MEETING NOTES

DATE: 16 March 2011, 5pm – 7pm
SUBJECT: APIL East Anglian Regional Meeting
LOCATION: Swynford Paddocks, Newmarket
ATTENDEES: Sharon Allison, Ann Asquith, Richard Barr, Ruth Booy, Tom Cook, Mark Copley, Robert Curry, Simon Davis, Crystal Eaton, Richard Foyster, Fergus Gracey (speaker), Deborah Hargreaves, Tom Harrison, Sarah Hefferon, Pamela Hoare, Ayla Humphrey (speaker), Corrinna Hyett, Siobhan McWhinney, Richard Moon, Justina Molloy, Victoria Mortimer-Harvey (APIL EC Member), Jan Parry, Daryl Robinson, Hannah Rutterford (Regional Co-ordinator), Jane Stockings, Paul Tapner, Paul Taylor, Mick Upton (Regional Secretary), Michael Wangerman.

1. INTRODUCTION BY HANNAH RUTTERFORD (HR)

HR welcomed everyone to the meeting and introduced the speakers, Victoria Mortimer-Harvey (VM), Dr Fergus Gracey and Dr Ayla Humphrey.

2. NEUROPSYCHOLOGICAL ASSESSMENT: PICKING UP THE PIECES BY DR AYLA HUMPHREY (AH). (CAMBRIDGE CENTRE FOR PAEDIATRIC NEUROPSYCHOLOGICAL REHABILITATION.)

AH presented a talk covering the differing types of neuropsychological testing and how differing questions require differing assessment procedures. For example, assessments carried out to answer a research question, such as "are there dissociations between long term memory and short term memory?" will differ to assessments aimed at answering a more practical-based questions such as "can this person go back to work?"

Standardised tests such as the Wechsler test will not be able to answer many practical questions such as "how do the problems stemming from the injury manifest themselves in everyday life?" Standardised tests will be able to help indicate, for example, a person's general level of intellectual functioning or whether their level of functioning has declined from a pre-morbid level but to assess the real day-today impact, there has to be a behavioural and functional approach to the assessment.

AH went on to explain what neuropsychological testing was and the areas it can cover. She outlined how the questions raised in a patient's/client's referral can determine what type of assessment needs to be carried out, as can the area of the brain which has been damaged.

AH gave an overview of some of the tests which are used in assessment such as the standardised Wechsler tests and "ecologically valid" Test of Everyday Attention for Children (TEA-Ch) which is said to properly assess the day-to-day attention of children and switching of attention.

AH talked about assessment following acquired brain injury and the reasons why clinicians sometimes have different findings in relation to the same person and what factors should be considered when interpreting these test results/findings.

The bottom line in that the more information you can give to the assessor about the person injured and what you need to know from the assessment, the better the quality of the resulting report will be.

A handout of AH's talk is available on the APIL website.

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3. **WHAT IS REHABILITATION – APPROACHES WITH CHILDREN AND ADULTS FOLLOWING BRAIN INJURY? BY DR FERGUS GRACEY (FG), CONSULTANT CLINICAL NEUROPSYCHOLOGIST. (CAMBRIDGE CENTRE FOR PAEDIATRIC NEUROPSYCHOLOGICAL REHABILITATION AND OLIVER ZANGWILL CENTRE FOR NEUROPSYCHOLOGICAL REHABILITATION.)**

FG spoke about the differing approaches to rehabilitation of those with brain injury. He began by looking at definitions of rehabilitation and what its aims are and then moved on to look at the how neurorehabiltation can be restorative (train the lost body process), substitutional (help other body processes take over the impaired process) or compensational (use of strategies to minimise the impact of the impaired process on activities and in social situations).

FG outlined that the rehabilitation process has four core components, namely assessment (which will determine the relevant rehabilitation approach), planning (which will lead to identification of goals), interventions (to meet the goals identified) and evaluation of the intervention. FG stressed the importance of holistic rehabilitation taking into account the injured person's "interactive domain" and understanding how and when an injured person experienced certain problems. Or example does a memory problem only affect a person at work and when studying but not social situations or when engaging in leisure activities? Does the person function well at work and in social situations but then struggle with memory in terms of tasks related to daily , independent living? It is important that the rehabilitation takes into account the context of the person's surroundings and life-style.

FG also outlined the importance of involving those close to the injured person so that they continue to practice and develop the skills they have learnt when they get home, rather than the family doing everything for them.

In adults the aim is to try and get them back, as far as possible, to the level they were functioning at prior to injury. Rehabilitation also needs to help those injured to cope with the social adjustment following brain injury.

Children injured would have still been developing at the time of injury so it is important to try and facilitate a continued development trajectory and understand the consequences of the injury and its impact on, for example, schooling as the child will be very dependent on those around them to help them continue developing. There needs to be a focus on the child's family and school.

FG was asked how well, in practice, schools implement recommendations. FGs experience was that schools' responses were variable. Some are very receptive and others do not want to engage. The variability of parent's personalities and the extent to which they have been traumatised or depressed by their child's injury also affects the extent to which they will fight for their child. Usually schools will take on board some of the recommendations made.

In FG's experience teachers will say that the child is doing fine if there are no behavioural problems but it is usually difficult to get more subtle observations from them as to the child's ability. He finds it difficult to get teachers to understand that the issue is not about behaviour but about ability and development.

FG was asked about the number of referrals he has had. He currently has 30 referrals and he gets about 2 per month. There are 3 non-brain-injured patients. He was not sure to what extent the number of referrals correlated with the number of injured children going through Addenbrooke's Hospital.

4. **EC UPDATE BY VICTORIA MORTIMER-HARVEY (VM)**

VM provided an update on the latest issues which APIL are focusing on.

APIL have recently submitted a response to the M.O.J. regarding the reform of civil litigation funding and costs and proposed reform of Legal Aid. APIL are working with MPs and Westminster to raise their concerns. There seems to be an appetite for fixed costs but APIL are raising their concerns about the impact on clients.

APIL encourage members to lobby MPs about the current proposals as it would mean that a baby with brain damage would not be able to get Legal Aid and would lose damages under the Jackson proposals. The Claimant should be in the position he would have been in had the accident not occurred but if a client has to pay costs out of damages he would not be. The increase in general damages by 10% is unlikely to cover costs.

APIL encourage members to lobby MPs about the potential expansion of the new RTA process further as it still needs to bed-in and be reviewed before it is expanded. The portal company regularly meets both the Claimant and Defendant sides to discuss problems.

The proposals for an employer's liability scheme has not been well received but APIL are still pursuing this issue. APIL are also still pursuing the issue of an employer's liability insurance tracing scheme.

Lots of work is being done by the Clinical Negligence Special Interest Group about the attack on C.N. costs. APIL have produced various proposals on staged success fees, expansion of the fast track voluntary code to higher value cases and the creation of a streamlined system for more straight forward cases.

MICK UPTON (Taylor Vinters, Cambridge)
Associate

17.05.11