Case Example 9:
Brain injury Specialist Social Work Team (Sheffield)

Type of organization: Specialist social work team offering a case management service to people with brain injury, co-located with health on a rehabilitation ward. The team is supervised by a senior social worker, but each member of staff is also part of a multi-disciplinary team working across health and social care.

Staffing: One specialist acute social worker, who works in a multi-disciplinary team with two medics and two specialist brain injury nurses. Two social workers who work in the sub-acute multi-disciplinary team, supporting people in hospital to make the transition back to the community. One care-coordinator in the community service (not a qualified social worker).

Services: The team gets involved as soon as people are admitted to hospital, and then works with them during rehabilitation and throughout their move back into the community, at which point they are handed over to generic community social work teams.

Funding: The specialist acute social worker is funded by the hospitals trust, but on a local authority service level agreement. All three community and sub-acute staff are local authority employees.

Evaluation

Rehabilitation outcomes for services users are routinely measured and a small user-led qualitative evaluation of the brain injury service as a whole is currently underway. However, the specialist social work team in itself has not been formally evaluated.

Features of Good Practice

Meeting practical, emotional and social needs

The case management approach is holistic. As well as physical or sensory impairment, clients may have severe cognitive impairment, poor memory or concentration, emotional, psychological, sexual or behavioural problems. A lot of clients become socially isolated after their brain injury because of changes in their personality. Relationship breakdown is common, and people may have difficulties forming new relationships. Being part of an interdisciplinary team means that the social workers can draw on specialist support from other disciplines to help tailor support to the needs of the individual.

Flexibility

People need (and want) different amounts of support and the team can accommodate this. Some people are able to do their own support planning, others need help, and some people do not want to engage with the support planning processes at all, opting instead for the more traditional type of care.

It is important that packages are reviewed and reversible as it is hard for people to predict what support they will need. People are in a better position to make choices once they are at home and have some experience of receiving care. The team will review the package after several weeks to see how people feel about the options they have chosen, and whether they want to refine or change anything.

Specialist expertise

All team members are specialists in brain injury, and the team delivers training in brain injury annually to all social care professionals in Sheffield (and some personal assistants). They can also train independent providers, so that if a person choses to move to a non-specialist home or disabled unit, they can educate the staff there about that person's specific needs and the complexities of brain injury more generally.

Key workers and coordination

People have the same social worker throughout the sub-acute stage into the community, but will at some point move on to the generic social work team. At this stage the specialist team will pass any successful strategies they have developed for working with a person with complex needs on to the community social worker. How long the specialist team continues to work with someone once they are in the community varies depending on the complexity of the case.

Long after they have left the service, clients can telephone the team for advice. Many clients are not eligible for formal services at this point, but will still need some support. The team provides support to people below the official critical and substantial FACs threshold in order to prevent them needing more support in the future. For example, they may arrange a small package of support for people with moderate needs to help them maintain their tenancies.

Further Information

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