

Boston House, Oldham Opening January 2020



Our Support

Our Acquired Brain injury (ABI) services are dedicated to providing support for people with complex needs following a brain injury. We understand that no two people and no two brain injuries are the same. We offer a variety of supportive pathways, personalised to suit each person's specific needs. We are focused on the strengths, interests and dreams of each person we support.

Our services are able to offer:

- Transitional (short, medium or long term) rehabilitation goal focused placements
- Short term community skill assessment/ cognitive assessment placements
- Specialist emotional/behavioural support placements
- Slow stream rehabilitation
- Supported living tenancies
- Specialist outreach support in your home
- Vocational support
- Respite placements

Clinical Input

Our clinical team work intensively and closely with staff, to support people to develop effective cognitive, communication, emotional and behavioural strategies. The team includes:

- ABI Specialist Advisor
- Clinical Support Nurses
- Specialist Behavioural Advisors

Specific input and support available if needed:

- Neuro-Occupational Therapy
- Neuro-Physiotherapy
- Neuro-Speech and Language Therapy
- Neuro-Psychology
- Specialist Behaviour Input
- Vocational Rehabilitation



All therapeutic input is incorporated into people's daily lives in line with their goals and aspirations. Each person's progress is monitored through a recognised outcomes measurement tool. This is regularly reviewed by our own inter disciplinary and wider multi-disciplinary team.

New ABI Service Proposal

We have a longstanding relationship with Oldham and the wider Greater Manchester region with regards to Byron Lodge, our specialist ABI residential service. Aligned with this is our commitment to and ongoing development of a rehabilitation pathway where the individuals we support can successfully transition back in to their community via our Supported Living services or home to families.

In order to build on our existing offering, we believe we are able to support the Local Authority and Clinical Commissioning Group by strengthening local resource with regards to supporting individuals affected by brain injury.

We will be creating a Specialist ABI Rehabilitation service that can accommodate and support individuals with a wide spectrum of needs, from intermediate nursing care stepping down through our care pathway and where appropriate to discharge back to independent living/Support Living service.

We know from experience that providing consistent support throughout the rehabilitation process is critical. Demand for specialist ABI provision is high nationally and it is our experience through our local service delivery that demand in Oldham reflect this national trend. We currently have waiting lists in both our Residential and Supported Living services in Oldham and we believe the development of our new service will address this need and provide a clear transitional pathway, personalised to the individual needs of each person supported.

Proposed Care Pathway:

We believe that the following model of care will offer Oldham access to a resource that is both in demand within the authority and cost effective in that it will prevent more complex clinical case having to be placed out of borough: -

- **5 x Nursing Care beds** – Nurse led service offering care with both Tracheostomy and PEG management requirements
- **6 x Residential Care beds** – En-suite rooms with full access to our specialist clinical and skills development support teams.
- **6 x Studio Apartments** – En-suite rooms with kitchens for continued independent living skills development.



Service Model

We are committed to delivering personalised support, in a brain injury aware environment, which reflects the diverse paths to recovery. The overall goal of our rehabilitation services is to improve function and skills and to promote autonomy.

This is achieved by delivering individually tailored support packages, in a highly structured brain injury aware environment, which provides a pathway through to independent living. Our approach is multi-disciplinary and focuses on creating a therapeutic environment, in which the people we support are able to develop the strategies they need to manage their cognitive, behavioural, physical and vocational needs.

The services will have on-site access to nursing, physiotherapy, occupational therapy, speech and language therapy, psychology, and social and vocational support. The design and structure of the service, in three separate wings, and the availability of our rehabilitation teams and clinical support, will allow the service to support people with complex needs, including those with dual diagnosis and those requiring intensive nursing support.

Our on-site team are further supported by our Clinical Support Team, who provide clinical support and training. The focus of the team is to facilitate the people we support to develop effective cognitive, communication, emotional and behavioural strategies. The team includes our Specialist Brain Injury Advisor, Clinical Support Nurses and Positive Behavioural Support Advisors. We are extremely keen to link in with local GP's with a view to coproducing more effective and proactive relations with the individuals we support to not only ensure a consistent approach to physical health but also to enhance the sustainability of the service and further reduce reliance on primary care services.



Outcome Focused

We are committed to ensuring that our services can demonstrate clear, measurable outcomes. We use the Goal Attainment Scale (GAS Goals) to track progress, and this is supported by clinical tools such as the **BIIES** – (Brain Injury Independence and Emotional Scale) which measures independent living skills and emotional well-being. We also use the **SASNOS** (St Andrews Swansea Neuro-behavioural Outcomes Scale) which is an internationally recognised measure of social interactions, relationships, engagement, emotional control, cognition, inhibition and communication. These allow us to track and share demonstrable progress in graphical form to support assessment, review and outcome measurement. Outcomes and support plans are reviewed monthly with Key Workers and the person supported. This review focuses on monitoring their active GAS goals, celebrating achievements and adjusting support where progress is not as anticipated

This model of an integrated brain injury pathway, delivering highly personalised, outcome driven rehabilitation and support has proved highly effective in our existing provision in the area. It allows for costly, out of area placements to be brought back closer to home, facilitating family and informal social supports and enables people to transition back more effectively. Our focus on the development of skills through physical, cognitive, social and behavioural support enables the person supported to build on their strengths, interests and aspirations and actively promotes community participation, autonomy and vocational pathways.