**CBIT**

**THE COMMUNITY BRAIN INJURY TEAM**

**Understanding our Service**

May 2019

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| MISSION STATEMENTThe Community Brain Injury Team aims to provide high quality neurorehabilitation to adults affected by brain injury, living in the community.Our service addresses the physical, psychological and social consequences of brain injury. Working with client, family and carers, we offer personalised care plans and collaborative goal settings to facilitate enablement and adjustment to provide effective self-management. |

**Service Description and Operating Procedures**

**Community Brain Injury Team (CBIT) Service Description**

The Community Brain Injury Team seeks to address the physical, emotional and social consequences of brain injury experienced by adults living in the community. Working with the client, family and carers, we aim to facilitate adjustment to their change in circumstances and help them find new ways of participating in everyday life.

We provide community brain injury services including physiotherapy, occupational therapy, speech and language therapy and neuropsychology to adults (over the age of 18) with acquired (non-deteriorating) brain injury who are living at home or in a community setting within the Medway and Swale area. The team provides clinical care and health promotion for problems affecting the individual, their family and carers as a result of acquired brain injury. Our aim is to help the individual optimise their physical health and mental health and to live as fulfilling life as possible .

Our service is underpinned by our Trust's values.

Our service is based at the Disablement Service Centre (Medway Maritime Hospital) and is available Monday to Friday, 08:30 – 17.00. We see patients in their own homes but may also see them either at the Disablement Service Centre, or Medway Maritime Hospital, or other community settings.

**CBIT Team**

The CBIT provides an integrated, holistic multidisciplinary service and our commissioned establishment consists of one senior occupational therapist (0.80 FTE); one clinical specialist physiotherapist (0.58 FTE); one speech and language therapist (0.4 FTE); one clinical psychologist (1.0 FTE); one senior rehabilitation worker (0.5 FTE). We are supported by administrators.

**Referral Criteria**

Have a single incident, non-deteriorating acquired brain injury (moderate to severe). This includes:

* Are aged 16 and over
* Have a single incident, non-deteriorating acquired brain injury. Traumatic sub arachnoid haemorrhage is accepted. (Strokes and spontaneous events are served by stroke services)
* Brain injury resultant from, for example cerebral anoxia, encephalitis, meningitis etc
* Have complex needs and require therapy from at least two or more disciplines in the team
* Demonstrate potential for improvement
* Are living in a community setting in the Sittingbourne, Isle of Sheppey or Medway area
* We also provide intervention for people who, following brain injury are in a vegetative/low awareness state and are being cared for in the community

**Referral Exclusions**

* Strokes and spontaneous events who are served by stroke services
* Clients who have significant problems with drug and/or alcohol abuse and are not able to actively engage in therapy.
* Clients who, premorbidly, had significant learning difficulties and are not able to actively engage in therapy.
* Clients with progressive brain disease ie tumour.
* Service users whose needs are best met in mainstream mental health services or specialist mental health services
* Service users whose main presenting problem arise as a result of congenital or peripartum problems such as cerebral palsy.

Where possible we would be happy to work in an advisory capacity to those already working with the client.

**Referral Sources**

Referrals are accepted from:

* GPs
* Medical Consultants
* Allied Health Professionals
* Primary, Secondary and Tertiary care including regional neurosciences centres
* We accept self-referral, but request that GPs/ clinicians provide medical diagnostic history

**Referral Pathways**

Referrals into the service are discussed at the weekly team meeting, where the appropriate referral pathway is identified (see *overview of referral process* flowchart) .

The primary assumption is that the service user requires therapy from at least two or more disciplines in the team and demonstrates potential for improvement: this is *Pathway 1.* However, referrals for some service users, indicate specific neuropsychological input only (e.g., neuropsychological assessment). Therefore, assuming the individual meets all other criteria for our service , *Pathway 2* is offered. The clinical psychology resource is shared between both pathways .

* Overview of referral process
* Pathway 1 - CBIT
* Pathway 2 - Neuropsychology only

**REFERRAL PROCESS**

**COMMUNITY BRAIN INJURY TEAM**

**MEDWAY & SWALE**

**REFERRAL PROCESS**

Team meeting

Accepted referrals – pathway determined

**PATHWAY 2**

**NEUROPSYCHOLOGY ONLY for ABI**

**PATHWAY 1**

**CBIT**

Requirement for input from minimum 2 HCP’s

Senior Clinical

Psychologist

Speech & Language Therapist

Clinical Specialist Physiotherapist

Senior Occupational Therapist

At any stage, may refer into Pathway 1 if other HCP required

Supported by

Senior Rehabilitation Worker

**COMMUNITY BRAIN INJURY TEAM**

**REFERRAL PROCESS**

**PATHWAY 1**

**CBIT**

Referral declined if not appropriate

* Letter back to referrer

Initial assessment

2 members of the team.

Initial goals set

Patient discharged

Completion letter to referrer.

Copy GP and patient

May determine additional HCP input

Follow up GPM’s initial goals achieved and/or intervention complete

Frequency of input considered in collaboration with patient

Team input

GPM – help patient determine goals for therapeutic intervention and self-management

Some team input may occur before GPM

Goal Planning Meeting (GPM) date agreed – letter sent to patient (within approx. 6 weeks)

Referral declined if not appropriate

* Patient discharged, letter to referrer
* Refer to other services if appropriate

Patient may determine input not required. If so discharged

Determine input

(Requirement for 2 HCP)

Acceptance letter sent to patient – copy to G.P.

Insufficient information – Referral on hold. Request for more information from referrer

Referral accepted

Initial assessment date agreed

(within approx. 6 weeks)

Letter sent to patient and referrer

Team meeting – referrals discussed

Focus on input (‘goals’) determined with patient. Plan of care letter to G.P. – copy to patient

Patient discharged

Completion letter to referrer

Copy GP and patient

Initial Assessment can take several sessions

Frequency of sessions will be reviewed

Focus on input regularly reviewed until ‘goals’/input no longer required

Will refer to other HCP’s (Pathway 1) if need identified

Depending on individual need and in collaboration with patient, sessions may be weekly, fortnightly, monthly, quarterly

Sessions offered

Appointment offered for

Initial Assessment

(appointment offered within approx. 12 weeks)

Accepted Referrals

Placed on waiting list for (Neuropsychology)

Team meeting – referrals discussed

**COMMUNITY BRAIN INJURY TEAM**

**REFERRAL PROCESS**

**PATHWAY 2**

**NEURO-PSYCHOLOGY ONLY**

**Goal Planning Approach**

CBIT adopt a goal planning approach to their intervention with the service user. We work with the service user to help them identify and reach achievable goals. This ensures that rehabilitation remains focused and relevant to the service user. After the initial assessment, a goal planning meeting is arranged to enable the setting of goals. Adopting a collaborative approach, the service user, with the support of their family/carer and CBIT, will be helped to identify realistic goals that they would like to work on (e.g., related to mobility, domestic activities, leisure, return to work). For each goal set, the service user is encouraged to identify a difficulty rating to achieve the goal. These goals are used to monitor service user progress.

CBIT will continue to work with the service user, providing realistic goals are still being worked towards. Active input from the team might fluctuate depending on the service user needs. Follow up goal planning sessions with the service user occur approximately every 4 months to review their progress towards goals and to identify any new goals.

**Discharge**

Discharge from the team is discussed and planned with the service user. As this is service user driven, there is no set number of goals to be achieved before discharge. Discharge will occur when achievable goals have been reached (or exhausted) or when the individual can take forward their own rehabilitation, as progress often continues after discharge. Our involvement is service user driven and hence there is no 'typical' service user and no definitive duration for our input. However, generally speaking, there are possibly three strands of required input: some service users might require minimal input (e.g., it might be sufficient to provide a couple of educational sessions about the sequelae of brain injury); others might require more targeted/regular input over several months; a portion of service users may require, long-term, on-going intervention and review.

CBIT will work with service users for as long as intervention can continue to improve symptoms and as long as the service user continues to work towards meaningful, realistic goals.

**Additional Services**

We offer the opportunity to our services users and their family/carers of attending support groups. CBIT hold an annual event, with educational elements, to current/former service users.

Group education sessions for service users are provided if appropriate. Separate sessions providing education for carers are also available, when required.

**Review**

This document will be reviewed bi-annually.