



GETTING HOME
Riverside Supporting Patients in the Community
STAYING HOME





Mrs Smith



The Riverside Group

Established in 1928, Riverside is one of the largest providers of social and affordable housing in England. As a charitable housing association we own and manage over 50,000 homes, and house nearly 100,000 people across 169 local authority areas.

Our vision “Transforming Lives, Revitalising Neighbourhoods” refers to regeneration for future generations. We aim to be the foremost social purpose regeneration company providing homes, housing services and support and care solutions throughout the UK.



Transforming lives
Revitalising neighbourhoods

Riverside has a dedicated care and support division headed by its own Executive Director, and multiple awards attest to both quality and innovation.

Care and support are provided to a broad portfolio of customers both in specialist accommodation services and in their own homes.

All services maximise customers choice and control of the support they receive, promoting holistic wellbeing through the delivery of personalised services that encourage independence, recovery and reablement. Our goal at all times is to empower customers to remain as independent as possible.

Riverside’s care and support services work in partnership with a wide range of voluntary and statutory agencies to provide integrated packages of care. Working with customer’s formal and informal circles of support, and we acknowledge the role of families and informal carers as central to our work.

All our care services are run in accordance with national care standards set by the Quality Care Commission; they are regularly reviewed and always rated as providing high levels of service.

Introduction to “Mrs Smith”

Mrs Smith is an exemplifying case study of a woman in her eighties with a range of long term health and social care problems, for which she needs care and support.

Mrs Smith is bewildered by the complexity of the health and care system and finds it difficult to navigate. Although she receives excellent care, she dislikes the number of assessments she goes through and the fact that she has to tell her story many times to different people. Sometimes things go wrong because information gets lost or misdirected and it then takes her longer to get the help she needs.

Mrs Smith has been a hospital inpatient for ten days following a fall in her home. Her discharge has been delayed by a number of factors including: needing adaptations to her home; requirement for a short-term care package; poor social support and concerns she will not be able to comply with her post-discharge treatment programme.

Mrs Smith’s story is typical of many vulnerable people leaving hospital. Riverside works with many ‘Mrs Smiths’. Throughout this brochure Mrs Smith will be used to demonstrate how Riverside could help improve both her experience and her outcomes.



GETTING HOME STAYING HOME

“...for those people with urgent but non-life threatening needs we must provide highly responsive, effective and personalised services outside of hospital. These services should deliver care in or as close to people’s homes as possible, minimising disruption and inconvenience for patients and their families.”

**Sir Bruce Keogh,
Urgent and Emergency Care Review 2013.**

In response to the challenge laid down by the Keogh Review, Riverside has considered the reasons that people remain in hospital longer and return to urgent care more frequently than should be necessary. Additionally, we have seen how targeted preventative services can assist people to remain as independent as possible in the longer term.

With a long track record of providing care and support services in community settings, Riverside is well placed to deliver these services: reducing costs and inefficiencies within urgent and emergency care settings as well as improving the patient experience.

We have developed a range of community solutions that can be purchased individually as well as adapted to the needs of a particular group of patients. This modular approach allows commissioners to adapt the range of service offers to the local health economy and ensures best fit with existing infrastructure.

Building links between Health and Housing

With both the health and social care sectors facing unprecedented demand on resources we face a changing landscape and challenges in providing quality services to the most vulnerable in our communities. One of the key features of The Care Bill, mirrored in Sir Bruce Keogh’s review, is that care should be personalised in, or near, the home.

Riverside has considerable expertise in supporting vulnerable people in their homes and providing specialist housing which helps them recover in their community. Across the country our staff help people manage long-term health conditions in the community, access services appropriately and build strong networks of support, reducing the pressure on primary and secondary care services.

Housing’s link to health and the pivotal role that good housing plays in addressing the health and wellbeing of individuals is a key issue which Riverside has taken a lead on promoting within our sector.

I am proud that Riverside is taking the lead as the first housing organisation to pilot the Fundamentals of Care Certificate. Along with making the Social Care Commitment, we are committed to supporting integration by strengthening the links between health, care and housing.

**Léann Hearne
Executive Director, Care and Support**

SERVICES

Care Navigation

Personalised service to help customers access the care and support they need and make the best of their formal and informal networks.

Intermediate Care

Hotel style accommodation with 24-hour care for recovery - focussed short stays.

Home Preparation

Practical assistance to make a customer’s home safe for them to live in.

Telecare Monitoring

24-hour monitoring and support to ensure response in case of an accident or emergency.

Home Care & Support

Personalised care and support delivered in the home to help vulnerable customers remain in their community.

Supporting Primary Care

Cross sector liaison to address issues underlying ill health.



Whether moving directly home or via an intermediate care service, navigating the complex social care environment can be a significant challenge to patients at a vulnerable stage in their lives. Delayed transfer of care is a major contributing factor to unnecessary time spent in hospital.

Care Navigators are skilled professionals who work alongside the customer to identify and remove barriers causing extended stays in hospital. They provide access to services that ensure independence can be managed in the long term, thus preventing unnecessary readmission.

A Care Navigator offers a single point of contact and consistency for customers as they move on from inpatient care. Easily accessible, they improve the patient experience

- A Care Navigator offers a single point of contact
- Care Navigators are trained and experienced staff
- Provide support from hospital through to the home

providing reassurance to patients who may be making significant adaptations following a stay in hospital.

Care Navigators are trained and experienced staff who can support customers from hospital through any intermediate care arrangements and swiftly into adult social care services as required. They ensure the best network of health, social care and informal support is in place for the patient, preventing readmission in both the short and long term.



What this means for Mrs Smith

Mrs Smith has been allocated a Care Navigator called Clare. They have built a really good relationship and Mrs Smith is confident she is able to tell Clare what is and isn't working for her.

The fact that Clare is able to work across the system of health and social care as well as organise resources from the voluntary and charity sector, has allowed Mrs Smith to feel reassured that, despite a worrying time, she has someone whom she can rely on.

With Clare to assist her, Mrs Smith's journey through the system is much smoother. She is reassured by having a single point of contact to answer all her questions, and by knowing that a care plan is being put in place that deals with all her concerns.

Mrs Smith feels in control of her journey through the system. This allows her to be confident in returning and staying in her own home sooner than would have been possible otherwise.



Care Navigation - Flexibility, Partnership, Inclusion

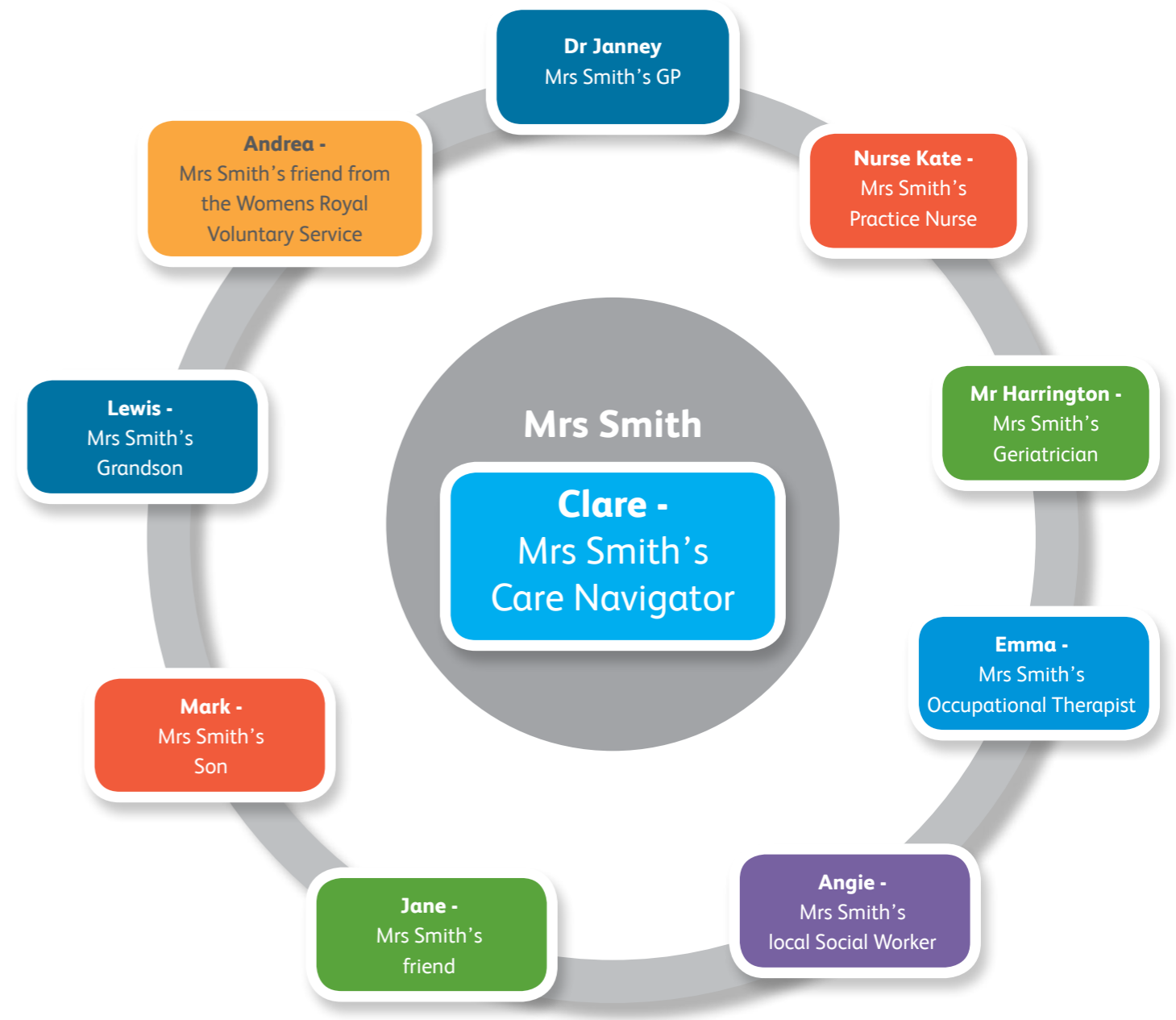
Care Navigators have a flexible brief and are able to work with any patient as directed by hospital staff. There are few restrictions on the work that they carry out.

From practical tasks such as assisting the patient home and ensuring that the environment is suitable, to taking a role in complex multi-agency discharge plans; if it assists the patient to return home sooner then it is within their remit.

Similarly, their ability to cross the boundary from the hospital into the community allows a much broader scope to solve the often simple, real-world problems that keep people in hospital.

Our services are able to supplement the work of existing services both within the hospital and the community to ensure a timely and effective discharge is achieved. By being embedded within existing patient flow or hospital discharge teams, they are able to identify vulnerable patients and agree a joint plan of action with patients, families and other professionals.

Care Navigators recognise that people on the verge of hospital discharge may be vulnerable for a host of reasons. By taking a person-centred approach they improve the patient experience by involving the customer in all aspects of decision-making and allowing them control of their care.



Flexibility, Partnership, Inclusion

The circle of support Riverside's Care Navigators co-ordinate.



At present there is little provision bridging the gap between hospital and home. Although not in need of the medical care provided in hospital, there are a range of customers who are unable to be discharged as: their home may not be suitable; there is insufficient available community support; or they still require a level of care that cannot be provided in the home.

Riverside provides specialised, short-term accommodation that bridges this gap. For individuals leaving hospital we can offer fully-furnished, fully adapted accommodation with 24-hour onsite care.

This service allows patients to move from hospital earlier to an environment more akin to a hotel with onsite care. The cost of this provision is significantly lower than hospital care, and we aim to move customers back to their own home as soon as it is practicable. Care navigators

work with the customer, other parts of the service and other agencies to ensure this is achieved as soon as possible, and that patients spend no longer than is strictly necessary here. The emphasis is always on getting home.

Our specialist housing accommodation is DDA compliant and equipped with Tunstall technology to enable link up to telehealth services. All facilities are CQC registered and maintain high infection control standards. All our specialist housing is maintained to a high standard of cleanliness and repair. It is also subject to frequent, stringent health and safety checks to ensure the safety and comfort of our customers.

For the future, options exist to partner with NHS services to provide a higher level of nursing care within this type of setting, allowing ever faster discharge from hospital.

- Specialised, fully adapted accommodation
- 24-hour on-site care and support
- Reablement and recovery focussed to help customers get home



How this works for Mrs Smith

No one likes to be in hospital and Mrs Smith is no exception. Doctors have identified that Mrs Smith no longer needs the acute services of the hospital however, she has not yet fully recuperated and more arrangements for her care at home need to be made before she can return.

A placement is organised at a Riverside Intermediate Care Service. This feels very different from a hospital ward and is much more homely. She has her own room and staff on hand to assist her to prepare for her eventual move home. Whilst at the service, visiting Occupational Therapists are able to work with Mrs Smith on the practical tasks she will need to complete at home, in an environment that is much more like the real thing.

Mrs Smith badly wants to get home, however she understands she is not quite ready. She is using the intermediate care service to best prepare herself following a challenging time. Friends and family are able to visit frequently and everyone is encouraged that Mrs Smith will achieve her goal of getting home as soon as possible.



To help customers return to their homes as quickly as possible, Riverside have a team of staff who are able to prepare their home to ensure it is safe to return.

Frequently, and particularly where no family members are available to assist, patients are unable to be discharged because some aspect of their home is not suitable.

The Home Preparation Service can undertake a range of simple, practical tasks that are not eligible for adult social care funding, but can make the difference in getting patients back home.

Alongside fitting fire alarms and smoke detectors, moving furniture such as beds and changing bulbs, trained staff can also undertake minor adaptations to the home such as fitting hand-rails and grab-rails, changing taps and handles and installing door entry intercoms and key safes.

Our staff are able to advise on and arrange other alterations to enable the customer to remain in their home for as long as possible. This may include level access bathing facilities, hoists and lifts and other works.

- Practical changes to the customer's home
- Assessment, advice and assistance on major adaptations
- Professional, discrete service



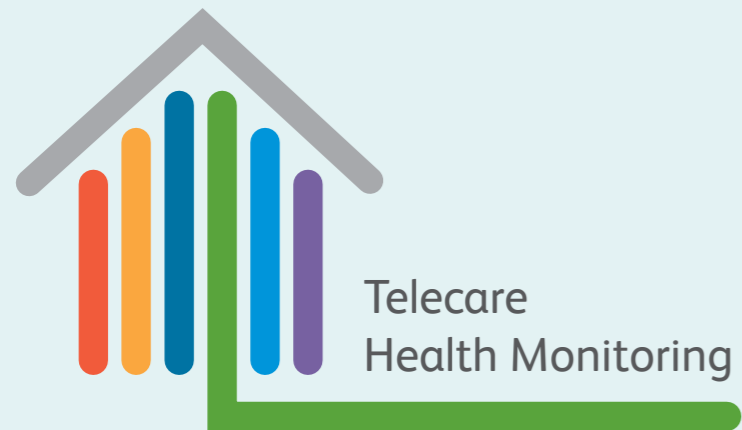
Preparations for Mrs Smith

Following her hospital stay some small changes to her home would make things easier for Mrs Smith, so she would be able to get home and stay there safely.

The home preparation team meet with Mrs Smith and Clare to talk about what she needs doing for things to be easier at home. This makes Mrs Smith feel like her journey home is becoming more of a reality with every passing day.

As a short-term measure until she regains her mobility, our team move Mrs Smith's bed downstairs and move furniture to make it easier for her to get around with a walker. The home preparation team fit a safe key at her house to make access for visiting staff easier and install a telehealth monitor.

The team fit a porch rail and bathroom grab rails to help Mrs Smith get about more easily. Although the team have done assessments for more major adaptations, it is the small things they have done that are helping Mrs Smith get home to recover in comfort and safety.



We operate a 24-hour Telecare monitoring service which provides essential support for over 4,000 older and vulnerable people through our Liverpool and Carlisle monitoring centres.

The service is designed to offer a cost-effective method of continuously monitoring the wellbeing of our customers. It can be used to enable a vulnerable person to remain in their home, as an alternative to 24-hour staffing or to facilitate an earlier return to the home for hospital patients.

Using the latest state-of-the-art technology, each customer carries a personal trigger and/or fall detector, which once activated sends an automatic call to our highly trained, dedicated team.

Upon referral into the service, we will install an alarm unit and pendant in the customer's home within 24 hours.

- 24-hour continuous monitoring service
- Rapid response to accidents or emergencies in the home
- Peace of mind for vulnerable customers and their families

In the event of an alarm call, our team can talk directly to the customer to ascertain the appropriate course of action, arrange for a care navigator or healthcare worker to visit the customer or, if the customer is unresponsive, the operator can call the emergency services.

Examples of assistive technical solutions include:

- Community alarms provide monitoring and emergency response at the touch of a button;
- Fall and motion detection sensors send a signal in response to motion or lack of activity;
- Bed sensors send a signal if a patient has not returned to bed for a set amount of time.



Monitoring how Mrs Smith is doing

It takes Mrs Smith a while to get used to the idea of the Telecare system, but once she has had a demonstration and asked some questions Mrs Smith hopes she understands that help is only seconds away. The fall alarm is not cumbersome and she becomes used to the regular checks made by staff via the system.

Mrs Smith hopes that she will never have another emergency and need to use the Telecare system, but she does find that knowing it is there helps her feel more secure.

Mrs Smith's son, Mark, was worried that she would need to go to a care home as she wasn't safe at home and he couldn't always be there for her. Now the Telecare system is in place he still worries about his mum, but some of his understandable concerns are abated by the knowledge that Mrs Smith is being constantly monitored, and that he will be contacted if there is a problem.



Care and Support at Home

Delayed transfer of care, whether to adult social care services, or more informal support, frequently leads to unnecessary hospital stays. In addition, the criteria for access to adult social care has risen significantly in many areas of the country meaning that simple practical responses fall outside of this funding threshold.

Riverside are able to provide short term care and support that allows patients to return home whilst longer term arrangements can be made. This can include help to attend appointments, assistance with medication, simple shopping, cooking and cleaning tasks, as well as personal care. Transport is also available.

Riverside are registered with CQC to deliver quality care services. We are committed to achieving Cavendish Compliance and our healthcare workers are trained to the highest standard. As a responsible employer, Riverside ensures all staff earn a living wage, are paid for travel and training and have excellent terms and conditions of employment. We are also a trial site for the forthcoming Fundamentals of Care Certificate, as recommended by the Cavendish Report.

Whilst receiving this service, Care Navigators will ensure that sufficient services are in place in the community to enable the customer to sustain their independence in the longer term.

- Personalised, flexible care in the home
- Reablement focussed one-to-one support to enable recovery and re-engagement with the community
- Practical assistance that enables customers to remain active and independent in the home



Supporting Mrs Smith at home

Mrs Smith is really pleased to be back at home. However, she does need more help than before. Clare, her Care Navigator, is in discussion with social services about a permanent care package, and in the meantime she receives regular care visits from one of Riverside's staff.

Some of the help she needs, like shopping and cleaning assistance in the short-term, is not funded by adult social care, but she is able to get home sooner with provision for these modest tasks to be completed.

Now at home, and in control, Mrs Smith is able to plan with her family and assistance from Clare for the longer term. With well-coordinated services, designed around her, she feels that despite the fall she will be able to retain her independence, dignity and standing in her local community for many years to come.



Patients frequently visit their GP surgery, seeing a Doctor or Nurse in a routine or emergency appointment for a range of problems, not all of which have a medical cause. GPs sometimes find that treating the presenting medical issue will not resolve the underlying circumstances that have led the patient to their surgery. Additionally, some patients find it hard to follow the advice and course of treatment prescribed without further assistance.

In all of these scenarios being able to call on additional support services, which can provide additional help to the patient, will enable the patient to recover more quickly. This can reduce pressure on Primary Care by minimising inappropriate appointments, and reducing the need for further appointments as the patients' needs are more fully met.

Sometimes referred to as "Social Prescribing" we can support primary care using our care navigation skills. Our team can help to deal with both presenting and underlying issues, as well as establishing longer-term links for ongoing support. Our skilled Support Workers can either co-locate with Primary Care Services or receive referrals direct from the practice, and will work with the patient to ensure holistic recovery.

- Additional support to help patients manage primary care treatment
- Cross-sector liaison to address issues underlying ill health
- Co-location in Primary Care Settings and communities



Supporting Mrs Smith with her Primary Care

Mrs Smith has been recovering slowly since her hospital admission, and she hasn't had any more falls in her home. After her discharge she visited her GP to let him know what had happened and who was helping her now. As autumn turns into winter she has had an exacerbation of her COPD and has a minor chest infection that won't go away.

Dr Janney has noticed that she is always wrapped up in lots of layers and when he has visited her at home the house has been very cold. He thinks that Mrs Smith's cold home might be contributing to her

respiratory problems, and refers her to the Riverside team based at his surgery for some help.

Mrs Smith finds it difficult to talk about money but explains that her boiler is broken and she can't afford to fix it. As she owns her home she didn't think she would be able to get any financial or practical help to fix it. The Riverside team arrange for a handyman to visit and assess her boiler, giving her an affordable estimate for the work that needs doing. A support worker will help her look at her finances and potentially get some emergency financial support

to get the work done. An affordable warmth advisor visits Mrs Smith to help her make the most of her money, while keeping her house warm enough to keep her healthy.

Mrs Smith didn't find it easy to admit she needed help, but the team have been really supportive and made things really easy. Getting her boiler fixed has made her home much more comfortable and her chest infection is responding well to treatment. Mrs Smith hasn't had to visit the GP surgery again but she knows help is there if she needs it.

Find out more

Riverside are committed to developing services which respond to the needs of communities and commissioners. We work in partnership to create bespoke service models that deliver high quality care and support solutions and respond to the needs of the customer.

In order to get people home and help them stay home, Riverside ensure flexibility and responsiveness for customers and commissioners alike.

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A charitable Industrial and Provident
Society



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