SharedLives

WORKING WITH FAMILY CARERS

Shared Lives and Intermediate Care and Reablement

Introduction

A number of Shared Lives schemes have been approached to provide short term emergency accommodation for older people who are well enough to leave hospital after treatment, often for an unplanned intervention, but who are unable to go back to their normal home as they have little or no support available. Although this falls outside the normal Shared Lives offer, some schemes have indicated they are interested in offering an intermediate care or reablement service.

Intermediate care comprises four main headings:

- Crisis response – services providing short-term care (up to 48 hours only)
- Home based intermediate care – services provided to people in their own homes by a team with different specialties, but mainly health professionals, such as nurses and therapists
- Bed based intermediate care – services delivered away from home, for example, in a community hospital or care home. This is an area Shared Lives schemes could develop
- Reablement – services to help people live independently again, usually provided in the person's own home by a team of mainly social care professionals

This guide explores the differences between intermediate care and reablement and some of the challenges for a Shared Lives scheme considering offering these services.

What is intermediate care?

The aim of intermediate care (IC) is to reduce the length of hospital stays and/or to prevent the need for admission to hospital or to long-term residential care by providing alternative support for a limited period of time. However, the emphasis and funding is predominantly aimed at supporting people to leave hospital rather that preventing their admission in the first place.

Intermediate care offers short term rehabilitation to people following illness or accidents. It may take place in the user's own home (often referred to as Home from Hospital schemes) or take place in a care or residential home or in a community hospital. It can last a few days or weeks, depending on the service user's circumstances.

There are three main aims of intermediate care are to:

- Help people avoid going into hospital unnecessarily
- Help people be as independent as possible after a stay in hospital and
- Prevent people from having to move into a residential home until they really need to.

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Key points

IC is most often used for older people – a recent audit of IC services found that users of IC had an average age of 82 years and the proportion of people over 85 years had increased from 48% in 2012 to 52% in 2013. (National Audit of IC 2013, NHS Benchmarking Network)

IC users mostly need joined up integrated care involving all aspects from GP services and hospitals, through to community and social care. This care needs to be delivered by a wide multi-disciplinary team, including specialist care (such as mental health services) if necessary.

In 2013, 70% of service users in bed based IC care came from hospital wards, meaning that the pressure to support those leaving hospital had taken priority over developing preventative services.

The November 2013 NHS audit of IC showed provision to be geographically patchy and generally in need of investment.

The proportion of home based services relying on the service user's own GP for medical cover appeared high (71%) when reviewed against the levels of care being provided by these services.

A variety of different professionals can be involved in delivering this type of specialised care, from nurses and therapists to social workers. Whether the person or team providing the care plan is from health or social care will depend on the individual's needs at that time.

Some people cannot go home straight from hospital due to a number of factors. These may include physical aspects of their homes e.g. steps and stairs or the lack of any support other than support from paid social care or health workers.

Intermediate care is usually commissioned by health and is therefore free to the service user. This service is currently provided by a number of charities including RVS, Red Cross and Age UK as well as some private home care organisations.

Developing IC within a Shared Lives scheme

Shared Lives takes a uniquely person centred approach to all aspects of social care and for people needing IC services Shared Lives could offer a service that goes beyond the usual limits of traditional Home from Hospital services. To do this the following factors would need to be addressed:

- Working directly with hospital care teams
- Making the business case for Shared Lives
- Matching processes
- Training and supporting carers

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Working directly with hospital teams

Some IC schemes are contracted by their local acute hospital trust where the majority of the issues around the discharge of older people occur. However, there will be potential for engaging with the new Clinical Commissioning Groups whose budgets are affected when discharge is delayed and who will be looking for cost-effective solutions that will lead to lower rates of re-admission.

One of the first steps will be to identify who are the current providers of IC are in your area and what sort of care they are contracted to provide e.g. in the service user's home or in community facilities. Very often, where discharge occurs into a residential home, this will be done on the same basis as respite care i.e. with no special plans in place. Shared Lives could offer a constructive alternative to this by introducing an element of reablement into their plans.

Business case

It may be quite difficult to make a business case for Shared Lives in this field as many of the independent sector competitors offering Home from Hospital care will use volunteers to support people being discharged from hospital, making their comparable unit costs low. Shared Lives schemes may do better to position themselves in direct competition with care home providers for people who, for whatever reason, cannot return to their own homes.

Shared Lives could be a very attractive alternative to short term residential care residential care for the following reasons:

- It prevents people from becoming institutionalised. For many older people or people living with dementia it is difficult to differentiate between one institutional setting or another, whereas going to a Shared Lives carer's home would be a clear transition
- Shared Lives can be more flexible in responding to the individual's needs – it's not a one size fits all service
- There may be financial savings against care home fees, although this would depend on local circumstances
- If older people are discharged from hospital to a care home, there is some evidence to suggest that they are less likely to return to their own home, but may well take up residence permanently. This is due to a number of factors including the lack of encouragement to start again to do practical activities which would enable them to live independently. Shared Lives can provide support in a natural home environment which encourages and enables service users to do things for themselves

IC schemes are based around enabling the person to be discharged and then to be safe at home. If there is no formal reablement

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plan, the service user may not receive much encouragement to start doing things for themselves or testing their limitations. A Shared Lives intervention at a Shared Lives carer's home can offer a 24/7 opportunity to enable the service user to become more independent gradually but in a safe environment.

Matching

One of the main barriers to Shared Lives schemes offering IC is the lack of time for matching to take place. Very often once a clinical decision has been made to discharge someone from hospital there is only 24/48 hours available. However, if schemes have an established relationship with the commissioners of IC services and the local acute hospital, it should be possible to identify people who are likely to need residential IC at an early stage and start considering options, including whether a Shared Lives arrangement would be suitable and undertaking an introduction to a potential carer.

This would need careful management, as the person in hospital may find it difficult to think about the future while dealing with their physical complaints, especially if they are older. For many older people, once in hospital there is a fear that they will never go home again and an acceptance that a residential care home is their only option. This means that the matching process will need to be handled very carefully and that it may only be possible for the service user and carer to meet once or twice.

Training and supporting Shared Lives carers

This will be a very different area of work for Shared Lives carers compared to the traditional role. There will be a much shorter lead in time to accepting a new service user and there may be a large element of health involvement, especially if the user still needs medical care eg dressings changed etc. The people using this service are most likely to be older people with a multiplicity of conditions and will probably need ground floor accommodation, including a bathroom, or a stair lift.

Shared Lives carers will need additional training to understand IC services, support in working with a range of health and social care professionals and additional support to manage the short term nature of the intervention.

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What is reablement?

Reablement is a short and intensive service which is offered to people with disabilities and those who are frail or recovering from an illness or injury. The purpose of reablement is to help people who have experienced deterioration in their health and/or have increased support needs to relearn the skills required to keep them safe and independent at home and minimise the need for ongoing homecare support. This may be offered to people who have undergone a phase of intermediate care but also to people who remain within the community, requiring support to live at home without having been in hospital. Reablement usually takes place in the user's home but can happen during a respite stay in a residential facility.

Reablement is not used to support people with degenerative or ongoing conditions unless some positive improvements can be made which would enable them to remain living independently e.g. people diagnosed with dementia.

Key points

- Reablement is about helping people to do things for themselves, rather than doing things to or for people
- Reablement is time-limited; the maximum time that the user can receive reablement support is decided at the start. In most reablement services, this is for six or eight weeks
- Reablement is outcome-focused: the overall goal is to help people back into their own home or community
- Reablement involves setting and working towards specific goals agreed between the service user and the reablement team.
- Reablement takes a very personalised approach – the kinds of support given are tailored to the individual user's specific goals and needs
- Reablement assumes that something should change by the end of the reablement intervention; people are working towards positive change
- Reablement builds on what people currently can do and supports them to regain skills to increase their confidence and independence
- Reablement may also involve ensuring people are provided with appropriate equipment and/or assistive technology, and understand how to use it
- Reablement aims to maximise users' long-term independence, choice and quality of life and to reduce or minimise the need for ongoing support after the period of reablement

Reablement is usually commissioned and delivered through adult social care services and receives referrals traditionally made to conventional home care, either from the community or via hospital discharge. Reablement teams are usually based within local authority adult social care services, with

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services delivered by in-house council care teams or commissioned providers working in tandem with physiotherapists, occupational therapists and other health professionals.

The kinds of support given through reablement services are typically more varied than traditional home care support, and are tailored to the individual user's needs, goals and preferences. They can include:

- personal care, for example help with washing and dressing
- practical support, for example help with preparing meals
- domestic support, for example help with making beds, washing dishes
- prompting for medication (reminding people to take medication; checking that they've taken it)
- assessing risk and ensuring a safe home environment, for example in relation to layout or equipment
- obtaining equipment for users, such as grab rails, walkers, trolleys
- teaching people exercises to help regain mobility, strength and confidence, and supporting and encouraging them to practise the exercises
- taking people out for a walk or to go shopping
- problem-solving to support independence; finding practical solutions
- supporting users to increase social contact, for example referring or informing users about lunch clubs, day centres, social activities
- advising on reducing the risk of falls
- helping people to budget and manage their money
- providing information and signposting

All of the above are activities which can be used to support the user to continue to live independently by doing these things for themselves. However traditional reablement has also been criticised as being too narrow, focussing on helping people to remain independent at home but with no reference to re-engaging with their communities or taking a strength based approach to focus on the positive aspects of the users' lives.

What are the main differences between Intermediate care and reablement?

Reablement is more universal than intermediate care, and is available to people who need support to continue living independently but are not at high risk of hospital or care home admission. Many people who would not meet the access criteria for intermediate care will be able to receive reablement services.

Intermediate care patients have a defined clinical need, and intermediate care services are clinician-led. In contrast, reablement service users have a social care need (which may result from a clinical need) and reablement services are not clinician-led and tend to adopt a social model of support.

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What is the difference between reablement and rehabilitation?

Rehabilitation is usually associated with supporting people to regain self-sufficiency after illness or injury and focuses on the medical model, whereas reablement can be available to people with lower level needs / gradual deterioration.

Developing Reablement within a Shared Lives scheme

Developing a reablement service is similar to working with IC but there are some differences and the following issues would need to be addressed:

- Working with reablement teams
- Making the business case for Shared Lives
- Training and supporting carers

Working with reablement teams

Where reablement is contracted out from a local authority team it is usually to a home care agency which will probably already hold a contract for traditional home care services. For Shared Lives schemes to enter into this market place, they will need to establish a clear pathway for working with users to achieve the agreed goals.

As there is unlikely to be a pre-existing relationship with the service user, the scheme will need to be pro-active in negotiations to be considered as a reablement provider. Initially for schemes to be successful in this area, it is more likely to be where reablement is offered as part of a respite service or day support rather than competing with home care agencies to provide the service in a user's home.

Making the business case for Shared Lives

There are a number of unique factors which Shared Lives could offer reablement teams to enhance the service received by the service user. These include:

- Users are often not actively involved in their reablement plans and are given poor information - it remains a service that is largely 'done to' the person. The Shared Lives approach means that users would be actively involved in the design and development of their plan with their carer
- Reablement services tend to adopt a 'one size fits all' approach with little, if any, choice over the nature of the support or who provides it. Shared Lives could add to the menu of potential support offering users, especially those on personal budgets, an alternative to the traditional providers

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- There is often little consideration of the value of friends and support networks in maintaining the person's wellbeing, or activities and opportunities in the community they could benefit from. Shared Lives could help embed reablement users back into their communities
- People who still require some support after a period of reablement are often not told enough about self-directed support and Personal Budgets. Shared Lives would be in a unique position to offer on-going support to older people, particularly those with degenerative conditions, through day care and respite services

Training and supporting Shared Lives carers

This will be a very different area of work for Shared Lives carers compared to the traditional role. They will be working within a strict time frame with very clear aims and targets to achieve by the end of it and there will be on-going assessments undertaken by the reablement team members to check progress. Schemes will need to decide how much Shared Lives carers can offer in their own homes or if some of this intervention needs to take place in the user's home eg if getting up and dressed in the morning is one of the aims, this would inevitably need to happen in the user's home whereas cooking a meal could take place in the Shared Lives carer's home. This will have financial implications for Shared Lives carers and schemes alike.

Shared Lives carers will need additional training to understand reablement services, support in working with a range of health and social care professionals and additional support to manage the short term nature of the intervention. It is unlikely that matching can take place over a substantial period of time because of the short term nature of the activity. However good matching will still be key to a Shared Lives scheme offering good reablement and will be another unique selling point for reablement teams.

Relevant legislation, guidance and circulars

The Community Care (Delayed Discharges etc.) Act (Qualifying Services) (England) Regulations 2003

The 2001 Intermediate care Guidance

The 2009 Intermediate care Guidance

Local Authority Circular LAC (DH) (2010) 6 Personal Care at Home Act 2010

The Outcomes Framework for the NHS in England 2013 / 2014

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