THE ROYAL BOROUGH OF
WINDSOR AND
MAIDENHEAD

Short Term Support & Rehabilitation Team

"A short-term service to promote reablement and maximise independent living at home."

Tel: **01628 621981**

24 hours a day, 365 days a year

NHS
Windsor, Ascot and Maidenhead Clinical Commissioning Group

Short Term Support & Rehabilitation

We help Borough residents over 18 to:

- Regain as much independence as possible after an operation, illness, or decline in health.
- Stay at home instead of being admitted to hospital or long-term care, if their main carer is unwell or there is some other social care crisis.
- Return home safely after being discharged from hospital.
- Remain at home for palliative care instead of at a hospice or in hospital.

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Who we are:

- The Intermediate Care Team for the Windsor Ascot & Maidenhead area joint funded by the Borough and Clinical Commissioning Group (CCG)
- 74 staff with a multi-disciplinary approach; occupational & physiotherapists, district nurse, rehabilitation assistants, social care co-ordinators, assessment officer & dementia advisor
- We operate from York House in Windsor, as a part of Adult Care Services

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Referral Sources:

- GP's
- Acute hospitals
- Community based professionals
- District Nurses
- Palliative care teams
- RBWM professionals
- Care agencies
- Housing associations
- Family, self referrals

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The team has been in existence since 2002 and in 2010 we updated to an Enhanced Intermediate Care service, to enable the following enhancements:

- 2 hour response times to urgent GP referrals to prevent inappropriate admissions to hospital.
- More timely access to preventative reablement programmes
- Direct access to service 24/7 was maintained
- Facilitate earlier hospital discharges

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How it works:

- We assess the situation and needs.
- The Service user and keyworker agree realistic goals within a treatment plan.
- Our Rehabilitation assistants visit daily to work on set goals.

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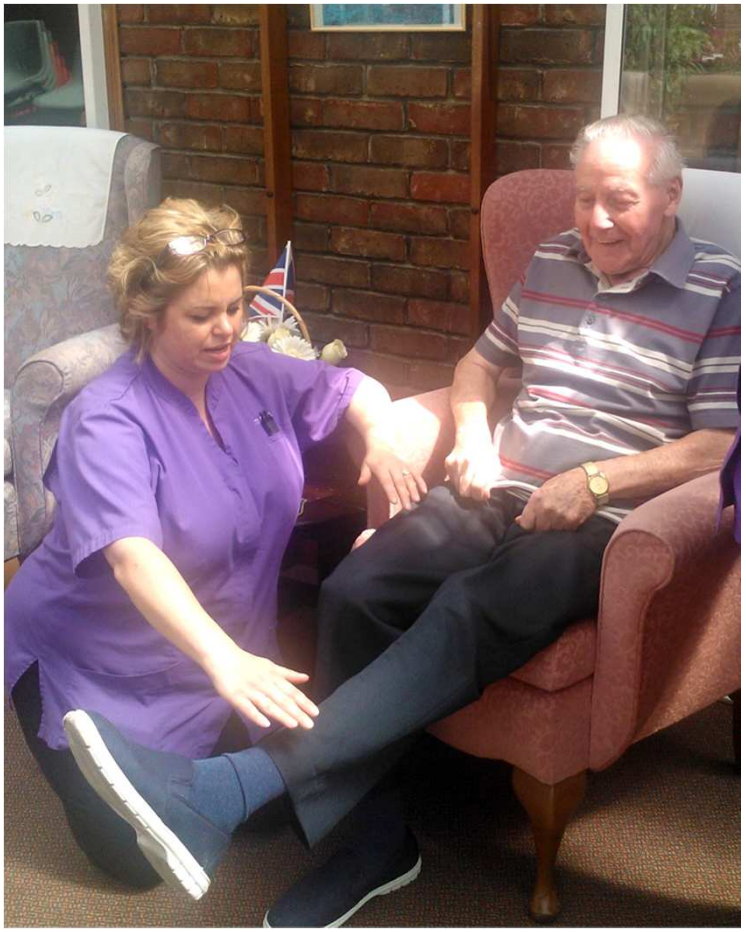
Interventions:

- Rehab to help manage daily tasks
- Exercise to rebuild strength and mobility
- Falls risk assessments
- Provide equipment and minor adaptations
- Early dementia support
- Advice and referring on



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Case study:

- Mr B was 79 yrs old and lived alone in a sheltered housing flat
- Acute hospital admission following a stroke, causing upper and lower limb, left sided weakness.
- Once medically stable, he was transferred to in-patient rehabilitation unit
- Discharged home with STS&R
- Assessments & goal setting
- After 6 weeks of intensive input at home, he became independent with the activities of daily living and care needs.

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Our rehabilitation service is free of charge for up to six weeks, depending on the needs of the individual.

Many people do not need any ongoing support once their service ends. If it seems likely they will need long-term support, we will refer them to the appropriate service.

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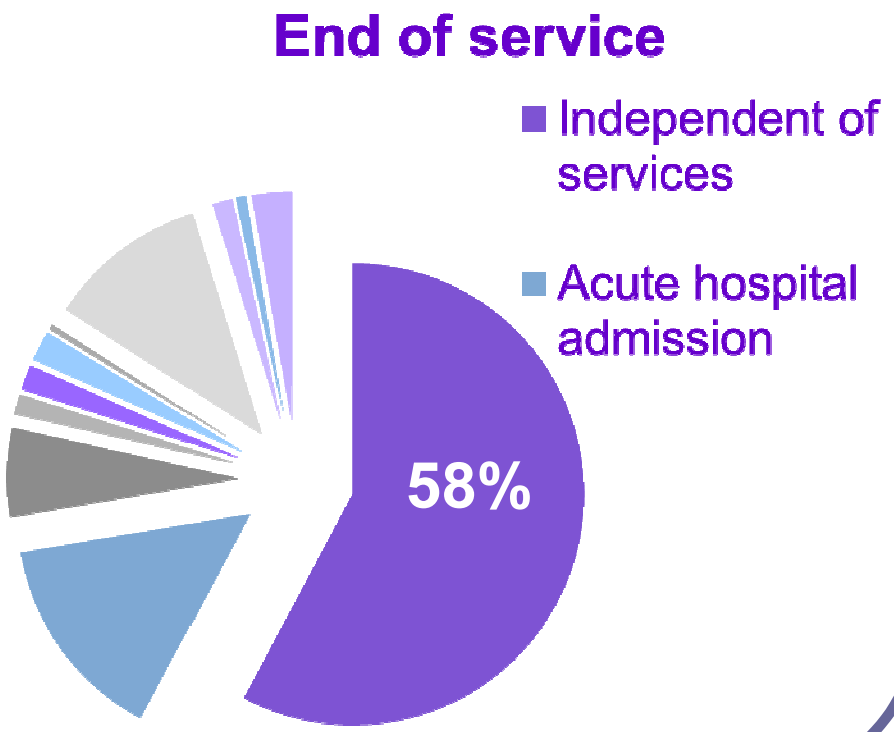
Service outcomes

Independence:

1. **Nearly 60% of service users leaving STS&R as independent**



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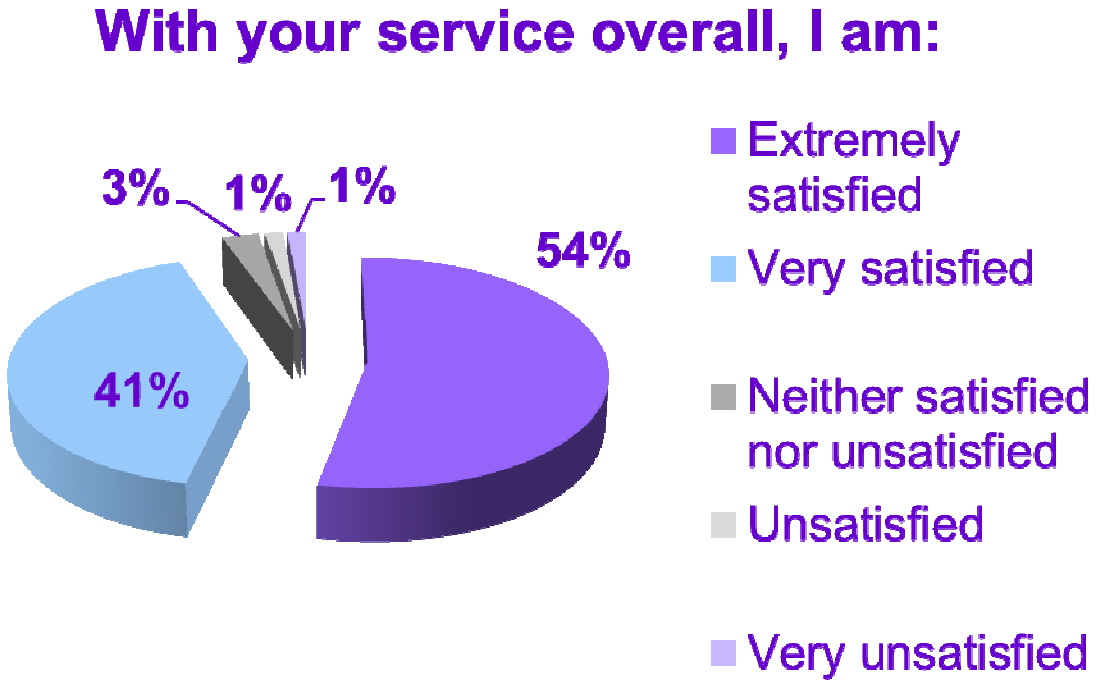
Service outcomes

Service user satisfaction:



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Our goals for the year ahead:

- Increase numbers leaving the service as independent
- Further integration with health partners
- Ongoing review to ensure delivery of the most efficient and effective service.
- More front line capacity with increased RCA posts
- Implementation of smarter mobile working methodology
- Reduced travel and mileage to increase contact time

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Any questions ?

Thank you