

SCHEDULE 2 – THE SERVICES

Version 4

A. Service Specifications (B1)

Mandatory headings 1-4. Mandatory but detail for local determination and agreement
Optional heading 5-7. Optional to use, detail for local determination and agreement.

All subheadings for local determination and agreement

Service Specification No.	11J/0221
Service	Acquired Brain Injury Service
Commissioner Lead	Service Delivery
Provider Lead	Brain Injury, Adult Asperger and Community Neurology Service
Period	from 1/7/2017
Date of Review	30/6/2018

1. Population Needs

1.1 National/local context and evidence base

The National Service Framework (NSF) for Long Term Conditions (2005) states among its Quality Requirements that:

- "People with long term neurological conditions who would benefit from rehabilitation are to receive timely, ongoing, high quality rehabilitation services in hospital or other specialist settings to meet their continuing and changing needs. When ready, they are to receive the help they need to return home for ongoing community rehabilitation and support";
- "People with long-term neurological conditions living at home are to have ongoing access to a comprehensive range of rehabilitation, advice and support to meet their continuing and changing needs, increase their independence and autonomy and help them to live as they wish";
- "People with long-term neurological conditions are to have access to appropriate vocational assessment, rehabilitation and on-going support, to enable them to find, regain or remain in work and access other occupational and educational opportunities".

The NICE guidance on Head Injury (June 2003), which was updated in September 2007, was considered in developing this specification.

"Rehabilitation following acquired brain injury, National Clinical Guidelines" published by the Royal College of Physicians in 2003 were used to inform the development of this specification.

In the United Kingdom 1.4 million people each year attend hospital with an Acquired Brain Injury (ABI) of which 135,000 people will be admitted to hospital because of the severity of their injury. Within the Dorset population 200 people sustain a moderate ABI each year. People who sustain a moderate ABI may have

behavioural, emotional and cognitive problems and some of these people might choose to access this service.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	
Domain 2	Enhancing quality of life for people with long-term conditions	√
Domain 3	Helping people to recover from episodes of ill-health or following injury	√
Domain 4	Ensuring people have a positive experience of care	
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	

2.2 Local defined outcomes

- Quality of Life Data Tool e.g. SF36;
- Achievement of rehabilitation goals;
- Return to work/community activities;
- Reduce dependence on the community ABI service;
- Service user satisfaction surveys.

Outcome goals are measured by the following:

- MOHO (Model of Human Occupation Scale);
- Validated tool to measure carer stress/burden;
- GAS goals improvement;
- Physical/mobility improvements;
- Person with an ABI and/or Carer/relative satisfaction;
- Improvement in personal management of behavioural difficulties.

3. Scope

3.1 Aims and objectives of service

- To provide services for individuals who sustained a minor, moderate or severe traumatic or acquired brain injury (ABI) as part of an Integrated team;
- To work as part of the multi-disciplinary brain Injury Service for the county of Dorset;
- To work across organisational boundaries to deliver the Sustainability and Transformation Programme to promote integrated team working;
- To provide assessment and treatment to people with a brain injury, to enable them to fulfil their goals in respect of community living, work, education and independence;
- To undertake joint working with Vocational Services, Mental Health, Addictions, self-management services, IAPT services and community rehabilitation and physical health services;
- To work collaboratively with other statutory and third sector providers including Social Services, Housing and Department of Work and Pensions;

The levels of service will include:

- A community based recovery and rehabilitation service for people with an Acquired Brain Injury who require this service;
- A community based rehabilitation service geared to providing episodes of care and support for people with ABI;
- A holistic approach to providing support and continuity of care;
- A focus on achieving the outcomes for people with ABI including a process for effectively discharging people from the service when they have obtained their achievable rehabilitation goals including support in returning to community living and where appropriate employment and other activities.

3.2 Service description/care pathway

This service specification reflects the range of services and support required to meet the diverse needs of people with an ABI, recognising the importance of both early intervention at/or just after injury, episodes of rehabilitation and the opportunity for people with an ABI to self-refer back to the service for further episodes of intervention where required.

The service includes the following components:

- Community rehabilitation;
- Specialist intensive cognitive rehabilitation;
- Vocational rehabilitation;
- In-patient therapy;
- Neuropsychology assessment formulation and neuropsychology programmes;
- Relevant ABI clinical case management during rehabilitation intervention period;
- Dorset HealthCare is commissioned to provide a Clinical Case Management for NHS Dorset CCG patients on the Named Patient Programme.

The community team and in-patient component consists of the following members: clinical neuropsychologists, clinical psychologists, occupational therapists, physiotherapists, speech and language therapists, rehabilitations assistants and a carer support officer.

Patients remain under the care of the Consultant in Rehabilitation and Brain Injury. These patients continue to be seen in outpatient clinics at Poole and Dorset County Hospital alongside community team interventions.

Appropriate care pathways are being developed with key partners and services. Current pathways include:

- ICRT/Therapy teams
- CMHT and Crisis
- Social services
- PIP/benefits/housing

Defining Acquired Brain Injury (ABI)

Acquired Brain Injury (ABI) is a general term referring to any injury to a previously healthy fully functional brain. The following are all examples of causes of acquired brain injury:

- Traumatic Brain Injury (TBI);
- Infections, such as meningitis;
- Hypoxia (lack of oxygen to the brain);
- Brain tumours;
- Neurotoxic disorders: drugs and alcohol, pesticides, gases, solvents can all lead to a brain injury;
- Strokes and aneurysms.

The provision of timely, sustained and comprehensive rehabilitation to individuals, their families and carers, is essential, to empower them successfully reintegrate into society and to promote the achievement of reasonable aspirations and outcomes in terms of their lives.

Discharge policy

The provider will operate an agreed multi-disciplinary/multi-agency care pathway to ensure that where the person with an ABI has achieved their rehabilitation goals and the agreed outcomes, they are appropriately discharged back to the care of their GP and/or Social Services.

Onward referral

- Commissioning partners and the provider will agree robust arrangements for onward referral, to other relevant services, as and when required, on completion of the provider's involvement with the person and their family;
- Onward referral will always be based on a thorough multi-disciplinary/multi agency review of the person's current situation and continuing need for support/treatment;
- The sign posting onto other services is an integral part of this service provision and must be fully documented in the person's record.

3.3 Any acceptance and exclusion criteria and thresholds

The provider must have demonstrable experience in the field of assessment and rehabilitation of a person with an ABI including the management of behavioural and cognitive problems, as may be exhibited by an individual with a brain injury.

The provider must develop and maintain policies and procedures for the delivery of rehabilitation services. These policies must have a statement of beliefs and guiding principles.

The provider must identify a primary therapist for each person with an ABI. This is the name of the therapist within the provider organisation who holds primary responsibility for the case.

The provider's assigned primary therapist is responsible for:

- The assessment to evaluate the needs of the person with an ABI for the purpose of developing a person-centred care plan which includes outcome measures:
- To provide a structured therapeutic care plan for the management of the identified problems;
- To enhance functioning and skills which would allow a person with an ABI to remain in a community based setting;
- Co-ordination and review of the person's care whilst in the service
- The provider must utilise a thorough assessment process that identifies problems, disabilities and, where possible, their cause. This assessment should also identify the person with an ABI's strengths and needs and from which services they would benefit.
- The Provider shall refer individuals as appropriate to other services such as physiotherapy, occupational therapy, Community Rehabilitation Teams, Palliative Care Teams, community matrons and speech and language therapy in line with locally agreed policies.

The initial assessment by the provider must be completed and at the end of the initial assessment, the person with an ABI will be given a summary sheet/plan by the provider. The summary sheet/plan will include a brief summary of key points discussed in the assessment and an agreed plan based on the content of the assessment. Where possible this will be written in the language of the person with an ABI. This will also detail the primary therapists name and contact details.

The provider will then write a report which is provided to the person with an ABI and to relevant health or social care professionals.

The plan should consider specific goals/outcomes and objectives relevant to the person. The objectives must be measurable, contain a performance criterion and a projected completion date.

The provider must document all direct contact (face to face meetings) with the person with an ABI and/or family. All direct contacts will be documented on the provider's electronic patient record which contains, at a minimum, date and length of the contact, summary of the contact which reflects progress on the treatment objectives including the intervention used by the therapist.

The provider must document all indirect service involvement. Indirect services are case related activities and are to be documented in the person's record. These notations will include the date, the time spent on the activity, the kind of activity provided and a summary. Indirect services include but are not limited to:

- Therapist telephone contacts with the person with an ABI or their family;
- Therapist contacts with other agencies about the person with an ABI's issues;

Rehabilitation services must be provided in accordance with the developed person centred plan.

The provider must review the person centred care plan and outcomes, at dates appropriate to individual person's need and at a minimum of three (3) monthly. That review must be documented in the person's records.

The provider must notify the person with an ABI of any change in schedule, or interruption of service. Any planned change in service provision must be notified to the person with an ABI two weeks prior to the planned change. Any unplanned change in service provision must be notified to the person with an ABI as soon as possible. The provider must provide support to ensure that administrative tasks are completed. That support must include, but not be limited to, the person's records, case assessments, time sheets, care plans and case notes.

The provider must retain an active relationship with the designated referrer to include the written communication regarding the person with an ABI's care plan, progress towards the goals and needs upon discharge.

The provider must keep the designated referrer informed of all service delivery concerns including the missed appointment, inability to locate the person with an ABI, escalation of problems that threaten the safe continuation of that person with an ABI's service plan, complaints and grievances and discharge notices.

The provider, with the person with an ABI's permission will share information with other providers as needed.

The provider must ensure access by authorised representatives of the commissioners to the person with an ABI's case files and medical records.

The provider must establish a system through which person with an ABI may present grievances/complaints about the operation of the service programme. The provider also agrees to advise the person of their right to appeal denial or exclusion from the rehabilitation services programme and their rights to a fair hearing process. The provider must have written documentation of this system, along with a written procedure of how these issues will be communicated to the commissioner.

Service availability and capability

Community settings with appropriate disabled access with the need to recognise requirements of individual plan, suitability of support and where it may be provided:

- Places appropriate for group work, providing adequate space, light, heating and equipment as needed;
- The person with an ABI's own home where appropriate;
- Places that are appropriate for one-to-one work in the community;
- The service will be available Monday to Friday 9am-5pm;
- The service will not normally operate out of hours or on weekend or bank holidays;
- The service will have in place arrangements for the person with an ABI and their families, to self-refer or seek assistance for crisis intervention from other appropriate services (e.g. the Out of Hours Service for Social Services);

- The service will seek to be creative in developing outreach to people with an ABI and their families, in ways that offer appropriate support in community settings without becoming intrusive.

Referral criteria & sources

The following criteria for access to the service will apply following an agreed assessment process:

- Adults over 18 years who have the potential to benefit from further community based rehabilitation and support;
- People aged between 16-17 are considered on a case by case basis as agreed with the lead commissioner;
- Adults over 18 who are registered with an NHS Dorset Clinical Commissioning Group GP;

The following are to be considered unsuitable for access to this service:

- People with a dual diagnosis which precludes their ability to address their ABI e.g. intensive medical treatment, florid psychosis, severe mental illness, active abuse of drugs and/or alcohol;
- People whose behaviour cannot be safely managed within the Provider's Clinical Risk Management Policy.
- Functional Neurological Systems (people can be seen for Neuropsychology Assessment, formulation and strategies/advice only);
- Progressive Neurological illness/conditions (people can be seen for Neuropsychology Assessment, formulation and strategies/advice only).

Sources of referrals

The services shall be accessed by all appropriate referrals from (list is not exhaustive):

- Dorset County Hospital NHS Foundation Trust
- Poole Hospital NHS Foundation Trust
- Dorset HealthCare NHS University Trust
- Royal Bournemouth and Christchurch Hospital Foundation NHS Trust
- Borough of Poole Social Services
- Bournemouth Borough Council Social Services
- Dorset County Council Adult and Community Services
- Job Centre
- NHS Dorset CCG GP
- Self-referral from patient/carer
- HMP/Probation Officer

Support and involvement of people with an ABI families/carers

The involvement of the person with an ABI in the assessment process will be vital to ensure a personalised service.

Enablement of the person with an ABI who has additional communication or cognitive needs must be facilitated to allow them to fully participate in the assessment process.

For purposes of this service, 'family' is defined as the person(s) who live with or provide care to the person with an ABI and may include a parent, spouse, children, relative or in-laws.

The needs of families and carers must be integral to assessment, care planning and treatment plans and review arrangements.

Clear pathways will ensure carers access support services from all sources.

Where services are provided to members of a person's family, the services must be:

- For the purposes of assisting the family in implementing the plan of care;
- To strengthen the support network.

Referral route

A single point of access for receipt of referrals and consultation on degree of urgency will operate and be well publicised to all potential referrers. Referrals will be accepted from any health or social care professional, family, carer, or the person with an ABI.

The Single Point of Access for receipt of referrals will provide both information and screening services to all persons referred, to ensure all new referrals and re-referrals are managed consistently across the area and afforded proper access to multidisciplinary assessment and follow up regardless of whether a person is:

- Undergoing specialist inpatient rehabilitation and approaching the discharge planning stage;
- An outpatient or GP patient;
- At home post discharge, not previously referred;
- At home previously referred, but not currently in receipt of services or support;
- A person living in the community, with a history of ABI, but not previously treated, assessed, supported or known to services in the Dorset area;
- A person residing in a nursing or residential home previously referred or otherwise.

The Single Point of Access for receipt of referrals will ensure that access to the service is agreed by multi-disciplinary, assessment using an agreed clinical pathway and a standardised process and set of documentation.

The enhanced service will have in place arrangements for the person with an ABI and their families, to self-refer or seek assistance for crisis intervention from other appropriate services.

- All referrals to the service will be prioritised according to the person's clinical need;
- Referrals can be made during office hours using an agreed referral form which can be received via post or electronic means. (There will be no referral taking required out of hours or on weekends or bank holiday service provision);
- Consent to share data and information with family/carers, as appropriate, will be obtained during the first appointment with the person with an ABI

- Inform referrer where a person with an ABI is accepted into the service;
- If a person with an ABI is deemed ineligible, then the referral will be returned to the referral source with an explanation of the reasons for refusal given;
- The Provider will accept further discussion with the referrer to reconsider eligibility, if the referrer considers it appropriate;
- From the receipt of referral, the person with an ABI will have an assessment and agreed primary therapist: 50% within 28 calendar days and 95% within 84 calendar days until the end of March 18 and then the 75% within 28 calendar days and 95% within 56 calendar days. Neuropsychology remains as the 18 week RTT;
- It is expected that all referrals will be acknowledged within 2 working days of receipt;
- Each referral will be assessed by a suitable qualified and experienced practitioner against the agreed referral criteria;
- Practitioner to contact referrer for additional information if required;
- If the person with an ABI does not attend (DNA) then offer two further appointments after which return referral to original source;
- Data and information sharing must comply with all relevant legislation and the Data Protection legislation.

3.5 Interdependence with other services/providers

- Portland Ward, Poole Hospital NHS Foundation Trust
- Royal Bournemouth NHS Foundation Trust
- The Day Hospital Christchurch Hospital
- Dorset County Hospital NHS Foundation Trust
- Emergency Departments
- ESD services
- Vocational Services
- Mental Health
- Addictions
- Self-management services
- IAPT services and
- Community rehabilitation
- Physical health services
- Social Services
- Voluntary Sector

Expectations regarding partnership working

The Provider shall work collaboratively to deliver the ABI service equitably across Dorset.

The Provider shall establish and maintain contact, communication links and appropriate clinical arrangements with appropriate clinical colleagues working across primary and secondary care.

The Provider shall establish appropriate knowledge of the support available to people with an ABI and carers from Social Services, the NHS and/or the voluntary

sector and provide guidance and advice to patients to enable them to access services.

Communication with patients

Whole System Relationships

The Community Brain Injury Team works closely with Poole Hospital NHS Foundation Trust, operating as the Brain Injury Service for Dorset. It also has established links with Vocational Services and Social Services.

The enhanced service will offer people with an ABI written information about their condition and treatment as appropriate.

The Provider will ensure that all communications relating to a person's care and treatment is copied to the person with an ABI in accordance with current NHS policy and procedures.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

Applicable service standards include:

- **National Service Framework for Long Term Conditions (Neurological)** sets out 11 quality requirements 2005. The aim is to develop a structured systematic approach to care of adults with long term neurological conditions. (2005)
- **NICE guidelines CG 56:** Head Injury Triage, assessment, investigation and early management of head injury in infants, children and adults (2007).

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

4.3 Applicable local standards

To be developed with provider.

5 Applicable quality requirements and CQUIN goals

5.3 Applicable quality requirements (See Schedule 4 Parts A-D)

The following are considered the most relevant to this service:

- All patients with long term conditions will be offered a personalised care plan.
- Ensure patients are given access to appropriate services within 18 weeks.
- Ensure timely transfer of patients to other providers

5.2 Applicable CQUIN goals (See Schedule 4 Part E)

None identified as specific to this service

6 Location of Provider Premises

The Provider's Premises are located at:

- Individual's home
- Clinical premises
- Portland Ward, PHFT
- Out patients hospital clinics
- Wider community as required e.g. individual employer's premises/residential services

7 Individual Person with an ABI Placement