciplinary clinical therapies with physical activity in the outdoors. The centre opens in early 2020.

Rehabilitation Survey Results

Visit the Calvert Reconnections website at https://www.calvertreconnections.org.uk/

and follow on twitter @CalvertReconne1

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

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

British Psychological Society

Parliament and the 'Frontal Lobe Paradox'

30 July 2018

On 18th July 2018, representatives of the Division of Neuropsychology visited parliament to discuss and present recommendations related to the Frontal Lobe Paradox.

The group consisted of Dr Katherine Carpenter, Consultant Clinical Neuropsychologist and chair of the DoN, along with Dr Camilla Herbert, Dr Sam Gilbert, Dr Melanie George, Dr Mark Holloway and Chloe Hayward (who was responsible for convening the meetings).

The group also met separately with Emma Lewell-Buck MP and Baroness Finlay.

What is the Frontal Lobe Paradox and why is it important?

The Frontal Lobe paradox (Walsh, 1985), otherwise known as the 'knowing doing dissociation' (Teuber, 1964) is a fascinating and puzzling phenomenon that can affect anyone who has sustained damage to the frontal lobes of their brain.

This is a huge region, making up a third of the surface area of the brain, which is involved in regulating our thinking skills and decision-making.

Although some individuals with frontal lobe injuries may have significant difficulties with everyday tasks, such as cooking, organising their paperwork or remembering to take their medication, they show little awareness of this and moreover, strenuously deny that they need any help or support.

The person should not be seen as knowingly/ consciously denying their difficulties or even lying. Their presentation reflects the fact that the areas of the frontal lobes that are responsible for self-monitoring and developing insight have been affected by their brain damage.

This is referred to as a 'paradox' because certain individuals can appear entirely unimpaired in an office-based assessment, yet have significant functional difficulties in everyday life.

Without specialist expertise in acquired brain injuries, it can be almost impossible to spot the presence of the Frontal Lobe Paradox because, in many cases, people will have preserved language skills and therefore appear remarkably unimpaired during a short one-to-one conversation.

How many people present with the phenomenon?

This is likely to found in a much higher number of people than you might first imagine. We have seen people present in this way, following brain damage caused by strokes, infections and blows to the head.

We have also seen this in people who have longstanding and poorly-controlled diabetes or forms of dementia that affect the frontal lobes of the brain.

The Frontal Lobe Paradox is a familiar term to neuropsychologists. Amongst professionals in this group it is well-known that an office-based assessment of an individual may give a poor and inaccurate indication of their functional abilities in everyday life.

However, the DoN has come to realise that there is very limited knowledge and understanding of it amongst other professionals and members of the public.

The Frontal Lobe Paradox and the Mental Capacity Act (2005)

The Mental Capacity Act (2005) was developed to safeguard the needs of people who have lost the Mental Capacity to consent to certain decisions.

The Alzheimer's Society has written a helpful overview of the Act. More information about this can be found at the following link:

- https://www.alzheimers.org.uk/categories/support/mental-capacity-act

As most people are aware, community support in the UK is funded by the local authority. A range of health professionals (i.e. a GP or clinical psychologist) may recommend that an individual requires a care package or other forms of support following a brain injury.

However, local authority social workers and care managers need to conduct Mental Capacity Act assessments to ensure that the individual has the ability to consent to this type of care.

Local authority social workers and care managers usually conduct these types of assessments on their own because they are solely responsible for paying for the care (they are known as the 'decision makers' in these situations).

They tend to make their decision about an individual's mental capacity to consent to care (or to decline care) on the basis of a short face to face interview. They have the power to overrule decisions made by others.

What are the risks associated with the Frontal Lobe Paradox?

It is important to stress that local authority social workers and care managers are, in our experience, hard working professionals who are motivated to act in the best interests of those under their care.

The problem is that many of them receive little or no specialist training in brain injury. If they have not observed people with the Frontal Lobe Paradox struggle with everyday tasks, they may also overestimate their

ability to live independently. More worryingly, they may misclassify them as having the mental capacity to decline care and support.

This situation can lead to people not receiving help that they desperately need. In the longer term, this can place them at risk of self-neglect.

This can be a frustrating situation for brain injury experts and also for loved ones who have seen evidence of the fact that the person is 'good in theory but poor in practice'.

We submitted several case studies to Baroness Finlay and Emma Lewell-Buck to illustrate the problems that this can create.

In a recent paper written by Melanie George and Sam Gilbert, the authors note:

> A key barrier to mitigating the risks associated with this issue is that it is little known outside of neuropsychology. This gives rise to a 'double whammy' whereby most professionals but also the patients themselves are unaware of the problems.
>
> This patient group is in particular need of advocacy and support. However, for reasons outlined in this paper, they are often the least likely to receive it.
>
> (George & Gilbert, 2018, p.63)

What would the DoN like to happen?

We are contributing to a set of recommendations, requested by Baroness Finlay, which we hope will inform the current debate regarding the amendment to the Mental Capacity Act that is currently going through the Lords.

More information on this can be accessed at:

- https://www.parliament.uk/business/news/2018/july/lords-debates-mental-capacity-amendment-bill/

The DoN is working closely with other professional groups including UKABIF represented by Chloe Hayward and the Brain Injury Social Work Group represented by Dr Mark Holloway who plan to meet with Lord Patel, the new chair of the social work regulator in the UK, called 'Social Work England' in the near future.

You can read more about the role here:

- http://www.communitycare.co.uk/2018/06/04/social-worker-named-chief-executive-new-social-work-regulator/

Together with UKABIF and BISWIG, we will request that all social workers receive training on brain injury, prior to conducting MCA assessments.

We have also requested that MCA assessments routinely include information about the individual's ability to complete important tasks and maintain a safe level of independence in everyday life.

This would mean requesting results from assessments carried out by occupational therapists and seeking the views of family members and others who know the person well.

References

George, M.S., & Gilbert, S. (2018). Mental Capacity Act (2005) assessments: why everyone needs to know about the frontal lobe paradox. The Neuropsychologist, 5, 59 - 66.

Further Links:

The British Psychological Society (BPS) Division of Neuropsychology recently contributed to revised NICE guidelines on this topic which are due out in the next few months:

- https://www.nice.org.uk/guidance/indevelopment/gid-ng10009

Designations of the group

- Dr Katherine Carpenter, Consultant Clinical Neuropsychologist and chair of the British Psychological Society Division of Neuropsychology (BPS DoN)
- Dr Camilla Herbert (Consultant Neuropsychologist and BPS lead for the Mental Capacity Act)
- Dr Sam Gilbert (Associate Professor from the Institute of Cognitive Neuroscience)
- Dr Melanie George (Consultant Neuropsychologist from Kent Clinical Neuropsychology Service, KMPT)
- Dr Mark Holloway (social worker and specialist brain injury case manager from 'Head First')
- Chloe Hayward (UK Acquired Brain Injury Forum and the Brain Injury Social Work Group).

4. Parliamentary material

Debates

Commons debate: Acquired Brain Injury

HC Deb 02 July 2019 | Vol 662 c4445 WH-

http://bit.ly/2FQBzRl

Commons debate: Acquired Brain Injury

HC Deb 18 June 2018 | Vol 643 c132-

http://bit.ly/2u9wFZc

Commons debate: Acquired Brain Injury

HC Deb 09 May 2019 | Vol 659 c700-

http://bit.ly/2LA04aW

Member's debate contribution

[Department for Education Estimates]

Chris Bryant

HC Deb 26 February 2019 | Vol 655 cc260-2

http://bit.ly/2Ezp7W4

PQs

Engagements

Asked by: Chris Bryant

When researchers recently screened all the women prisoners at Drake Hall prison in Staffordshire for brain injuries, they found that nearly two thirds had a serious brain injury before they committed their first offence and that, of those injuries, two thirds were the result of domestic violence. There is a real danger that we are criminalising the victims of domestic abuse. The Domestic Abuse Bill is going through pre-legislative scrutiny at the moment. Would not it be a good idea to change it by adding a clause to provide that all female prisoners will be screened for brain injury, and that all female prisoners who have had a brain injury will have proper neurorehabilitation, so that we can rescue their future and prevent crime? If the Prime Minister has some spare

time, will she co-sign that amendment with me, perhaps as vice-chair of the all-party parliamentary group on acquired brain injury?

Answered by: The Prime Minister | Department: Prime Minister

We take the issue of prisoners' brain injury very seriously and, indeed, action is being taken by the Ministry of Justice to look very carefully into the issue. Obviously, I look forward to the debate that will take place—[Interruption.] Well, I have had many invitations across the Chamber in the past. I have never quite had this invitation from the hon. Gentleman and I have to say, I think I will approach the invitation to work with him with caution given some of the arguments that we have had in the past, but I welcome the fact that I will be able to—or expect to be able to—contribute to the debate on that Bill when it goes through this House. It is a very important piece of legislation, which I want to see genuinely transforming what we can do to deal with domestic violence.

HC Deb 12 June 2019 | Vol 661 cc658-9

Pupils: Injuries

Asked by: Fallon, Sir Michael

To ask the Secretary of State for Education, what steps his Department is taking to ensure that pupils with acquired brain injuries are fully supported in mainstream education.

Answering member: Nadhim Zahawi | Department: Department for Education

Teachers must be able to adapt teaching to the needs of all their pupils. Teachers must also have an understanding of the factors that can inhibit learning and how best to overcome them.

The 2015 Special Educational Needs and Disabilities (SEND) Code of Practice sets out high expectations of schools and colleges about how they identify and meet the needs of pupils with SEND. It covers both those who have Education, Health and Care plans with more complex needs and the much larger group of pupils whose needs can be met without a statutory plan, that is, those on SEND support.

HC Deb 10 June 2019 | PQ 258875

Prisoners: Injuries

Asked by: Burgon, Richard

To ask the Secretary of State for Justice, what estimate he has made of the number of people in prison with traumatic brain injuries.

Answering member: Robert Buckland | Department: Ministry of Justice

The MoJ does not hold information on the number of prisoners who have suffered a traumatic brain injury. NHS England commission health

care services in prison and include questions on head injury in the secondary health screen which all prisoners receive.

Recent studies that have examined the prevalence of traumatic brain injury in prisons in England and Wales indicate this may affect between 46 to 70 per cent of the male population. On 6th February 2019, The Disabilities Trust published their 'Making the Link' Evaluation Report on their service to support female offenders with acquired brain injury in HMP Drake Hall. The report found that, of the 173 female offenders screened at HMP Drake Hall, 64% reported a history indicative of a brain injury. Additionally, in 2017-2018, The Disabilities Trust ran a Brain Injury Linkworker pilot at six sites in the adult male estate. It is expected that the evaluation from this pilot will be published in due course.

MoJ has formed a cross-government group on Acquired Brain Injury with colleagues from NHS England, DHSC, the Home Office and HMPPS. This group will consider the findings from both pilots, alongside other emerging evidence, to help determine next steps to better support this cohort of vulnerable offenders.

HC Deb 17 May 2019 | PQ 252676

Brain: Injuries

Asked by: Nandy, Lisa

To ask the Secretary of State for Health and Social Care, what plans he has to establish a cross-departmental taskforce to address the issues and recommendations outlined in the report of the all-party parliamentary group on acquired brain injury entitled Acquired brain injury and neurorehabilitation - time for change.

Answering member: Seema Kennedy | Department: Department of Health and Social Care

Officials at the Department worked with colleagues across Government to respond to recommendations of the report by the all-party parliamentary group (APPG) on acquired brain injury. This response, which outlined the broad range of activity underway to address the issues raised by the APPG, was issued on 19 February 2019. A copy of the response is attached.

HC Deb 16 May 2019 | PQ 253567

Prisoners: Injuries

Asked by: Burgon, Richard

To ask the Secretary of State for Health and Social Care, if he will introduce a pilot to trial screening for traumatic brain injuries on entry into prison.

Answering member: Jackie Doyle-Price | Department: Department of Health and Social Care

NHS England has commissioned liaison and diversion services in custody suites and courts aimed at identifying those who are vulnerable. It is anticipated that by 2020-21, that service will cover the whole of England.

All children and young people within the secure estate are screened for brain injury through the comprehensive health assessment tool.

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. If an adult prisoner presents with a significant brain injury, a specialist neurological referral is made.

There are specific diagnostics for those whose presentations suggest a cause for concern. Where individuals so assessed are then sentenced to custody, this information will be passed to the escorts for prison reception.

HC Deb 16 May 2019 | PQ 252677

Topical Questions

Asked by: Chris Bryant

If you were to look in the faces of the vast majority of people who have an acquired brain injury, you would not be able to spot anything wrong whatsoever, but inside is somebody who has a massive sense of fatigue. They might have major memory problems or have completely lost their executive function, unable to make proper decisions for themselves, but when the assessor from the DWP comes they will want to please them and will exaggerate the improvement in their condition. Will the Secretary of State guarantee that every single person who, on behalf of the DWP, goes to see somebody with a brain injury fully understands how brain injury can fluctuate?

Answered by: Amber Rudd | Department: Work and Pensions

I thank the hon. Gentleman for raising that, and I know how much he has done to support people with brain conditions. We are ensuring that we do that through the welfare system, so that those with

acquired brain injury and associated neurological complications receive the right support, but I recognise the issue he raises. We are doing more to ensure that our health assessors have all the necessary training, so that they are able to recognise different challenges, such as acquired brain injury.

HC Deb 13 May 2019 | Vol 660 c18

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 Dinenage | 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

Government response February 2019

http://qna.files.parliament.uk/qna-attachments/1126064/original/DHSC%20APPG%20ABI%20Response.pdf

All-Party Parliamentary Group on Acquired Brain Injury

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

HM Prison and Probation Service guidance *Traumatic brain injury in the prison population* 3 October 2019

https://www.gov.uk/guidance/traumatic-brain-injury-in-the-prison-population#what-can-we-do-better-to-help-people-with-tbi

UK Acquired Brain Injury Forum *Manifesto for Community Rehabilitation* 23 September 2019

https://ukabif.org.uk/news/470907/Manifesto-for-Community-Rehabilitation.htm

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/

DEBATE PACK
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