NEUROREHABILITATION

1. **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**

2. **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**

3. **A national review of neurorehabilitation is required to ensure service provision is adequate and consistent throughout the UK**

4. **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.**

5. **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 Rehabilitation Prescription model was developed from an expert working group with representation from a wide range of medical specialties, patients, clinical professionals such as physiotherapists and occupational therapists, and a range of interest groups in 2011, including the British Society of Rehabilitation Medicine.

At the time, the group agreed that the Rehabilitation Prescription (RP) was a revolutionary concept that could not be implemented by simply devising one or even a few specific forms, and/or by setting up rehabilitation services separate from other services. It could only be implemented by setting up a full rehabilitation service across whole systems. Therefore, the working party agreed that the best way to implement the RP was by recommending standards that should apply to rehabilitation after trauma, and it was these that were subsequently developed to inform major trauma service provision. However, the working group acknowledged that Trauma patients are all managed within rehabilitation services that see patients with many other disorders. Therefore, this approach should be relevant to all rehabilitation within all NHS services, not simply to rehabilitation after trauma.

NHS England's Major Trauma Service is nationally commissioned to an agreed specification. This sets out that patients should be reviewed by a Rehabilitation Medicine consultant or alternative clinician with skills and competencies in rehabilitation to provide an initial formulation and plan to complete and inform the initial RP. This first consultation should take place within 72 hours of admission with the rehabilitation prescription completed at patient discharge.

The prescription for rehabilitation should reflect the assessment of the physical, functional, vocational, educational, cognitive, psychological and social rehabilitation needs of a patient. The prescription may identify no further need for rehabilitation, or may simply recommend monitoring or may require full active engagement of the wider rehabilitation team.

At discharge, all patients should have a patient held record which continues their clinical information and treatment plan from admission through to specialised or local rehabilitation (supported by the prescription for rehabilitation).

The National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs Following Major Injury organisational audit, commissioned by NHS England and published in October 2016, found that although reported RP completion rates had increased over the previous 3 years, compliance still varies between Major Trauma Centres (MTCs). Recording rates range from 52% to 99%. The audit recommended MTCs take action to improve compliance.

The audit report appears to have had a significant impact. The most recent data (Apr-Jun 2018) from the national trauma audit (TARN), which monitors completion of the RP, shows that 19 MTCs now achieve more than 90% compliance (10 of these achieve 100%) and the lowest MTC compliance rate is 75%. Overall, the national mean is now 94.3% compliance with the RP.

NHS England, together with patient and professional representatives, has undertaken further work over the past 12 months to more clearly define the requirements of an RP, with different versions for adults and children. This sets new standards for communication and involvement of patients, families and carers and should also improve communication with General Practitioners (who have contributed to the development). Part of the new RP will include the collection of key audit data (via TARN) that will allow for monitoring and service evaluation. The new RP has been reviewed and tested by major trauma centres and has been positively received by both clinicians and patient groups such as the ABI Alliance. The data collection system is currently being trialled and is now available for all Major Trauma Centres to use. The new RP should become part of best practice tariff for major trauma from April 2019 (this is at the consultation stage at present). The new RP will also be promoted by the Major Trauma Networks (MTNs) for use in all Trauma Units that also provide rehabilitation for these patients and NHS England intends to introduce a new best practice pathway (and tariff) for Trauma Units that includes use of the new RP. In the future, it is anticipated that clinicians may adapt this system for use for other patient groups i.e., non-trauma ABI.

Regarding an increase in neurorehabilitation beds and neurorehabilitation professionals, NHS England's service specification for major trauma requires that a Rehabilitation Medicine (RM) consultant should attend the MTCs at least 3 times per week to assist in the management and transfer of patients. The National Clinical Audit found that only half

of the MTCs met this standard and a quarter did not have any designated paid sessions for a consultant in RM. In addition, Many MTNs did not have a Director of Rehabilitation to coordinate the provision of rehabilitation services

The audit recommended that Major Trauma Centres review arrangements for access to rehabilitation consultants and to appoint a Director of Rehabilitation if one was not in place to ensure need is appropriately met. Furthermore, the audit report advises that all organisations within a trauma network should work together to review the capacity and pathways for specialist rehabilitation in the light of the information provided in the audit.

Audits play a vital role in helping to drive improvement and benchmark performance. The aim of the 2016 organisational audit, which ran from July 2015 to June 2016, was to identify the specialist rehabilitation services providing care to trauma patients, and to map the pathways of care into and out of these services. It is important to note that this was only the first part of this audit programme of work.

From July 2016 and June 2017, prospective clinical audit of new patients presenting within the major trauma centres who have complex needs and receive specialist rehabilitation, was undertaken. This was published in September 2017. Also, a feasibility study for identifying the pathway and outcomes from existing data sources for patients who require specialist rehabilitation on discharge from major trauma centres, but do not subsequently attend took place between June 2017 and January 2018. This report is set to be published later this year. The Healthcare Quality Improvement Partnership (HQIP) which oversees the audit programme on behalf of NHS England, has recently agreed a short extension to the programme to enable a complete analysis of the initial cohort of patients, with a draft report to be submitted to HQIP and NHS England for publication in due course.

It should also be recognised that there is a national shortage of trained rehabilitation specialists and this is part of the wider workforce issue faced by the NHS. The development of the major trauma system has helped to improve recruitment into this specialty. In addition, a high proportion of patients suffering major trauma, including traumatic brain injury, are now over the age of 65 years. Major trauma services throughout England have recognised that this group of patients require additional medical and social support to maximise their rehabilitation and recovery and this is being provided by Physicians in Health Care of the Elderly.

Regarding bed capacity in specialist centres, the Specialist Rehabilitation Audit found that 95% of patients receiving specialised rehabilitation were assessed and admitted within a reasonable space of time. However, a small number experienced a disproportionate delay in transferring to specialised rehabilitation when they were fit to do so. The audit report states that it, with exception of certain cases, is unclear exactly why all these waits occur where but has recommended all centres review levels of bed

provision to ensure delays are kept to a minimum.

Whilst the audit report only covers a small number of patients with ABI, as was stated in the debate tabled on 18th June, NHS England recognises the value of high quality rehabilitation services regardless of the level at which they are commissioned. 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 ten '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. Building on this, in 2016, NHS England published further rehabilitation guidance commissioning guidance covering both adults and children, setting a commissioning model, evidence base for the economic benefits of delivering high quality rehabilitation services.

NHS England expects commissioners and service providers to work effectively together to ensure not only that patients with suspected ABI are appropriately identified and treated; drawing on expert guidance from the National Institute for Health and Care Excellence, but also to ensure patients rehabilitation needs are appropriately met for as long as they are needed.

Whilst NHS England currently has no plans for a review, the new Rehabilitation Prescription will allow the collection of accurate data on rehabilitation service provision in trauma (including traumatic brain injury) and will also allow for development of a Rehabilitation Dashboard to monitor the performance of the system and service as an important improvement mechanism.

Turning to the issue of improved data collection on attendances at Accident and Emergency Departments with Acquired Brain Injury, and recording the numbers that require and receive neurorehabilitation. Current A&E data collection is not sufficiently detailed in terms of diagnosis and treatment codes for the identification of 'Acquired Brain Injury'. There are 39 diagnosis codes/categories, one of which is code 04 – Head Injury which can be divided into Concussion or Other Head Injury but here is no further detail available. Treatment codes are similar in that they record at a very high level and it is not possible to identify neurorehabilitation.

As of September 2016, A&E service providers began to shift to submitting their data using new coding sets; Emergency Care Data Set (ECDS). This collection utilises SNOMED Codes for recording and classifying diagnosis and treatment of A&E attendances. SNOMED is a much more extensive coding system and allows for much more detailed recording of the type of injury and the treatment required. At the time of writing, not every provider is submitting under CDS 6-2 Type 011 and there are known data quality issues with some submissions. Therefore, ECDS is currently regarded as an experimental dataset. Further information on the SNOMED codes can be found on the

NHS Digital website: https://digital.nhs.uk/services/terminology-and-classifications/snomed-ct

The current plan is that all A&E providers will be using this new coding type by the 1st April 2019 and that the previous recording method will cease to flow. At this point NHS Digital will make ECDS data available to external customers to allow for more meaningful analysis based on the detailed information collected. Until this time, NHS Digital will maintain the publication of the prior measurement method.

Finally, regarding cooperation between the Department of Health and Social Care (DHSC) and the Department for Work and Pensions (DWP) and support for patients outside of acute care settings, as set out last year in the *Improving Lives: the future of work, health and disability command paper*, the Government is committed to help those with health conditions and disabilities move nearer to the labour market and, when ready, into work by building more personalised tailored employment and health support. People with health conditions and disabilities can access personalised support by:

- Investing in a wide range of employment support measures to ensure support is available for a large, diverse claimant group, such as the Work and Health Programme;
- Continuing to build the capability of work coaches and strengthen our engagement with those in receipt of benefits - From April 2017, the Personal Support Package for claimants on Employment and Support Allowance and Universal Credit was introduced to expand and improve the support offered to those with disabilities and health conditions;
- Working with employers to create an inclusive environment and enable them to offer more job opportunities to these groups, and;
- Continuing to build our evidence base to understand what works

From April 2017, the new Personal Support Package (PSP) became available for people with disabilities and health conditions. So far, DWP have recruited 300 new Disability Employment Advisers, allocated £15 million to the Flexible Support Fund and completed the roll out of the Health and Work Conversation. This is in line with the ambition to provide a support system which can be tailored to individuals' needs.

As part of the Personal Support Package, £330m is being invested in support for people on the Universal Credit/Employment and Support Allowance health journey, delivering a range of interventions and initiatives providing support tailored to people's individual needs. These initiatives give claimants the opportunity to access personalised support to help them move closer to work, enable employers to offer more job opportunities to these groups and provide more support for our colleagues to help disabled people and people with health conditions.

Further to this, support packages are being developed in order to introduce new mental health training for work coaches. This will test a number of ideas to build an evidence base of what works, such as closer working with local authorities and offering three way conversations between a claimant, work coach, and healthcare professional.

These initiatives will be continued to be built on with further investment in new measures. For instance, the exploration of customer engagement measures and activity to support work coaches, including increasing work coach time for claimants with health conditions and disabilities.

Finally, a joint Work and Health Unit between DWP and DHSC has been established to lead the drive for improving work and health and outcomes for people with health conditions and disabilities, as well as improving prevention and support for people absent from work though ill health and those at risk of leaving the workforce. The unit is working to improve integration across health and employment service generally, as well as supporting employers to recruit and retain more disable people.

EDUCATION RECOMMENDATIONS

6. **Acquired Brain Injury should be included in the Special Educational Needs and Disability Code of Practice**

7. **All education professionals should have a minimum level of awareness and understanding about Acquired Brain Injury and the educational requirements of children and young people with this condition (i.e. completion of a short online course for all school-based staff). Additional training should be provided for the named lead professional who supports the individual with Acquired Brain Injury, and for Special Educational Needs Coordinators**

8. **The Acquired Brain Injury Card for the under 18s (produced by the Child Brain Injury Trust) should be promoted in all schools, hospitals and Local Education Authorities**

9. **Many children and young people with Acquired Brain Injury require individually-tailored, collaborative and integrated support for the return to school, and throughout their education. An agreed 'return-to-school' pathway plan is required, led and monitored by a named lead professional, to provide a consistent approach and support for the individual, their family and teachers.**

10. **An enhanced education campaign should be implemented in schools to improve awareness and understanding of sport-related concussion with the support of government departments**

The Special Educational Needs and Disabilities (SEND) system is designed to get the right support in place for all children and young people with additional needs. Any children and young people with SEND need to have the right combination of education, health and care provision to help them fulfil their potential, just like other children.

The reforms to the SEND system are key to this; they are the biggest changes in a generation. The Government has strengthened the systems for joining up education, health and care support for those with complex needs, and placed families at the heart of the decision-making about their children. The Education, Health and Care plan process is crucial in meeting the needs of those with complex needs, including ABI. The arrangements for SEND are intended to support:

- joint working between health, social care and education;
- multi-professional assessment of a child or young person's needs involving relevant experts; and
- the development of an individual Education, Health and Care plan to meet those needs.

This should provide a basis for the sharing of information and of expertise to ensure the needs of children and young people with ABI are supported in school. These arrangements have the involvement of children and young people, and their families at

the heart of the process. Their wishes and views are sought as part of the assessment and planning process.

Children with high needs resulting from brain injury may also be eligible for a package of continuing care, where their needs are so complex that they cannot be met through existing universal or specialist services. In many areas, there are parallel approaches to special educational needs and continuing care. At the heart of the system is the SEND Code of Practice. For the most part, the Code sets out a system that will help deliver support to those with any SEND. The Code does not mention ABI or numerous other specific conditions: it doesn't need to. What it does is to help ensure that schools, health bodies and all the other players in the system put support in place that makes a difference.

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. This can be found at the following link: www.gov.uk/government/publications/supporting-pupils-at-school-with-medical-conditions--3

The guidance covers a range of areas including the preparation and implementation of school policies for supporting pupils with medical conditions, the use of individual healthcare plans, medicines administration, roles and responsibilities, consulting with parents, collaborative working with healthcare professionals and staff training. It was developed with a range of stakeholders including the Health Conditions in Schools Alliance (HCSA), school leaders, academy organisations, unions, young people and their parents, and Department of Health and Social Care officials and is based on good practice in schools.

Staff training is critical in enabling school staff to provide the support needed to pupils with medical conditions. The statutory guidance states that governing boards should ensure any member of school staff providing support to a pupil with medical needs has received suitable training. This training should be sufficient to ensure 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 (IHPs).

Teachers' Standards include a requirement to adapt teaching to meet the strengths and needs of all pupils. To be awarded qualified teacher status, trainees must meet the Teachers' Standards and 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.

The Department for Education (DfE) continues to work with organisations such as the HCSA to help raise further awareness of the duty on schools. Regarding the promotion of the ABI Card in schools specifically, it is up to individual schools to decide whether to

promote the card. Within hospitals, NHS England and the National Clinical Director for Trauma, Professor Chris Moran, would be happy to promote its use via the Major Trauma Networks to try and embed its use into all parts of the trauma system.

CRIMINAL JUSTICE RECOMMENDATIONS

11. Criminal justice procedures, practices and processes need to be reformed to take into account the needs of individuals with Acquired Brain Injury

12. Training and information about Acquired Brain Injury is required across all services including the police, court, probation and prison services

13. Brain injury screening for children, young people and adults is required on entry to the criminal justice system and, if identified, an assessment of the effects, deficits, severity and impact is required with the appropriate interventions planned and implemented by a trained team

14. All agencies working with young people in the criminal justice system, schools, psychologists, psychiatrists, general practitioners and youth offending teams should work together to ensure that all the needs of the individual are addressed

The Government recognises the significant impact that ABI can have on the day to day life of individuals and the need to ensure that public services, including those working across the criminal justice system (CJS), are able to meet the needs of these individuals effectively. Prisoners typically have more complex physical and mental health needs than the general population. These needs are more prevalent in prison populations and may include brain injury Supporting prisoners to engage effectively with rehabilitative activities will help them lead productive lives and reduce re-offending. The CJS can provide an opportunity to diagnose ABI and enable these individuals to engage in wider rehabilitative interventions to support their recovery. The Government recognise that this can be achieved through Justice and Health partners working together to improve staff awareness, through workforce training, and that effective screening and referral routes lead to improved outcomes.

In the context of operational policing, it is important that police officers and staff are given appropriate guidance and training to support them to identify individuals who, when they first become suspects in a criminal investigation (whether or not they have been arrested) would be considered as 'vulnerable'.

Provisions in the Police and Criminal Evidence Act 1984 (PACE) Code of Practice C *Requirements for the detention, treatment and questioning of suspects not related to terrorism in police custody* (updated in 2018) require the police to take steps to identify such persons, as set out in at paragraph 1.4. These provisions are necessary to ensure that the special help to which vulnerable persons are entitled, and need, is provided. It should be noted that the required functional assessment (of symptoms) applies irrespective of any medically defined cause of the difficulty and as such, ABI would be one of a number of examples. The functional approach to vulnerability arising from Code C paragraph 1.4, together with the risk assessment and essential health related safeguards (e.g. involving medical professionals etc.) in sections 3 and 9 ensure consideration and support can be

provided to those with ABI. PACE Code C can be found at the following links: www.gov.uk/government/publications/pace-code-c-2018

The requirement set out for vulnerable persons in Code C, are mirrored for those detained under the Terrorism Act as set out in Code H in paragraph 1.10 at the following link. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/729852/pace-code-h-2018.pdf

The Ministry of Justice (MoJ) is currently considering the findings of the *Time for Change* report with its health and justice partners, particularly NHS England which has responsibility for provision of health services in prisons. The findings from this report were discussed at a meeting between Minister Argar, Minister Stewart, the APPG on ABI, and members of the United Kingdom Acquired Brain Injury Forum in November 2018. Senior Officials will continue to engage directly with members of the APPG as well as The Disabilities Trust to assess how to implement evidence-based best practice to achieve the most effective outcomes for individuals with brain injury both in custody and in the community.

The MoJ will consider the report alongside other emerging evidence. In 2017, the Disabilities Trust was contracted to pilot, develop and test a proof of concept for understanding and meeting the needs of prisoners with Acquired Brain Injury. The Trust received over £200K of grant funding from then then National Offender Management Service (NOMS) Innovation Grants Board in 2017 to run a Brain Injury Linkworker pilot. The pilot ran across six sites in the male secure estate– HM/YOI Deerbolt, HM/YOI Aylesbury, HM/YOI Bullingdon, HMP Cardiff, HMP Durham, and Mandeville House (Approved Premises). Within the English sites, the pilot ended in July 2018. The Executive Committee for HMPPS Wales agreed to finance an additional 3-month Linkworker Service at HMP Cardiff and Mandeville House. In these sites the pilot ran until mid-October 2018.

In December 2018, the Disabilities Trust finalised the evaluation of this pilot. In their report, the Trust noted that there has been an increased research interest in the relationship between offending behaviour and Traumatic Brain Injury and the impact of Traumatic Brain Injury on engagement in offender rehabilitation. The MoJ have begun initial discussions with the Disabilities Trust to explore the Trust's report findings and recommendations. The Disabilities Trust will also be launching the evaluation of another Brain Injury Linkworker pilot conducted at HMP Drake Hall in February 2019. This pilot specifically focussed on female offenders and the MoJ will assess the evaluation findings as they are made available. The MoJ has set up a working group with representatives from HMPPS, DHSC and NHS England to fully assess the emerging evidence and engage with the Criminal Justice ABI Interest Group in January to scope next steps.

The MoJ will be responding fully to the criminal justice recommendations put forward by the APPG shortly.

Children and Young People

Currently, all children and young people (under 18), within the children and young people secure estate, are screened through the Comprehensive Health Assessment Tool (CHAT), an evidence based tool, validated for use with under 18s. Part 5 of the CHAT is specifically to screen for neuro-disability. Where a young person transitions to the adult estate, a transition plan will follow them into the adult estate and will be responded to in order to meet their needs. There is a specific section within the Healthcare Standards for Children and Young People in Secure Settings (RCPCH 2013) on transition (section 7). The standards to manage the effective transfer to the adult estate are described as follows:

> *TRANSFERS TO ANOTHER SECURE SETTING OR THE ADULT JUSTICE SYSTEM*
> *7.9 A summary of the young person's health record including any recommendations for future care (health discharge summary) is sent to the GP and healthcare manager at the new secure setting/adult prison and any other relevant agencies.*
> *7.10 Consideration is given to a young person's healthcare and any assessments and treatment when a transfer between secure settings/to adult prison is planned.*

As part of its commissioning intentions, NHS England has undertaken work to establish better integrated pathways for those moving through the custodial or detained estate to better support and manage integrated care, continue to develop continuity of care pathways and the Children and Young People transitions agenda. These pathways will be aligned to the ongoing reconfiguration of the male secure estate and the developments articulated in the 2018 Female Offender Strategy.

Adult Prisoners

Whilst there are no current plans to introduce specific screening for brain injury within the secure estate for adults, it is a part of the general health screen. Where an adult presents with what is suspected to be a brain injury, a specialist neurological referral would be made. A working group, set up by the MoJ, will also explore screening practices for ABI within the criminal justice system.

All newly received prisoners (both male and female) have a reception assessment where learning disabilities are identified and any presentations of cognitive impairment will be flagged and noted. A further assessment is completed within 7 days of the reception screening. This specifically references any head injuries and/or periods of unconsciousness as well as presentations that suggest cognitive impairment and a specific question as to whether such impairments would impact on their abilities

to participate in the criminal justice process. Information from the assessments are subsequently used to inform complex case reviews and robust joint care plans to support an individual's health care and management across the establishment.

Liaison and Diversion

Earlier this year, the NHS England Health & Justice Liason & Diversion (L&D) programme team partnered with 'Headway' the brain injury charity, to deliver workshops in London and Leeds to raise awareness of the prevalence of ABI within criminal justice populations. The objectives for the workshops were to enable Liaison and Diversion Practitioners to:

- Be able to identify people with brain injury
- Be aware of the effects of brain injury, and how these may lead to people coming into contact with L&D services
- Be able to identify the Headway Brain Injury Identity cards and understand the necessary implications
- Be aware of services to refer and signpost for further support and guidance

The workshops were designed in a 'Train the Trainer' format, with an expectation that attendees were expected to return to their services and cascade learning from the events to their colleagues. Representatives of all NHS England commissioned L&D services attended the workshops.

For individuals who have been able to engage in Liaison and Diversion interventions in Custody Suites or in Courts, there will be 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.

In 2017/18, L&D services identified ABI in 195 adult cases and 10 children and young people's (CYP) cases (65,572 adult cases were seen, so identification rates are very low – c. 0.3% for adults and even lower for CYP). 101 cases of ABI in adults were identified in Q1 2018/19, representing 0.5% of cases seen.

SPORT–RELATED CONCUSSION

15. The Government should ensure that there is collaborative research 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.

16. An enhanced education campaign should be implemented in schools to improve awareness and understanding of sport-related concussion with the support of government departments (i.e. Department for Education and Department of Health and Social Care)

17. Sport, government and professional clinical bodies must work collaboratively to improve professionals' knowledge of concussion management

18. The National Health Service should develop better pipelines for the diagnosis and care of sport-related concussion.

The Government's sport strategy, *Sporting Future*, published by the Department for Culture Media and Sport (DCMS) recognises that everyone participating in sport should be looked after and protected.[1] As a result, the former Minister for Sport asked Baroness Tanni Grey-Thompson to carry out an independent review of the Duty of Care that sport has to its participants, which dedicated a chapter to safety, injury and medical issues.[2] DCMS is very grateful to Baroness Tanni Grey-Thompson for her work on the Duty of Care review, and expects everyone in the sports sector to think carefully about the recommendations from this report, as well as those made by the APPG on ABI.

National Governing Bodies (NGBs) are responsible for the regulation of their sport and for ensuring that appropriate measures are in place to protect participants from harm, including serious injuries. With that in mind, DCMS looks to individual sports to take responsibility for the safety of their participants. DCMS is pleased to see that positive progress has been made in this area over recent years, such as the Rugby Football Union's (RFU) 'Headcase' campaign and efforts by the British Horseracing Authority to improve its concussion management protocols. However, DCMS recognises that much more work is still needed to ensure that robust measures are in place to reduce the risk, and improve the diagnosis and management of sport-related concussion all levels of sport.

The Sport and Recreation Alliance's Forum on Concussion in Sport and Physical Education have produced concussion guidelines for the education sector, jointly with NGBs, representative bodies and medical experts.[3] These have been circulated to schools

[1] https://www.gov.uk/government/publications/sporting-future-a-new-strategy-for-an-active-nation

[2] https://www.gov.uk/government/publications/duty-of-care-in-sport-review

[3] https://www.sportandrecreation.org.uk/policy/research-publications/concussion-guidelines

in England via the Association for Physical Education, to ensure that everyone familiarises themselves with the advice these guidelines contain. It is known that awareness levels are typically low, so DCMS is committed to working closely with DfE and DHSC to explore what more the Government can do to raise awareness of sport-related concussion.

There will always be risks associated with participating in sport, but it is vital that robust measures are in place to reduce the risks of major injuries, and that procedures are in place to protect players' health if such injuries do occur. While much positive progress has been made, this is an issue which requires the continued engagement of organisations from across the healthcare, sporting and education sectors, to ensure that everyone taking part in sport is protected from harm.

In January 2014, NICE published *Head injury: Triage, assessment, investigation and early management of head injury in children, young people and adults*. This outlines evidence based best practice on the referral of patients who have sustained a head injury to a hospital emergency department and offers best practice advice on the care of both adults and children with head injury. The guidance was updated in 2017, ensuring it remains aligned with the latest evidence.

In February 2016, NICE published *Major trauma: assessment and initial management.* This supports clinicians in the rapid identification and early management of major trauma, including traumatic brain injury in pre-hospital and hospital settings, including ambulance services, emergency departments, major trauma centres and trauma units. It aims to reduce deaths and disabilities in people with serious injuries by improving the quality of their immediate care.

In primary care, the GP curriculum sets out what is required to practise as an independent General Practitioner in the UK NHS. This covers the care of acutely ill people, such as those who may have suffered a serious head injury. Head injuries with or without loss of consciousness, concussion and more serious cranial or intracranial injuries are also identified as a key area of clinical knowledge in the RCGP Applied Knowledge Test (AKT) content guide; a summative assessment of the knowledge base that underpins general practice in the United Kingdom which is a key part of GPs' qualifying exams. Once fully qualified, doctors are responsible for ensuring their own clinical knowledge remains up-to-date and for identifying learning needs as part of their continuing professional development.

The Government recognises the value of high quality research investment to improve our understanding of diseases and disorder and to support the development of those approaches to care, treatment and support of individuals that offer the most benefit. Therefore, DHSC is investing over £1 billion a year in health research through the National Institute for Health Research (NIHR). The NIHR is funding brain injury research from basic science to translational research including:

- Investing over £100 million (over 5 years up to 2022) in a Biomedical Research Centre in Cambridge that is working in a range of areas, including developing new approaches to reduce the impact on patients' health and well-being of neurological disorders stroke and acute brain injury
- Investing £5million to co-fund the Surgical Reconstruction and Microbiology Centre (SRMRC, Birmingham) in partnership with the MoD since 2011. The Centre specialises in trauma research, taking discoveries from the military frontline to improve outcomes for all.
- Investing 16 million in brain injury research since 2014 through the NIHR Health Technology Assessment Programme
- Investing almost £2 million over three years through NIHR Global Health Research Group on Neurotrauma, which aims to advance global neurotrauma care and research to save lives, reduce disability and improve the quality of life for patients with brain injury

The usual practice of the NIHR is not to ring-fence funds for expenditure on particular topics: research proposals in all areas compete for the funding available. The NIHR welcomes funding applications for research into any aspect of human health, including ABI. These applications are subject to peer review and judged in open competition, with awards being made on the basis of the importance of the topic to patients and health and care services, value for money and scientific quality.

WELFARE BENEFITS SYSTEM

19. All benefits assessors should be trained to understand the problems that affect individuals with an Acquired Brain Injury

20. Re-assessment for welfare benefits for people with Acquired Brain Injury should only take place every five years

21. A brain injury expert should be on the consultation panel when changes in the welfare system are proposed

In Employment and Support Allowance (ESA), Work Capability Assessments (WCAs) are conducted by Health Care Professionals (HCPs) working for the Centre for Health and Disability Assessments (CHDA). Claimants with Acquired Brain Injury and associated neurological complications such as limb paralysis, limb sensory impairment or coordination difficulties are assessed by Registered Medical Practitioners and Registered Physiotherapists; those with only cognitive impairment, deafness, loss of taste/smell or epilepsy can be seen by any HCP.

Headway, the brain injury association, is a member of CHDA's customer representative group. Case discussions about claimants with ABI form part of new entrant training for all HCPs undertaking WCA and all HCPs have access to a self-directed learning module on ABI that was updated in 2018 and quality assured by Headway

In Personal Independence Payment (PIP), all health professionals are trained to assess all conditions, including conditions affecting the central and peripheral nervous systems. The focus is on ensuring that the health professionals are experts in disability analysis, focusing on the functional impacts that a person's health condition or disability has on their daily life. The Department for Work and Pensions (DWP) has worked extensively with the PIP assessment providers (Independent Assessment Services and Capita) and disability representative groups (Epilepsy Action (England), Motor Neuron Disease Association, MS Society, MIND, Mencap and RNIB) to make improvements to guidance, training and audit procedures in order to ensure a quality service. It will continue to work with disabled people and their organisations.

The premise of the WCA is that eligibility for benefits should not be based on a person's condition, but rather on the way that condition limits their ability to function. Reassessment is important; it is designed to ensure that claimants receive appropriate financial support, and takes account of changes in how health conditions and disabilities affect people over time. For claimants with ABI, the severity and prognosis will vary from person to person and therefore it would not be appropriate to set a fixed 5-year reassessment date.

However, since September 2017, those placed in ESA's Support Group and the Universal Credit equivalent who have the most severe and lifelong health conditions or disabilities,

whose level of function would always mean that they would have Limited Capability for Work and Work-Related Activity, and be unlikely ever to be able to move into work, will no longer be routinely reassessed. DWP has worked with healthcare professionals and other stakeholders to develop new Severe Conditions Criteria. Rather than being defined through a list of specific medical conditions, the Criteria will be considered as part of the WCA. This gives claimant the best opportunity to share with the most up to date information about the functional impacts of their condition.

Reviews of PIP, which can be paid at one of eight different rates, are an important feature of PIP and ensure that not only do awards remain correct where needs may change, but that contact is maintained with the claimant. Importantly, the length of an award is based on an individual's circumstances and can vary from nine months to an on-going award, with a light touch review at the ten-year point. PIP already recognises that for the most severely disabled claimants, the award review process could seem unnecessarily intrusive. That is why DWP introduced changes so that existing claimants with the most severe, lifetime disabilities, whose functional ability has remained the same, are more likely to have their evidence reviewed by a DWP Decision Maker and will not need to have a face-to-face assessment with a healthcare professional.

In August 2018, the DWP introduced a change to guidance which will ensure that PIP claimants receiving the highest level of benefit, and where their needs are not going to improve or indeed may get worse, will receive ongoing awards with a light touch review at the 10-year point.

When considering reviews and potential changes to ESA, neurologists have previously been represented on consultation panels to inform discussion and drive recommendations. This is something we fully expect to continue in the future, and DWP have agreed to invite a clinician with specific expertise in ABI to future consultation panels.

The PIP assessment is designed to treat all health conditions and impairments fairly. DWP considered the needs of people with conditions such as ABI in developing the assessment, and remains committed to providing support to disabled people, to better enable them to lead full, active, and independent lives.

The development of the PIP assessment was carried out in an iterative, transparent and consultative manner. It was developed in collaboration with a wide range of experts and through comprehensive public consultation to which organisations representing those with ABI, such as Headway, contributed. Headway has also been invited to be part of the England PIP Forum, the purpose of which is to work with our national stakeholders to improve the PIP service. The main aims of the Forum are to:

- build awareness and understanding about PIP by providing updates on development and performance, and providing an opportunity for questions;
- understand and hear first-hand disability and support organisations' perspectives and issues;

- seek input and views on specific initiatives and developments so that the Department can continuously improve the service it provides

Before implementation, PIP was thoroughly tested to ensure it worked as intended and has since been subject to two independent reviews. Since its inception, the system of assessing claimants' eligibility for PIP has been continually reviewed and refined in order to improve its efficiency, effectiveness and the claimant experience.