

Intermediate care guidance for Shared Lives

2019



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Share our advert

[Moving home from hospital](#)

If you're recovering after an operation, illness or unexpected visit to hospital, like Ken, you could enjoy the comforts of a Shared Lives carer's home and support to get you back to your own home as soon as possible. [Watch our 2 minute film](#)

Introduction

About Shared Lives

A Shared Lives carer shares their home and family life with an adult who needs care or support to help them live well. Local schemes, which are regulated and consistently rated best performing for quality and safety by the Care Quality Commission, individually match, train and approve Shared Lives carers with people who need their support.

The goal is an ordinary family life, where everyone gets to contribute, have meaningful relationships and are able to be active, valued citizens.

People are supported by their Shared Lives carer to develop or maintain independent living skills, friendships and live as part of their local community; giving them a sense of wellbeing in a safe and supportive environment.

There are an estimated 11,880 people supported in Shared Lives in England and 13,450 across the UK. They are primarily adults with learning disabilities, mental ill health, autism and dementia, older people, young adults in transition, and people with a wide range of other support needs¹.

In 2016/17 there were 2.3 million delayed transfer days in England, an increase of 25% on the previous year². A delayed transfer of care is where a patient is ready and safe to leave hospital, but unable to do so. In 2012, it was identified that intermediate care provision would need to double to meet demand, yet by 2017 this level had still not been achieved³.

Shared Lives is in a prime position to deliver support to people leaving hospital and reducing pressure on stretched NHS and social care services.

1. Shared Lives Plus, The State of Shared Lives in England 2017. [online] Available at: https://sharedlivesplus.org.uk/images/Low_res_The_State_of_Shared_Lives_in_England_2017.pdf [Accessed 19 June 2018]

2. Briefing paper by Alex Bate, Delayed transfers of care in the NHS, (2017). [online] Available at: <http://researchbriefings.files.parliament.uk/documents/CBP-7415/CBP-7415.pdf> [Accessed 19 June 2018].

3. National Audit of Intermediate Care, Summary Report – England 2017, [online] Available at: [https://s3.eu-west-2.amazonaws.com/nhsbn-static/NAIC%20\(Providers\)/2017/NAIC%20England%20Summary%20Report%20-%20upload%202.pdf](https://s3.eu-west-2.amazonaws.com/nhsbn-static/NAIC%20(Providers)/2017/NAIC%20England%20Summary%20Report%20-%20upload%202.pdf) [Accessed 19 June 2018]

Traditionally Shared Lives has worked predominantly with people with learning disabilities and mental ill health, but there are examples where successful arrangements have been made with people in later life and those living with dementia and more recently for people who have been discharged from hospital. Although with small numbers at the moment, there is growing evidence that Shared Lives is a suitable provider for these services and that different and more imaginative ways of providing these services are needed.

How could Shared Lives help?

Shared Lives could be adapted to provide intermediate care and reablement by:

- Becoming involved when a person enters hospital and they cannot go straight home afterwards. An introduction to a potential Shared Lives carer would be made at the earliest appropriate stage to see whether it was a suitable match.
- Reablement needs would be identified in a similar way, but with more time to achieve a good match. The range of support the user would receive from other health and social care agencies e.g. occupational therapist would be underpinned by the on-going support from the Shared Lives carer.
- Shared Lives would be able to continue to provide support at the end of either the reablement period or the intermediate care stay through day support and short breaks, enabling people to remain independent for longer and providing additional support to their family carers.
- Older people with multiple health issues requiring frequent visits to hospital would receive on-going support for all aspects of their care from the same Shared Lives carers, providing continuity.
- Supporting people after a life changing illness such as a stroke to regain their skills and confidence to be able to return home and live independently again.
- People at risk of entering residential care could have a time limited Shared Lives arrangement to help them to re-learn skills needed to remain living in community. This could also provide people valuable time to review their long term care options.

Background to the intermediate care pilot

In 2016 Shared Lives Plus received grant funding from The Dunhill Medical Trust and Department of Health Innovation, Excellence and Strategic Development (IESD) Fund to develop Shared Lives as an intermediate care service with an initial emphasis on developing a Home from Hospital service. This project has supported the development of Shared Lives as an intermediate care service, enabling people to be supported by a personalised service in a family home, building positive and often lasting relationships. This has given individuals the opportunity to regain health and independence skills in a supportive home environment in preparation for them to return to their own home.

The project is being evaluated by National Development Team for Inclusion (NDTi) and a final report is due in May 2019. The experiences and the learning from this project has been used to inform these guidance documents.

As part of the project seven Shared Lives schemes piloted the development of intermediate care, testing new ways of working and feeding back their findings on what worked well and the challenges they encountered.

We would like to acknowledge and thank the following schemes for their support:

Durham Shared Lives

Tricuro Shared Lives (Bournemouth)

Shared Lives South West

PSS Midlands

Positive steps Shropshire

New Directions Sefton

Wigan Council Shared Lives

What is intermediate care?

The Second National Audit of Intermediate Care (NAIC) 2013⁴ defines intermediate care in the following way:

‘Intermediate care services (also known as care closer to home) are provided to patients, usually older people, after leaving hospital or when they are at risk of being sent to hospital. The services offer a link between places such as hospitals and people’s homes, and between different areas of the health and social care system, community services, hospitals, GPs and social care.’

The aim of intermediate care is 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. However, the emphasis of the Shared Lives intermediate care offer is predominantly aimed at supporting people to leave hospital and increase their independence to enable them to return home. Traditionally intermediate care has been provided either in bed based

⁴ National Audit of Intermediate Care, Summary Report – England 2013. [online] Available at: <https://static1.squarespace.com/static/58d8d0ffe4fcb5ad94cde63e/t/58f08f9fe3df28353c556761/1492160435696/naic-report-2013.pdf> [Accessed 19 June 2018]

services such as community hospitals and residential care or community based services delivered within the persons own home.

Reablement is more universal than intermediate care, and is available to people who need support to continue to live independently but are not a high risk of hospital or care home admission. Many people who would not meet the criteria for intermediate care will be able to receive reablement services. Both intermediate care and reablement could be delivered in a Shared Lives carers home; however, reablement is more traditionally used when someone can remain in their own home with the reablement team going in.

Who uses intermediate care?

The NAIC found the average age of intermediate care service users was 80 years in home based services. Given the high percentage of older people in acute hospital beds who no longer need to be there for medical reasons, it was anticipated that Shared Lives schemes would receive referrals for older people. However, referrals were made for other groups of people including:

- Individuals in hospital either due to a period of mental ill health or have a medical condition but discharge is delayed due to the persons mental ill health.
- Individuals with a learning disability who are admitted to hospital and require additional support on discharge from hospital prior to returning home.
- Younger people (under 65) who have had a stroke and require further rehabilitation prior to returning home.
- People whose housing is not suitable and there is a need to find alternative accommodation to enable them to live independently again.
- Support for individuals when their family/informal carer need to go into hospital.

Shared Lives intermediate care should be available to everyone whose needs can be met within a Shared Lives carer's home. It is hoped that in the future Shared Lives will be seen as a first option for people being discharged from hospital and not just when traditional options have been exhausted.

Shared Lives has the scope to support individuals who attend A&E frequently by matching them when they are well so they have alternative support

available to them when they feel unwell but do not require medical intervention in a hospital setting.

This guide has been developed to inspire and support Shared Lives schemes to diversify and grow the services they offer to support people who require support following a stay in hospital or to avoid admission to hospital or residential care. The guide should be used alongside other Shared Lives Plus guidance, in conjunction with organisational policies and procedures and national advice, information and guidance.

Getting started

Shared Lives can be developed and delivered as an intermediate care service, also referred to as 'home from hospital'. If you are considering supporting people who are ready to leave hospital you may want to think about how you can adapt your service to reach the most people.

This guidance has been produced following our project working with 7 project schemes to develop Shared Lives for people who are ready to be discharged from hospital but not yet ready to return home. The guidance draws on the experiences of Shared Lives schemes, it includes what has worked and what you could find challenging.

As noted already the background section of the guidance Shared Lives can be adapted to provide intermediate care and reablement by:

- Becoming involved when a person enters hospital and it is clear that they will not be able to go straight home after the intervention. An introduction to a potential Shared Lives carer would be made at the earliest appropriate stage to see whether it was a suitable match.
- Reablement needs can be identified in a similar way, but with more time to achieve a good match. The range of support the user would receive from other health and social care agencies e.g. occupational therapist would be underpinned by the on-going support from the Shared Lives carer.
- Shared Lives can continue to provide support at the end of either the reablement period or the intermediate care stay through day support and short breaks, enabling people to remain independent for longer and providing additional support to their family carers.
- Older people with multiple health issues requiring frequent visits to hospital could receive on-going support for all aspects of their care from the same Shared Lives carers, providing continuity.
- Supporting people after a life changing illness such as a stroke to regain their skills and confidence to be able to return home and live independently again.
- People at risk of entering residential care could have a time limited Shared Lives arrangement to help them to re-learn skills needed to remain living in community. This can also provide people valuable time to review their long term.

The difference Shared Lives can make – Kaml's Story

Kaml has a mild learning disability, periods of mental ill health and type 1 diabetes. Kaml was frequently being admitted to hospital. Initially the district nurse needed to visit 3 times a day to administer her insulin. It had been presumed that Kaml was unable to read and unable to safely draw up her own injections. The Shared Lives carer was able to spend time with Kaml and noticed that she had difficulty with her vision. The Shared Lives carer took her to the optician where it was discovered she had very poor sight and required strong prescription glasses. Once she had these Kaml was able to read and soon began to administer her own medication and insulin resulting in the district nurse services no longer being required.

Staff capacity and resources

Developing Shared Lives as a home from hospital service requires staff time and resources. You should consider whether any funding is available to increase team capacity. A business case to develop Shared Lives for Intermediate Care is available from Shared Lives Plus and can be found on page 70 of this guidance. You can use this to demonstrate the benefits and cost effectiveness of Shared Lives to Local authorities, CCG's and funders.

Shared Lives schemes who are able to dedicate staff time to develop the service have had more success. They were able to make links with health teams, recruit and assess more carers and promote the service. However, even without additional resources you can still deliver a home from hospital service as part of your day to day service. Many schemes have been able to build this into their local offer and take referrals from discharge teams.

Shared Lives South West explain how they were successful in securing funding to increase staff capacity to deliver their home from hospital service.

“We contacted our local authority commissioners and submitted a clear business proposal for the project. We provided the background around the challenges facing the health services and the costs they were incurring, then outlined how Shared Lives could not only provide cost savings but also personalised support to the individuals that delivered better outcomes over a shorter period of time. We outlined the expected costs for the overall project and provided a proportional assessment of the costs for scaling up the project in their region. In each authority there exists different funds for development project, and in the case of Cornwall Council, the

commissioner was able to use the business proposal to secure the necessary funding.”

Carers

Having Shared Lives carers available when taking referrals is vital. When starting it can seem like a chicken and egg situation. If Shared Lives carers are ready but no referrals have been made yet, they can find the wait frustrating. On the other hand, if referrers are excited about the opportunity to refer to Shared Lives but there is no availability they can be reluctant to contact again. There is no easy solution to this but being upfront about this issue will ensure people have realistic expectations.

A lack of available carers will limit your ability to expand into intermediate care, so you will need to think about how you can increase the number of carers you have. You can approach your current carers to see whether they would be interested in supporting individuals being discharged from hospital. Individuals using Shared Lives have a variety of needs and you will find your current carers already have a lot of the skills required. Many Shared Lives carers have previous experience that they have not yet utilised. Project sites noted that many of the positive outcomes for individuals and Shared Lives carers was due to the past experiences carers had from their past careers.

Apart from approaching current carers you can recruit new carers especially for this area of work. This could open doors to people who would not have considered being Shared Lives carers before. This will mean thinking about where you can promote Shared Lives in your area to attract new people. For ideas on the different ways to recruit carers you can refer to Shared Lives Plus guidance no. 7.07.

Shared Lives schemes in the project tried different ways of engaging with current carers and recruiting new carers:

"I've done cream teas, 1:1 sessions, mailchimp round robins to encourage our carers to come and talk to me about the work and their fears. This has worked to a certain extent as I now have a pool of carers in the pockets where home from hospital work is happening"

Some things you could try:

- Word of mouth – this has proved to be the most effective method. Harness this and ask your carers to put the word out to people they and their family know, work with, socialise with etc. Also include them in recruitment campaigns and events so they can talk to potential carers.

- NHS/CCG local communications – putting adverts and stories into local communications that reach health can raise profile of Shared Lives. Try approaching the local CCG/NHS communications officer.
- When speaking to health professionals, discharge teams etc as part of promoting Shared Lives as a service ask if anyone would be interested or know anyone who may like to find out about becoming a Shared Lives carer.
- Review your promotional materials. Would they attract new carers?
- Contact Shared Lives Plus about any promotional materials they have available. Leaflets and a DVD clip will be available to schemes.

Bolton used the following opportunities to reach those with a health background.

- A monthly bulletin sent to all CCG staff.
- An online noticeboard on the internal part of the CCG's website for staff.
- Our local Foundation Trusts circulate regular newsletters for staff which could contain an advert.
- CCG circulates a practice bulletin every week which goes to all GPs, practices nurses and practice managers in Bolton.
- Our local council also have regular bulletins that are circulated to all their staff who will obviously have a variety of backgrounds, but could include health backgrounds or they have friends/relatives who do.
- Engage with local Healthwatch – Bolton's voluntary members of Healthwatch have a varied mix of backgrounds, including retired health professionals.

Shared Lives carers can be concerned about whether they have the skills required to care for individuals with clinical support needs. They may not feel confident about working with a different client group. These can be addressed by identifying any training needs and careful matching. Carers can be concerned the person may not get support to move on and the arrangement going on for longer than expected. It is important there are plans in place for the transfer of care management when the person comes into Shared Lives. You will regularly monitor the arrangement to ensure plans are in place for the person to move on. Keeping your carers informed of the plans will alleviate any worries they have.

A guide for Shared Lives carers including FAQ is available from Shared Lives Plus can be found on page 40. This is a standalone guide and can be printed off for Shared Lives carers.

Getting processes right

To offer a specific intermediate care service you need to think about whether your current processes will work for people coming out of hospital. Shared Lives schemes who have provided support for people discharged from hospital found their current processes worked with some slight changes to accommodate the quicker arrangements.

This may be a good time to review your processes, so they will be appropriate for all referrals. The Shared Lives Quality Framework sets out a consistent framework for good practice in Shared Lives schemes across the United Kingdom. It is designed to be a practical tool, which aims to enable Shared Lives schemes to:

- identify and evidence good practice
- understand how they can improve, using the wealth of ideas for improvement contained in the quality framework
- provide effective Shared Lives arrangements, for individuals who use Shared Lives and Shared Lives carers
- implement quality as part of the everyday running of the scheme, instead of it being an add on.

The referral, matching and funding processes are discussed separately in this guidance. The other areas that you will need to think about are support planning and arrangement agreements.

Support planning should incorporate a person's goals. If you are using the Shared Lives Plus support plan you can easily include a person's goals on this. You should make sure an enabling approach is used. When setting goals you need to consider what they could do before, what their situation is now, what do they want/need to achieve and how are they going to achieve this. Project schemes did not identify any issues with incorporating a person's needs and goals into their current support plans.

The Shared Lives arrangement agreement is a written agreement made in relation to each individual Shared Lives arrangement. Shared Lives Plus guidance document 2.09 provides a template arrangement agreement.

Of particular importance to intermediate care arrangements are:

- Start and end dates. Here you should include what will happen should the arrangement end prior to these dates or extend longer than planned dates. This could be due to the person being able to return home sooner or requiring a longer arrangement than first planned. There needs to be agreement around a notice period if either party wishes to cease the arrangement.
- Care management responsibilities – the agreement should include who will be responsible for seeing the arrangement through. This is especially important if there is a transfer of care management between the discharge team and community team.
- Funding arrangements – This needs to state who is funding the arrangement. It needs to be clear who will pay the board and lodgings element, depending on circumstances this may be the commissioner or the individual. You can refer to the funding section of the guidance for more details.

Making links with health and getting referrals

Statistics, NHS trusts and news stories clearly demonstrate the need to increase options for people being discharged from hospital. However, it can be challenging to get health professionals to understand and trust the Shared Lives model. Referrals to Shared Lives home from hospital services has predominantly been from social care teams. Shared Lives South West pointed out *“They know us, they know what we do and understand what we can offer. We have a great relationship with them”*. There needs to be a shift in how health care professionals and organisations think about what is on offer and recognise Shared Lives is a positive and viable option for people. Building stronger partnerships with NHS Trusts, CCG’s and health professionals can take time but in the long term will bring a deeper understanding of Shared Lives amongst health teams.

There is a willingness and enthusiasm by commissioners and managers to commission Shared Lives, but this needs to filter down to professionals so they make referrals. You will find that raising awareness and introducing the Shared Lives model to professionals working with individuals can help them to make referrals. Initial referrals tend to come from people who are already familiar with Shared Lives or have links to the Shared Lives team. Although these partnerships work well it is important to increase the number of referrers to maximise the ability of Shared Lives to develop into intermediate care.

Having enthusiastic champions within teams can be effective at promoting Shared Lives. One scheme had a positive relationship with a local commissioner who helped to get referrals from the hospital to the local scheme. However, caution should be taken when relying on the relationship and knowledge of one individual. Teams can have high staff turnover and partnerships based on individual relationships can be unstable; if the person leaves then the connection is lost along with all the work that has been done making those connections.

It can be difficult to navigate through large acute hospitals to find who to contact. Think about targeting a specific ward or area first, as this can be more manageable. Shared Lives 'home from hospital' has worked well for people recovering from a stroke so linking up with the stroke ward could prove beneficial. Contact with mental health services can encourage mental health professionals to consider Shared Lives for people leaving hospital or to avoid admission. Community hospitals or step-down units are worth

contacting as there may be more time to assess an individual's suitability and match them with carers.

Where Shared Lives and health and social care teams have been co located referrals and arrangements have been achieved because conversations are easily held. Although co location may not be a possibility, building the relationships with teams and encouraging them to pick up the phone to talk about potential referrals is good practice. This allows the referrer to get an idea of availability and you can make an initial assessment whether the referral will be appropriate.

Getting health and social care professionals who have not heard of Shared Lives to understand and trust the model takes time. Getting the first referral may take time but if the arrangement is a success you are likely to get further referrals from that source.

To make appropriate referrals professionals need to know what Shared Lives can't do as well as what it can do. A referral checklist has been developed based on the Sunderland reablement tool, this can be used by health professionals as an easy guide to assess if someone's needs can be met in Shared Lives. This is available as part of this guidance.

For professionals to refer they need to know:

- What Shared Lives is?
- Who it can support and who it can't support?
- Who to contact?
- What is the cost and how is it funded?
- What is the process?

In some areas services are block purchased and this can restrict the ability to fund individual services. However traditional services are not appropriate for everyone and people should be offered a choice of support. We would like to see Shared Lives considered as a first option and the more it is used and shown to be successful the likelihood of further referrals increases.

More detail about the referral process is in the referral section of this guidance.

Top Tips

- Find out what your local discharge processes are.
- Make friends with referring teams.

- Take every opportunity to talk to teams and professionals about Shared Lives.
- Share successes.
- Target areas where traditional services do not fit.
- Use the learning from the Shared Lives intermediate care project.
- Be persistent.
- Don't give up.

Training Shared Lives carers to provide intermediate care

What training do Shared Lives carers need?

Intermediate care 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 intermediate care or reablement team members to check progress. The person using Shared Lives will require support to regain or increase their skills so they can return to their own home. This will involve the Shared Lives carer taking an approach that supports a person to do things for themselves rather than the Shared Lives carer doing things for them. Many Shared Lives carers already do this intuitively, but some may require additional support in this area.

Shared Lives carers will already have received general training as part of their assessment and induction to Shared Lives in addition to ongoing training for experienced Shared Lives carers. When reviewing the training offered, you should refer to Shared Lives Plus quality standard framework. Standard 1 states:

It is the responsibility of the Shared Lives scheme to compile training and development programmes suitable to meet the needs of Shared Lives carers. It is important that any training Shared Lives carers attend has a Shared Lives focus, rather than being generic in nature i.e. food hygiene training should focus on food hygiene in a domestic setting rather than a care home. It is also important that any training provided ensures that Shared Lives carers are able to develop the necessary knowledge and skills to support the specific groups of individuals using Shared Lives in the scheme. There is no definitive list of training that Shared Lives carers should attend, however the following list has been identified by Shared Lives schemes as being key:

- Understanding the role of the Shared Lives carer
- Safeguarding adults and children
- Medication and infection control
- Equality and diversity

- The Mental Capacity Act 2005
- Person-centred thinking and planning
- First aid
- Health and safety (including fire safety)
- Food hygiene
- Infection control
- Communication
- Moving and handling

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

Shared Lives carers providing intermediate care need to be able to:

- Focus on the persons own strengths and help them realise their potential to regain independence
- Work in partnership with the person to find out what they want to achieve, agreeing person centred goals.
- Build the persons knowledge, skills, resilience and confidence.
- Learn to observe and guide and not automatically intervene, even when the person is struggling to perform an activity
- Work with a multi professional team
- Understand positive risk taking

These skills and knowledge will meet recommendations made in the NICE guidance on what all staff delivering intermediate care should understand. The guidance also states that intermediate care staff should have the skills to support people to optimise recovery, take control of their lives and regain as much independence as possible. These are principles that will already be familiar to Shared Lives carers.

Understanding health

Individuals being discharged from hospital may have a wide range of health needs and there could be a large element of health involvement. Shared Lives carers will need to be able to understand and support that person with managing any long-term conditions such as diabetes, conditions associated with a stroke, mental ill health, sensory loss etc. Information on health conditions can be found on www.nhs.uk. Health professionals involved in the persons care can provide training to the Shared Lives carer to enable them to support the individual. A Shared Lives carer should not be expected to

deliver health care or a therapy to a person unless under the supervision and direction of a health care professional.

Setting goals

Successful intermediate care/reablement depends on the development of person-centred goals which have been agreed with the person and if appropriate, their family. If the person is being discharged from hospital they are likely to have had the involvement of a multi-disciplinary team and already have been set goals they are working towards. Shared Lives carers will be able to support that person towards these goals throughout their stay. It is therefore important that you and the Shared Lives carers understand the principles of goal setting. You will be able to incorporate any goals into the person's support plan.

Setting goals should always focus on a person's strengths and what they want to achieve. When setting goals they should be realistic and achievable. They do not have to lead to full independence. SCIE state 'The concept of independence is often central to goal-setting. However, there is no single, standard definition of independence'. They recommend that it is important to acknowledge that an individual's definition may be very different to the way a professional would define independence' For some people conserving energy can be more important than doing everything for themselves. For example, if the person can carry out their own personal care but this leaves them too exhausted to do anything else this may not be their preferred goal. Having support with the morning routine could mean they have the energy to go out and meet friends later in the day, this may be more important to the person than being completely independent.

Goals need to be reviewed regularly and the progress a person is making recognised. Shared Lives carers are in a good position to observe and identify what a person's strengths are and what they are struggling with. This can be shared with professionals planning the person's return home. You will know which carers already understand the principles of goal setting through their assessment and/or experience; you can then deliver training to those who require it.

Delivering training

Different approaches can be used to meet the training needs of Shared Lives carers and to ensure they have the required skills to provide safe and effective support to individuals using Shared Lives.

Shadowing the intermediate care team can be a good way to understand their roles and the principles of intermediate care and reablement. If you have a good relationship with the discharge or intermediate care team this could be beneficial to both the Shared Lives carers and the health care professionals as they can each learn about each other's roles.

You can find out what training is already available locally and tap into this. The local authority may already provide intermediate care training to staff and be willing for Shared Lives carers to be included in this. However caution should be used as the training will not be specific to the Shared Lives role. Training can be done on a one to one basis if specific needs are identified.

Individuals requiring intermediate care can have a wide range of needs so it can be difficult for Shared Lives carers to have all the skills required for every person who may be referred. Health care professionals can be asked to deliver specific training and are often happy to do so.

You will already consider what skills your Shared Lives carers have as part of the matching process. This will be the same for someone coming out of hospital. You will look at what the individual's needs are and decide if the Shared Lives carers can support those needs. At this time, you may decide that they require additional training or support prior to the start of the arrangement.

SCIE have an e-learning reablement course for managers and staff delivering intermediate care. This consists of four units each taking around 20 minutes to complete <https://www.scie.org.uk/e-learning/reablement/>

The referral process for Shared Lives intermediate care

You will already have a referral process in place for your scheme. Diversifying into other areas such as intermediate care gives you an opportunity to review your processes and paperwork to ensure they fit within the new area of work. Shared Lives Plus Quality Standard 2 aims to support you to develop efficient and effective referral, matching, introduction and establishing Shared Lives arrangement processes.

Referrals for Shared Lives intermediate care 'home from hospital' are received from various sources including professionals, discharge teams and wards. Many health professionals are unfamiliar with the model and unsure what it can and cannot provide. A Shared Lives referral checklist is available to help referrers see at a quick glance whether a referral may be appropriate. We recommend that referrers make an initial call to Shared Lives to discuss the referral. By doing this you have the opportunity at an early stage to assess whether the referral is appropriate and if you have carer capacity to offer a match.

Referrals should always include the necessary information about an individual and their support needs to enable you to determine the individual's suitability for Shared Lives and ensure you can meet their needs. You can obtain the information and documentation you need at the point of initial referral, then follow up missing information from the referring organisation, professionals, the individual and their family.

What does a good referral look like?

A good referral will have the following information:

- A completed Shared Lives referral form
- An up to date community care assessment and support plan for the individual
- Health needs assessment/OT assessment/reablement plan/goals
- A completed risk assessment where appropriate. If no risk assessment is provided you can request this or carry one out yourself.
- Discharge plan
- Information on person's abilities
- Who are the significant people in a person's life.

- Details of medication. Is this a new medication to the person since hospital admission?
- Reason behind the persons hospital admission.
- Information on specific health needs so any carer training can be identified.
- Any environmental requirements i.e level access

Although discharge planning should commence as soon as a person is admitted to hospital it is more likely that a referral to Shared Lives will come when the person is deemed fit for discharge. Discharge teams can come under pressure to reduce delayed transfers of care. Although you need to be considerate to the need for a prompt response you should not feel pressured to commence an arrangement before you have all the required information to ensure a safe discharge.

NHS England say a person is ready for discharge/transfer when:

- a) A clinical decision has been made that patient is ready for transfer
AND
- b) A multi-disciplinary team decision has been made that patient is ready for transfer
AND
- c) The patient is safe to discharge/transfer.

Contact with the referrer should be made as soon as possible and ideally within 48 hours. By having this early contact you can assess if this is an appropriate referral and whether you have a potential match. If not, the referrer can look at alternative services without further delaying the discharge.

For some individuals there will be more time in the discharge planning process. This can happen when the referral is for people who have been in hospital for some time, for example after a stroke or a period of mental ill health. This enables you to work with everyone involved to ensure a good match and an effective discharge and a successful Shared Lives arrangement.

Following referral

Once you have accepted a referral you can start the process of matching and supporting the persons discharge. It is important that all everything is in place prior to discharge.

You need to ensure:

- You have all relevant information prior to agreeing the arrangement.
- The individual understands what Shared Lives is.
- Funding has been agreed and you know who is paying and for how long.
- Details of medication and a plan how to get further prescriptions. Hospitals tend to send a limited supply home with the person.
- You have contact details of any health professionals involved.
- The person has somewhere to return home to.
- There is a plan for reviewing the arrangement.
- You have a named person who will be responsible for the care management. of the person following discharge.
- Any equipment needed has been arranged.
- The Shared Lives carer is happy and confident for the arrangement to go ahead.

Once the arrangement has commenced you will need to review regularly to ensure the match between individual and Shared Lives carers is working and any goals are being achieved. You will need to ensure that care management are working towards the planned outcomes to avoid the person staying in Shared Lives longer than they need to.

Referral pathway



Referral/arrangement checklist

Process	Yes	No
Is the referral appropriate?		
Has the referrer got the persons consent to refer to Shared Lives?		
Do you have enough information to accept the referral?		
Can Shared Lives meet their needs?		
Do you have a potential match?		
Is there a timescale for discharge?		
Has funding been agreed?		
Is the individual clear what they will have to pay.?		
Is it clear who is responsible for care management after discharge?		
Does the person have complex health needs that require the carer to have additional training?		
Are there any access requirements?		
Is there any equipment needed?		
Has the Shared Lives carer met with the individual?		
Has a discharge planning meeting been arranged?		
Is there a clear plan for moving on?		
Have you agreed a date for discharge?		
Will the person need to register as temporary resident with GP?		

Intermediate care referral criteria checklist

Name:
Completed by:

Date completed:

Domain	Category	Tick
Cognition	Severe disorientation/uncomprehending.	
	Marked problem of memory, disorientation of time, place or person.	
	Mild but definite problem of memory or understanding	
	Occasionally forgetful but orientated to time, place and person	
	Alert and orientated	
Personal Care	Dependent on one or more people with all aspects of care	
	Requires some help with certain aspects of care	
	Requires supervision or motivation	
	Requires assistance with minor aspects of care (e.g. socks)	
	Independent	
Transfers	Immobile/needs hoisting	
	Requires standing equipment and assistance to transfer	
	Requires assistance/supervision to transfer with/without equipment	
	Transfers independently with or without equipment	
Mobility	Unable to mobilise	
	Walks with physical assistance	
	Walks with supervision	
	Independently mobile with wheelchair	
	Independently mobile with frame	
	Independently mobile with crutches or sticks	
	Walks independently unaided	
Stairs	Unable to use stairs	
	Able to use with supervision	
	Independent/not applicable	
Outdoor mobility	Unable to mobilise outdoors	
	Independently mobile within garden/drive	

	Mobile in the community with supervision/assistance	Green
	Independently mobile in the community	Green
Food preparation	Dependent with all meals and drinks	Red
	Needs help with all meals, able to make hot drinks	Green
	Able to make snacks (e.g. cereals and sandwiches)	Green
	Independent (able to make hot meals)	Green
Contenance	All help required (incontinent of urine and faeces)	Red
	Requiring assistance/supervision with continence product	Green
	Incontinent of urine and/or faeces but self sufficient	Green
	Occasional incontinence	Green
	Continent	Green
Medication	Needs full assistance with medication	Green
	Needs helps to take medication out of packets	Green
	Needs reminding to take medication	Green
	Takes medication with or without aids	Green
Night time support	Requires waking night support	Red
	Requires support 1-2 times per night	Amber
	Wakes during night but no support required	Green
	Independent sleeps well	Green
	Red = Not suitable Amber = Matching consideration Green = suitable	

Based on Sunderland reablement tool.

Matching

One of the most important responsibilities of a Shared Lives scheme is to ensure that effective matching and introductions occur between a Shared Lives carer and an individual wanting to use Shared Lives. Shared Lives Plus quality framework standard 2 covers the referral, matching and introduction process and should be referred to alongside this guidance.

Matching is an important element that makes Shared Lives unique. When someone is ready to leave hospital, there is pressure for discharge to take place quickly. However, it is essential that the ethos of Shared Lives remains and matching the individual to a suitable and compatible Shared Lives carer still takes place.

As a Shared Lives scheme you need to consider how you will manage the limited timescales available to do the matching and introductions. You will already have a good knowledge of the Shared Lives carers skills, knowledge, experience, values, personal interests and the suitability of their home and who they live with. Some schemes contacted all carers when first starting home from hospital and build a lot of carers interested in this area of work. By using this information you can start to get an idea of who may be a suitable match when you receive a referral. You can use Shared Lives carer profiles to introduce the idea of Shared Lives to an individual. These show them where and who they would be staying with. These profiles can be created in various formats ranging from photo profiles, talking books and videos.

Intermediate care arrangements are expected to be short term and time limited. You will therefore not be matching for long term compatibility. Until you have a good number of Shared Lives carers there will be more focus on suitability of accommodation and carers skills, but they still need to get along. Shared Lives carers need to be available for the whole of the agreed time so you will need to take into account how long the arrangement is expected to last.

Dependent on discharge plans it may not be possible for the person to have an introductory visit to the Shared Lives carers home. The Shared Lives carers should visit the person in hospital to start to build a supportive relationship and to get to know each other. This may only involve one or two visits. The visit needs to happen quickly to avoid delays to discharge. During

the intermediate care project Shared Lives schemes aimed to visit the day following referral. In some circumstances a home visit with the intermediate care team and occupational therapist is arranged to assess whether any aids are needed in the home.

To ensure a safe and suitable match a referral should include sufficient information about an individual and their support needs to enable you to determine if you have a suitable carer who can meet the person's needs. The potential carer will need also need to have information to decide if this is a suitable match. Hospitals will be under pressure to discharge patients and are unfamiliar with the matching process. Their assessment and referrals are unlikely to include the level of information that will support the matching process, therefore you will need to obtain further information from meeting the individual, their family and ward staff. Creating a pen picture at this time will help Shared Lives carers decide if this could be a suitable match.

If you have a good relationship with the intermediate care or discharge teams you can approach them with details of available carers and discuss whether anyone approaching discharge would be a suitable match. This helps to get referrals you can match. Always encourage referrers to pick up the phone to chat about the referral as this will save time and avoid referrals being made that you are unable to match. On occasion a person may be referred but a match is not available. This needs to be explained to the discharge team/referrer and the person as soon as possible so alternative arrangements can be made and delays to discharge are avoided.

The experience of Shared Lives schemes who made arrangements have found their current matching processes work. Scheme workers were adept at identifying matching issues at early stages. They found the limitations to matching related to the small pool of available carers. They found that although their matching processes worked extra consideration was needed to the following:

- Suitability of accommodation
- Expected length of arrangement – is there flexibility with carers if person is not ready to return home after this time
- Any health conditions the Shared Lives carers will need support to manage
- Shared Lives carers having commitments that might limit the length of the arrangement.

Many of the pilot schemes found that they were able to adapt to the shorter time limits whilst still maintaining a good match. Not all discharges need to be completed in a tight time frame. In many circumstances discharge can take place in a planned way allowing more time for matching and visits. A lot of this is dependent on where the referral is coming from and the circumstances of the discharge.

Funding information for schemes -

Shared Lives intermediate care

Background

The aim of intermediate care 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 time. Intermediate care offers short term rehabilitation to people following illness or accidents. It may take place in the user's own home, in a care or residential home or in a community hospital and now increasingly is being offered by Shared Lives schemes. Intermediate care can last a few days or weeks, depending on the individual's circumstances.

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. Reablement is generally provided to people whilst in their own homes; however, the principles of reablement can be applied to people using Shared Lives intermediate care.

Reablement is about helping people to do things for themselves, rather than doing things to or for people.

Funding for Shared Lives intermediate care may come from different streams. This information has been put together to help Shared Lives schemes to think about how and where funding may come from and what they will need to consider when developing into this area.

What does the service cost?

The fees for a Shared Lives arrangement comprises of a monetary payment to the carer, the scheme costs for providing, monitoring and managing the Shared Lives service and a contribution by the person using Shared Lives towards food and household costs. All arrangements are made through a Shared Lives scheme and not directly with carers.

Shared Lives can be funded by a local authority, health, personal budgets or someone funding themselves. To obtain funding from the local authority or health budgets an individual will need to meet the funders eligibility criteria. Funding will depend on the assessed needs of the individual.

Shared Lives schemes are either run by local authorities, charities, social enterprises and independent companies. Shared Lives schemes fees can vary widely depending on the provider and area. However, the average cost tends to be around £100 per night.

When you are considering fees for intermediate care you should recognise the additional support Shared Lives carers will be giving to individuals who are coming out of hospital. If you use a banding system, then a higher band is usually appropriate and can still be cost effective against other intermediate care services.

Management Fees

Management fees are charged by Shared Lives schemes to commissioners to cover costs involved in providing a Shared Lives service. This is to meet scheme costs including infrastructure costs, scheme staff, travel, office running costs etc and the cost of ensuring the Shared Lives carer(s)'s terms and conditions of service are met.

When providing Shared Lives intermediate care, you need to consider including a weekly management charge as part of the total arrangement fee. The management charge will be set at a level that reflects the total costs incurred by the Shared Lives scheme in supporting the arrangement. Non local authority schemes will already do this as part of their fee structure. If you are a local authority scheme you will need to look at how you include a management fee. You will also need to ensure processes are in place that will allow payment from sources other than social care.

This should be normal practice for independent schemes, however local authority schemes may need to look at how fees and management costs can be processed for non-local authority funded arrangements.

Accommodation, Board and Lodgings

Shared Lives fees are made up of 3 elements: care and support, accommodation and food and utilities (board).

In a traditional short break, the individual using the service would contribute an amount for their board. They would not normally be expected to pay a fee for their accommodation as they would still be paying this for their main residence. The accommodation cost would therefore be included in the fee paid by the funder. This will be no different for intermediate care.

The board and lodgings element is not so straight forward. People who use Shared Lives when discharged from hospital do so for various reasons therefore funding can come from different sources. If the arrangement is social care funded, then the person will be most likely have to pay the board and lodgings element themselves. If it is a six week intermediate care arrangement paid by intermediate care funding the funder may pay the full cost.

It is important you establish who is paying for what before the arrangement commences and that all parties agree. You need to include all details of the payment and fee structure in the arrangement agreement.

Cost comparisons

Shared Lives is a cost effective service and compares favourably to the cost of an excess bed day in hospital. Savings associated with longer term benefits to the health and wellbeing of individuals including any reduction in hospital re-admission rates can be made. If you collect evidence of this it can help you to demonstrate the benefits to developing Shared Lives intermediate care to commissioners.

The following costs are currently used for comparison:

- Excess bed day in acute hospital £303
- Bed based intermediate care service average cost £207 per day
- Shared Lives average £100 per day

Using these figures, Shared Lives can be a cost effective service compared to hospital and bed based intermediate care.

Comparing costs to residential care homes has been challenging due to the variables in care home fees. Residential fees vary widely between geographical areas, what local authorities will pay and the fees charged to self-funders. Therefore, it is recommended you find out what the costs are in your local area and to do a comparison against them.

Intermediate care and home from hospital services can be seen to be cost effective against a hospital stay, thus creating savings for health care. This however would not be a saving for social care commissioners and this needs to be considered when thinking about costs and who the savings would benefit. Social care commissioners may use the comparisons to residential care beds which may be lower than Shared Lives in some areas, so it can be useful to check in your area.

Cost should not be the only factor when considering Shared Lives as a home from hospital service; the positive outcomes for individuals and the benefits of being involved in the community and family life of Shared Lives carers should not be under estimated.

Commissioning a service

Shared Lives fees and how to contract with schemes can be variable depending on who they are run or managed by. Local authority schemes may have restrictions or an eligibility criterion for who they can provide the service to. People with direct payments may be required to have a managed budget to purchase from a local authority Shared Lives scheme.

Shared Lives schemes should think about what they charge for the service as this may not have been something they have considered before, especially if all referrals had previously come from the local authority. Providing Shared Lives to health or self-funders will require a clear pricing structure which includes carer payments and management fees.

When a service is being commissioned for a specific time scale then consideration needs to be given as how funding for further support will be provided if the arrangement is extended longer than first expected.

What are the likely charges to the service user

A local authority must not charge for rehabilitation, intermediate or reablement services. Charging regulations describe them as a programme of care and or support, that is for a specified period of time; and has as its purpose the provision of assistance to enable the individual to maintain or regain the ability needed to live independently in their own home. They state they must be provided free of charge 'for the first 6 weeks of the specified period or, if the specified period is less than 6 weeks, for that period'. This does not affect the fee for Shared Lives but will mean that an individual is not

charged for a contribution towards their care and support. www.legislation.gov.uk/ukxi/2014/2673/pdfs/ukxi_20142673_en.pdf

People may not meet the above requirements, for example if the delay in discharge is due to lack of availability of a home care package or if they are waiting for adaptations to their own home. In this case the person may be financially assessed and may need to pay a contribution towards their support.

The LA/CCG should make clear to the individual using Shared Lives what they will be charging them towards the arrangement.

Self funders

Self-funders are individuals who are assessed to be in a financial position to pay the full cost of their own support.

People may self-fund their care and support because:

- 1) They have not approached public authorities and made their own arrangements for their care and support.
- 2) They have been assessed by the Local Authority and do not meet the threshold for publicly funded assistance.
- 3) They have been assessed by the Local Authority as being eligible for care and support services but have savings or assets above the self-funding threshold set by the government currently, £23,250. For this guide this group will be referred to as full charge rather than self-funder.

Self-funders have the right to request guidance and practical help with arranging their care and support from their local authority. Self-funders can also arrange to meet their own needs if they are able to do this themselves or have adequate support to do this for them. Therefore, you may be approached by someone who wishes to purchase the service directly with no involvement from the local authority. You will need to have a clear fee structure so self-funders know what they are paying for.

Personal budgets

A personal budget is an amount of money that is allocated to meet individuals assessed eligible needs. This is funded by the local authority. The person can ask for

a direct payment or have a managed budget where the local authority manage and commission the services to meet the persons need.

If a local authority agree to pay for some or all of an individual's care and support they must offer choice over how to meet those needs.

An individual can use their personal budget to pay for Shared Lives. If the Shared Lives scheme is run by the local authority then the person may be required to pay for the service via a managed budget.

Personal health budgets

A personal health budget is an amount of money to support the identified healthcare and care needs of an individual, which is planned and agreed between the individual, or their representative, and the local clinical commissioning group (CCG). It isn't new money, but a different way of spending health funding to meet the needs of an individual.

Personal health budgets are one way to give people with long term health conditions and disabilities more choice and control over the money spent on meeting their health and wellbeing needs.

A personal health budget may be used for a range of things to meet agreed health and wellbeing outcomes. This can include therapies, personal care and equipment. There are some restrictions in how the budget can be spent.

Personalised care and support planning is essential to making personal health budgets work well. A personalised care and support plan helps people to identify their health and wellbeing goals, together with their local NHS team, and sets out how the budget will be spent to enable them to reach their goals and keep healthy and safe.

Continuing health care

NHS continuing healthcare is a free package of care for people who have significant ongoing healthcare needs. It is arranged and funded by the NHS. individuals can receive NHS continuing healthcare in any setting outside hospital, including Shared Lives. Continuing Health Care will fund care and support without any cost to the individual. CCG's will commission services including Shared Lives or the person could request a personal health budget.

Section 117

Section 117 aftercare will fund the support people require once they leave hospital. It is applicable to people who have been detained in hospital under a section of the Mental Health Act. This can cover all kinds of support like healthcare, social care and supported accommodation.

Section 117 of the Mental Health Act says that aftercare services are services which are intended to meet a need that arises from or relates to a person's mental health problem and reduce the risk of their mental condition getting worse, and having to go back to hospital. The Local Authority or CCG will be the responsible organisation to arrange services for those in receipt of section 117.

Section 117 funding is available to provide care, support and accommodation costs, therefore it may be used to fund the accommodation element of Shared Lives.

Equipment and adaptations

Shared Lives Carers may need to make some minor adaptations to their homes to make them more accessible for older people and others. This can present carers and schemes with the dilemma of who should pay for these. Ensuring a Shared Lives carers house is suitable for people being discharged from hospital could increase the number of people able to use the service and reduce the instance of delayed discharges. Therefore, it could be an incentive for local authorities to fund small adaptations or equipment, so it may be worthwhile having a conversation about this possibility.

Minor adaptations and equipment costing less than £1000 are provided by local authorities at no charge to those who require them. Minor adaptations include grab rails, chair and bed blocks, raised toilet seats and bath seats. These items would be assessed for individuals in need of them, but if these items are used at a Shared Lives carers home they would need to go with the person when they return home.

Disabled facilities grant's (DFG) are only available to adapt properties where a person lives, so would not be available to Shared Lives households providing short term arrangements. Further information about DFG can be found at <https://www.gov.uk/disabled-facilities-grants>

Care and Repair are able to do small adaptations and it is worth seeing if they are available in your local area.

Better Care Funding

The Better Care Fund is a mechanism to support joint health and social care planning and commissioning.

It brings together separate budgets from Clinical Commissioning Group, Disabled Facilities Grant and this is paid to local authorities for adult social care. These combined funds are referred to as the Improved Better Care Fund (IBCF).

The spring budget 2017 announced £2 billion extra funds to support adult social care. This money is included in the IBCF grant paid to local authorities. The additional £2 billion announced in the spring budget has been provided for the following purposes.

- Meeting adult social care needs.
- Reducing pressures on the NHS including reducing delayed discharges
- Ensuring the local social care provider market is supported.

<https://www.england.nhs.uk/wp-content/uploads/2017/07/integration-better-care-fund-planning-requirements.pdf>

Section 75 partnership agreements

Section 75 partnership agreements are legally provided by the NHS Act 2006, they allow budgets to be pooled between local health and social care organisations and authorities. These agreements enable resources and management structures to be integrated and functions be reallocated between partners. The pooling of budgets aims to allow greater flexibility in commissioning services to meet the needs of the local population. Flexibility across health and social care budgets can allow resources to be used where they are most needed.

What do Shared Lives schemes need to think about when delivering intermediate care?

Prior to any intermediate care arrangement you should ensure:

- Funding has been agreed and you know who will be commissioning the service.

- The person using the service are aware of how long the funding has been agreed for and what the plan is after that date?
- If funding is to be transferred from health to social care, how this will happen.
- It is clear to the individual using the service what they will be paying for i.e food/household costs.
- The agreements are clear about fees and who has the responsibility to pay these.
- Processes are in place to receive funding from all sources including health and self-funders.
- The scheme has agreed a fee structure for intermediate care.

Guide for commissioners - Shared Lives intermediate care

In Shared Lives, a Shared Lives carer shares their home and family life with an adult who needs care or support to help them live well. Local Shared Lives schemes, which are regulated by the Care Quality Commission individually match trained and approved Shared Lives carers with people who need their support. In Shared Lives, the goal is an ordinary family life, where everyone gets to contribute, have meaningful relationships and are able to be active, valued citizens.

People using Shared Lives are supported by their Shared Lives carer to develop or maintain independent living skills, friendships and live as part of their local community; giving them a sense of wellbeing in a safe and supportive environment.

There are an estimated 11,880 people supported in Shared Lives in England and 13,450 across the UK. They are primarily adults with learning disabilities, mental ill health, autism and dementia, older people, young adults in transition, and people with a wide range of other support needs.

Shared Lives can help to reduce delayed discharges and provide support to people who require intermediate care by:

- Becoming involved when a person enters hospital and it is clear that they will not be able to go straight home after the intervention.
- Working with hospitals and discharge teams to identify people who could benefit from Shared Lives when they are ready to leave hospital but not yet ready to return to their own home.
- Shared Lives would be able to continue to provide support at the end of the intermediate care stay through day support and short breaks, enabling them to remain independent for longer and providing additional support to their family carers.
- People with multiple health issues requiring frequent visits to hospital would receive on-going support for all aspects of their care from the same Shared Lives carers providing continuity. The person could then use Shared Lives for support when needed rather than a hospital visit.

Shared Lives has proved to be particularly effective for people leaving hospital where traditional services have not been suitable, for example younger people recovering from a stroke, individuals being discharged from hospital following a period of mental ill health and people requiring support until their accommodation is made suitable for them to return home.

Finding innovative and cost effective solutions to help deliver good quality outcomes for people who require intermediate care or reablement services is increasingly important. Shared Lives can offer financial savings as well as delivering positive outcomes for people and reduce the number of days people stay in hospital when they no longer need to be there.

The following costs demonstrate the savings that can be made:

- The mean cost per occupied bed per excess bed stay per day is £303 (DOH, reference costs 2016).
- The mean cost per service user for bed based intermediate care is £5672 per episode with an average length of service 26.8 days (NAIC 2015)
- The mean cost per reablement episode reported by commissioners is £1,484 for 2014/15 with the average time of service 34.5 days (NAIC 2015).

Compared to this the cost for a 24 hour stay with a Shared Lives carer is generally less than £100.

Steve's story

'I was living with my partner, running a B&B when I had a serious stroke and later two minor heart attacks. After four months in hospital, I was depressed, frail and my memory and cognition had deteriorated.

We knew I needed more support with daily living than my partner could provide. I was unable to return home and it made me frightened about my future, with clinicians uncertain about my further recovery. I wanted to live locally, so I could continue seeing my partner and I missed my dogs.

The Shared Lives scheme matched me, with two trained and approved Shared Lives carers who shared my sarcastic sense of humour, had dogs, and lived close by. They helped me through it all. When I arrived at their home, I never dreamt of being so independent again. I couldn't walk down the drive. Now I can nip up to town.

My Shared Lives carers helped me gain strength and confidence, walking a little bit further each time, until I could walk independently again. They helped me adapt to my memory loss with strategies for managing money and banking, and supported me to make meals and manage my diet.

Since then I have booked a holiday and travelled on my own. I am very optimistic about life and planning a move into my own flat. Without the Shared Lives scheme I would have undoubtedly spent longer in hospital, had less choice about where I lived, and had a slower recovery.'

Shared Lives schemes are keen to develop services for people being discharged from hospital and welcome conversations with commissioners to support this work. A challenge Shared Lives have in developing intermediate care has been the slow pace at which health and social care systems recognise and embed new and innovative models. However when Shared Lives has been commissioned to support hospital discharge or avoid a hospital admission it has proved successful.

You can find out more by talking to your local Shared Lives scheme or contacting us.

Your local scheme is:

[Place local scheme details here](#)

Or contact:

Shared Lives Plus

G04, The Cotton Exchange, Old Hall Street, Liverpool, L3 9JR

0151 227 3499

info@sharedlivesplus.org.uk

www.SharedLivesPlus.org.uk

Guide for professionals - Shared Lives intermediate care

What is Shared Lives?

In Shared Lives, a Shared Lives carer shares their home and family life with an adult who needs care or support to help them live well. Local Shared Lives schemes, which are regulated by the Care Quality Commission individually match trained and approved Shared Lives carers with people who need their support. In Shared Lives, the goal is an ordinary family life, where everyone gets to contribute, have meaningful relationships and are able to be active, valued citizens.

People using Shared Lives are supported by their Shared Lives carer to develop or maintain independent living skills, friendships and live as part of their local community; giving them a sense of wellbeing in a safe and supportive environment.

There are an estimated 11,880 people supported in Shared Lives in England and 13,450 across the UK. They are primarily adults with learning disabilities, mental ill health, autism and dementia, older people, young adults in transition, and people with a wide range of other support needs. Shared Lives is increasingly being offered to people who are ready to be discharged from hospital but not yet ready to return to their own home.

What support can Shared Lives provide?

The individual will stay with the Shared Lives carer as part of their home, family and community life. They can support individuals with:

- Personal care
- Increasing independence and regaining skills to return home
- Learning new skills
- Managing long term health conditions
- Reducing loneliness
- Making links back into the community
- Nutrition
- Support with medication
- Support to attend outpatient appointments

The person will be staying with the Shared Lives carer in an ordinary family home so the Shared Lives carer will not be able to provide 24 hour care and support. Complex health needs which require support that cannot reasonably be met within a family home will not be suitable for Shared Lives.

How can Shared Lives support hospital discharge?

Shared Lives can help to reduce delayed discharges and provide support to people who require intermediate care by:

- Becoming involved when a person enters hospital and it is clear that they will not be able to go straight home after the intervention.
- working with hospitals and discharge teams to identify people who could benefit from Shared Lives when they are ready to leave hospital but not yet ready to return to their own home.
- Shared Lives would be able to continue to provide support at the end of the intermediate care stay through day support and short breaks, enabling them to remain independent for longer and providing additional support to their family carers.
- People with multiple health issues requiring frequent visits to hospital would receive on-going support for all aspects of their care from the same Shared Lives carers providing continuity. The person could then use Shared Lives for support when needed rather than a hospital visit.

Shared Lives has proved to be particularly effective for people leaving hospital where traditional services have not been suitable, for example younger people recovering from a stroke, individuals being discharged from hospital following a period of mental ill health and people requiring support until their accommodation is made suitable for them to return home.

Is Shared Lives safe?

The Care Quality Commission (CQC) consistently rate Shared Lives as the safest and most effective forms of care and support and this continues to remain the case under their new inspection regime.

As of 20th December 2016, 86 Shared Lives schemes had published inspections, with 78 (91%) being rated as good, 4 (4.5%) outstanding and 4 (4.5%) being rated in need of improvement.

Shared Lives carers are assessed and approved following a rigorous process. They receive training specific to the support they provide and receive regular monitoring from the Shared Lives scheme.

How much does it cost?

Shared Lives is a cost-effective service compared to more traditional services. Generally, the cost is less than £100 per 24 hours which includes a payment to the carer, the scheme costs for providing, monitoring and managing the Shared Lives service and a payment for food and household costs. Each local Shared Lives scheme will set their own fees and can vary dependent on the person's needs. Funding needs to be agreed prior to any arrangement commencing.

How do I make a referral?

It is recommended that you contact the Shared Lives scheme direct to have a conversation about the potential referral. This will help to establish if the referral is appropriate, what the availability is and answer any questions you or the person has. The referral will need to be accompanied by a needs assessment, any health assessment, reablement plans and risk assessments. Once the referral has been made the Shared Lives scheme along with the Shared Lives carer will arrange to meet with the person and yourself. Discharge plans will be confirmed along with the plan for the person to progress from Shared Lives back home.

What do people say about Shared Lives?

Steve's story

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Since then I have booked a holiday and travelled on my own. I am very optimistic about life and planning a move into my own flat. Without the Shared Lives scheme I would have undoubtedly spent longer in hospital, had less choice about where I lived, and had a slower recovery.'

View from a social worker following hospital discharge

"The Home from Hospital Scheme offers a person centred, gradual approach to reintegration into the community. We were extremely pleased with the personalised approach to recovery from a long term hospital stay. The Shared Lives carer enabled the individual to regain confidence and identified areas of concern whilst feeding this back to both the shared lives team and their community team.

During the preparation to discharge, the individual was involved in all processes and central to all decisions. The shared lives carer offered a holistic approach to support identifying not only the individual's primary need of their mental health, but also supporting with their physical health.

This scheme offers a unique, personalised service that this individual considered as invaluable in their recovery. It's an excellent service that I would highly recommend."

How do I find out more?

You can watch a short animation film about Shared Lives and hospital discharge
https://www.youtube.com/watch?v=Yrl4c9_UMJQ&t=3s

You can find out more by talking to your local Shared Lives scheme or contacting us.

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Place local scheme details here

Or contact:

Shared Lives Plus

G04, The Cotton Exchange, Old Hall Street, Liverpool, L3 9JR

0151 227 3499

info@sharedlivesplus.org.uk

www.SharedLivesPlus.org.uk

Information for Shared Lives carers

What is intermediate care 'home from hospital'?

The aim of intermediate care is:

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

Everyday people remain in hospital when they no longer need to be there.

There are lots of reasons why some people are unable to return home straight away including:

- people waiting for their house to be made suitable.
- people requiring more time to recover following medical conditions such as a stroke or needing support to manage a long term medical condition.
- people who have had a period of mental ill health which required a hospital admission
- older people requiring more time to recover and regain their strength and confidence following a hospital stay
- people who are waiting for the start of domiciliary care services.

As a Shared Lives carer you would be supporting people when they leave hospital to regain skills and confidence and are better prepared to return to their own home.

Shared Lives carers intermediate care FAQ

Will I be able to meet the person first?

Yes, it is important that you get to meet the person and get to know each other. You would need to visit the person in hospital. Your Shared Lives worker will arrange this for you. Having a profile with photos and information about yourself and your home will help with the matching.

How much and how will I get paid?

Ask your scheme about the fees for intermediate care. The fees will take into account the level of support you will be providing. This is often at the higher rate

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due to the additional support people require when coming out of hospital. The Shared Lives scheme will administer the fees and pay this to you as per their local process. The fee will include payment towards care and support, accommodation and board and lodgings.

The arrangements for payment of the board and lodgings can vary dependent on whether this is a health or social care funded arrangement. Your local scheme will confirm the amount you will receive and how it will be paid; details of the fee will be included in the arrangement agreement.

If the person is able to return home earlier a notice period is required, this will be detailed in the arrangement agreement. You will be paid during this notice period.

How long are arrangements expected to last?

Intermediate care tends to last up to 6 weeks. However, the intermediate care project found some lasted longer and a few turned into long term arrangements. It is dependent on the individual's needs and circumstances how long an arrangement will last: however an idea of timescale will be known prior to the arrangement starting. If you have any commitments that will limit the time someone can stay, you will need to let the Shared Lives scheme know so that this can be considered in the matching process. If a person is considering a long-term arrangement after they have stayed in intermediate care the person may need to be matched to a long term Shared Lives carer.

What if the arrangement lasts longer than expected?

Arrangements are monitored regularly so any changes to timescales can be identified and discussed as soon as possible. If you are able to continue with the arrangement longer than first planned then the arrangement can be extended and payments will continue. This will be agreed with all parties and the agreement updated to take account of the change.

If you are unable to continue to provide support longer than the agreed period alternative support will need to be arranged. Your Shared Lives worker will work with those involved to make sure that services are in place so the person can move on.

I have been a Shared Lives carer for people with a learning disability, how will this be different?

Intermediate care is a different area of work compared to the traditional role. This will be short term arrangements with very clear aims and goals to achieve by the

end of it. The person using Shared Lives will require support to regain or increase their skills ready for their return home. This will involve you taking an approach that supports the person to do things for themselves rather than doing things for them. As a Shared Lives carer you probably already do this intuitively.

Alternative day support will not be in place and the person will be at home with you most of the time. Some individuals require support from therapists who will visit and work with the person in your home. This is likely to be more at the beginning of the arrangement and reduce as the person improves.

Will I have to do more paperwork?

As a Shared Lives carer you are expected to maintain records. For people coming out of hospital it is important that there is a record of how a person is working towards their goals, what they have achieved and any areas that they continue to require support with. You already need to complete records as a Shared Lives carer such as medication records and this will be no different for intermediate care. Your Shared Lives worker will be able to give you full details about what is expected.

What training will I receive?

As a Shared Lives carer you already have a lot of the knowledge and skills required. You need to support people to do things themselves rather than do things for them and therefore an understanding of the principles of reablement will be needed. SCIE have an e-learning reablement course for staff delivering intermediate care. This consists of 4 units each taking around 20 minutes to complete. This can be accessed on-line at <https://www.scie.org.uk/publications/elearning/reablement/>

An understanding of a person's medical conditions such as diabetes will be needed. Your Shared Lives scheme will arrange any additional training or support that you need to support the person. NHS has a resource online where you can look up conditions <https://www.nhs.uk/conditions/>

Information on health issues commonly associated with older people and other resources are available from Shared Lives Plus, your scheme worker will be able to access this for you.

You can discuss any concerns or training needs with your Shared Lives worker. If you have a support carer you will need to talk to your scheme worker about any training they may require and how this will be provided.

What if I need extra help outside office hours?

Your Shared Lives scheme will let you know what support they can offer outside of office hours. You will be able to use universal services such as GP out of hours, out of hours duty social work team, NHS 111. The persons support plan will include details of professionals involved and how they can be contacted. If the intermediate care team is overseeing the persons support, they can also be contacted.

What happens if it is not working out?

As with any arrangement, if it is not working out talk to your Shared Lives worker as soon as possible to see if anything can be done to help. If the arrangement cannot be sustained then the Shared Lives scheme will work with everyone involved to find alternative support for the individual. Sometimes things do not work out, it is important to talk to your Shared Lives scheme so that you are not left feeling worried or despondent.

Who else will be involved in a person's care?

When a person is discharged from hospital health and social care professionals may still be involved. This will be detailed in their support plan. The professionals may visit the person in your home or sometimes the person will access the services locally. You may be required to support the person to appointments, generally the person will pay the costs associated with this.

Will the NHS forget about the person once discharged?

It is important there are plans in place for the transfer of care management when the person comes into Shared Lives. Your Shared Lives scheme will regularly monitor the arrangement to ensure that plans are in place for the person to move on. Sometimes the individual will no longer require NHS involvement and the person will be transferred to a community team.

Lesley – Shared Lives carers experience.

'I worked for Medway council for 37 years before retiring to care for my husband who died last year after a long illness. Having been in and out of hospital over several years with my husband, I saw first-hand the numbers of people who were medically ready to leave hospital but had nowhere to go: no one to care for them at home, properties that were inaccessible or inappropriate to return to.

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With the experience of care giving, liaising with health professionals and a home that had been adapted and made accessible for my husband I wondered what to do next; I didn't want to just sit at home with my cats, fish and tortoise. That's when I found out about Shared Lives and applied to become a Shared Lives carer.

I particularly wanted to be able to use my skills and experience to support people coming out of hospital to provide a short stay before they were able to move home or on to an alternative setting.

I didn't want to do this on a full time, long term basis, so instead offer short stays for people who are leaving hospital or need a respite break for people living with a family carer. This means that I still have time for myself and my own family, and to have a break myself from time to time.

Since becoming a Shared Lives carer, I have supported a number of people. An older lady in her 80s stayed for around three months during which she gradually re-gained skills and confidence before moving on to her own property. Enabling people and seeing them re-gain independence gives me the 'wow' factor, a sense of elation and a boost to know that I am making a difference to the people I support which I find deeply rewarding.

I have also supported a gentleman who stayed for a few weeks after a hospital operation. During this time, I was able to support his family carer to learn the new procedures that were needed to support with his healthcare needs so that she was confident when he moved back home. This gentleman now visits my home for respite when his carer needs a break, both knowing that I know him well and can support his health and care needs: the alternative would be a nursing care home but both he and his carer are happier knowing he's going to a family home.

Initially my own family, children and grandchildren, were concerned that I'd be taking on too much, but since seeing Shared Lives for themselves they've embraced my new role. The people I have supported have been involved in family birthday gatherings and

Sunday dinners, and the grandchildren see it as second nature and the people I support are simply 'part of the family'.

Will I need to adapt my home?

Having accessible and ground floor accommodation will increase the amount of people who can be matched with you. However, this is not a requirement. The person's needs will be taken into account when your Shared Lives worker is considering a match. Some small pieces of equipment may come with the person for example toilet frame, chair raisers but this will be discussed prior to the arrangement.

Will there be opportunity to continue to help the person once they have returned home?

If the person continues to need support when they return home there could be opportunity for you or other Shared Lives carers to provide day support or short breaks. Many Shared Lives carers develop supportive relationships with those they have supported and will maintain some form of contact.

How do I find out more?

You can watch a short animation film about Shared Lives and hospital discharge https://www.youtube.com/watch?v=Yrl4c9_UMJQ&t=3s

You can find out more by talking to your local Shared Lives scheme or contacting us.

Your local scheme is:

Place local scheme details here

Or contact:

Shared Lives Plus, G04, The Cotton Exchange, Old Hall Street, Liverpool, L3 9JR

0151 227 3499

info@sharedlivesplus.org.uk

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Business case for Shared Lives

working with Intermediate Care

Introduction

Shared Lives remains a little-known form of social care which has been mostly used for people with learning difficulties and mental ill health. There are 150 schemes throughout the UK. Across England 12,350 people now use Shared Lives, an increase of over 30% in five years.

The majority of people using Shared Lives have a learning disability (69%) however 360 people who use Shared Lives have a support need associated with older age and 460 with dementia. Over the past 6 years the number of people aged over 65 who are using Shared Lives has increased by 800 people or 64%. The number of schemes offering arrangements to older people and people needing intermediate care is growing but is nowhere near its full potential. This paper looks at the potential benefits to people in intermediate care and reablement, their family carers, commissioning authorities and to the wider community.

Simon Stevens, Chief Executive NHS England introduced the Shared Lives State of the sector report 2016/17 by saying:

'This is a time when we need to think about new and radical options to support people with health needs, making use of community based solutions which can be more cost effective than traditional institutional care. Where people can receive the treatment they need whilst remaining in their community, living amongst family and friends, they have the best chance of building long term health and resilience.

Shared Lives offers an alternative approach for people who need support, where trained Shared Lives carers share their own homes and family lives with adults after a careful matching process. This approach has a strong track record as a social care service going back many years and as this report shows, continues to grow in what is an increasingly challenging context for social care.

There is real potential for new partnerships between the NHS and agencies which provide and commission Shared Lives. This report helps provide foundations for that dialogue, which could lead to many more people receiving the kind of care they want, where they want it, and challenge assumptions about what can be delivered in an ordinary family home.'

Introduction to Shared Lives

In Shared Lives, a Shared Lives carer shares their home and family life with an adult who needs care or support to help them live well. Local Shared Lives schemes, which are regulated by the Care Quality Commission individually match trained and approved Shared Lives carers with people who need their support. In Shared Lives, the goal is an ordinary family life, where everyone gets to contribute, have meaningful relationships and can be active, valued citizens.

Shared Lives enables people to live life to the full in their community, without having to live alone or in a care home. Individuals who need support are matched with compatible Shared Lives carers and families, who support and include an adult in their family and community life. In many cases that person moves in, to become a permanent part of a supportive household, although Shared Lives is also used as day support and as regular short breaks for unpaid family carers. People using Shared Lives are supported by their Shared Lives carer to develop or maintain independent living skills, friendships and live as part of their local community; giving them a sense of wellbeing in a safe and supportive environment.

There are an estimated 12,350 people supported in Shared Lives in England and around 14,000 across the UK. They are primarily adults with learning disabilities, mental health issues, autism and dementia, but also come from every type of adult social care client group. 18% of people using Shared Lives are aged 65 and over, 4% of these people have a support need associated with old age other than dementia.

The Care Quality Commission (CQC) consistently rate Shared Lives as one of the safest and most effective forms of care and support. The CQC State of Care report 2017 shows that 96% of Shared Lives schemes were rated good or outstanding by care inspectors in England, leading the social care sector for safety and quality.

Shared Lives carers are recruited and approved through a rigorous assessment process which is itself subject to quality assurance by independent panels in most schemes. Shared Lives carers help people to develop independent living skills, friendships and roots in their community. Shared Lives always involves the Shared Lives carer sharing their home and family life with the person using Shared Lives. It can be offered to anyone aged 18 or over and is increasingly being used in some areas to support young people in transition aged 16/17. A maximum of three people may be supported at any one time by a Shared Lives carer.

Types of Shared Lives arrangements

There are different types of Shared Lives arrangement that people access:

- Live-in Shared Lives: where an individual with support needs lives with a Shared Lives carer and their family – (this is sometimes referred to as “long term”).
- Short breaks: an individual will stay with their chosen Shared Lives carer on a regular basis, from one night to several weeks.
- Day support: an individual receives support from their Shared Lives carer during the day. The Shared Lives carer’s home is used as a base for community activities.
- Intermediate care – Short term arrangement to support an individual to return home following a stay in hospital, to prevent hospital admission or avoid a move to a care home.

Shared Lives Plus

We are the UK membership network and charity for the Shared Lives and Homeshare sectors. We also support the expansion of schemes and help them to develop their offer to people who need support due to a wide range of needs. Shared Lives as a sector is currently involved in projects to expand its offer to people with mental ill health, complex needs, health needs and through this project the provision of Shared Lives as a home from hospital service.

Evidence of need

Traditionally Shared Lives has worked predominantly with people with learning disabilities and mental ill health, but there are examples where successful arrangements have been made with people in later life and those living with dementia. In the last couple of years Shared Lives has increasingly been offered as an intermediate care/home from hospital service. There is growing evidence that Shared Lives is a suitable provider for these services, there is also evidence that different and more imaginative ways of providing intermediate care services are needed.

In 2016/17 there were 2.3 million delayed transfer days in England, an increase of 25% on the previous year. A delayed transfer of care is where a patient is ready and safe to leave hospital care, but is unable to do so. In 2012 it was identified that intermediate care provision would need to double to meet demand, yet by 2017 this level had still not been achieved. Shared Lives is in a

prime position to deliver support to people leaving hospital and reducing pressure on stretched NHS and social care services.

NHS Improvement (2018) identified that staying in hospital is bad for patients, it leads to deconditioning and harm and for many patients the outcome of never returning to their homes after their hospital admission. This has led to a renewed focus on reducing the length of stay for patients.

In 2016 Shared Lives Plus received grant funding from The Dunhill Medical Trust and Department of Health's Innovation, Excellence and Strategic Development (IESD) Fund to develop Shared Lives as an intermediate care service with an initial emphasis on developing a Home from Hospital service.

This project supported 7 schemes to pilot this area of work; the project is being evaluated and a final report will be made available in 2019.

Steve's story

'I was living with my partner, running a B&B when I had a serious stroke and later two minor heart attacks. After four months in hospital, I was depressed, frail and my memory and cognition had deteriorated.

We knew I needed more support with daily living than my partner could provide. I was unable to return home and it made me frightened about my future, with clinicians uncertain about my further recovery. I wanted to live locally, so I could continue seeing my partner and I missed my dogs.

The Shared Lives scheme matched me, with two trained and approved Shared Lives carers who shared my sarcastic sense of humour, had dogs, and lived close by. They helped me through it all. When I arrived at their home, I never dreamt of being so independent again. I couldn't walk down the drive. Now I can nip up to town.

My Shared Lives carers helped me gain strength and confidence, walking a little bit further each time, until I could walk independently again. They helped me adapt to my memory loss with strategies for managing money and banking, and supported me to make meals and manage my diet.

Since then I have booked a holiday and travelled on my own. I am very optimistic about life and planning a move into my own flat. Without the

Shared Lives scheme I would have undoubtedly spent longer in hospital, had less choice about where I lived, and had a slower recovery.'

The Second National Audit of Intermediate Care (NAIC) 2013 defines intermediate care in the following way:

Intermediate care services (also known as care closer to home) are provided to patients, usually older people, after leaving hospital or when they are at risk of being sent to hospital. The services offer a link between places such as hospitals and people's homes, and between different areas of the health and social care system, community services, hospitals, GPs and social care.

There are three main aims of intermediate care and they 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.

Reablement is described as a primarily a social care model that focuses on promoting and optimising independent functioning rather than resolving health issues (Social Care Institute for Excellence 2013).

Intermediate care services can be provided to people in different places, for example, in a community hospital, residential home or in people's own homes. A variety of different professionals can deliver this type of specialised care, from nurses and therapists to social workers. The person or team providing the care plan will depend on the individual's needs at that time. Intermediate care services are at the forefront of delivering joined up services to meet service users' needs at critical times of transition.

The National Audit Office found the NHS spends an estimated £820 million a year keeping older patients in hospital who no longer need to be there (National Audit office 2016). Delayed transfers of care due to waiting times for a package of care have increased by 163% over the past five years and by 40% in the past year. This appears to be a symptom of insufficient capacity in community and intermediate care services (National Audit Office 2016). The problem of workforce and service capacity and concerns over the fragile state of the home care provider market is now having an impact on the number of delayed discharges (Kings Fund,

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Humphries et al 2016). The average investment in 2015 for intermediate care was £1.9 million per 100,000 weighted population and reablement services £0.7 million. However, NHS Benchmarking Network suggest 'this level of spend is consistent with about half of the intermediate care capacity to meet demand', this along with increasing waiting times for intermediate care services is evidence of insufficient capacity to meet demand (NAIC, 2015). Professor John Young (National Clinical Director for Integration and Frail Elderly, NHS England 2013) said 'when we say the hospital is full, we really mean, the community is full'.

This all demonstrates that there is an increasing demand for intermediate care, but the demand is not being met by current provision. Therefore, Shared Lives is in a very good position to develop in this area and increase the capacity within this sector of the market.

Why Shared Lives works for people needing intermediate care and reablement.

Shared Lives provides highly personalised arrangements where decisions about support and care are made in partnership with the service user. The matching process takes into account service users' wishes on where they want to live and the type of household they want to live in. The process also ensures that wherever possible the service user and the Shared Lives carer share the same interests and that the Shared Lives carer can support the service user to pursue their hobbies and interests and help them remain part of the community.

Shared Lives could be adapted to provide intermediate care and reablement by:

- Becoming involved when a person enters hospital and it is clear that they will not be able to go straight home after the intervention. An introduction to a potential Shared Lives carer would be made at the earliest appropriate stage to see whether it was a suitable match.
- Reablement needs would be identified in a similar way, but with more time to achieve a good match. The range of support the user would receive from other health and social care agencies e.g. occupational therapist would be underpinned by the on-going support from the Shared Lives carer.
- Shared Lives would be able to continue to provide support at the end of either the reablement period or the intermediate care stay through day support and short breaks, enabling people to remain independent for longer and providing additional support to their family carers.
- Older people with multiple health issues requiring frequent visits to hospital would receive on-going support for all aspects of their care from the same Shared Lives carers, providing continuity.

Shared Lives can provide a personalised service to people who may not 'fit' traditional models. Shared Lives has been shown to work well for people coming out of hospital following a period of mental ill health and people who have had a long period in hospital following an acute health episode especially those under 65.

The SCIE Guide to Reablement 2013 makes a number of recommendations about how to improve the intermediate care and reablement experience; including the criticism that reablement often fails to meet people's social needs, which are often central to their perception of independence.

Shared Lives carer's experience

Lesley worked for her local authority before retiring to care for her husband who died last year after a long illness. Having been in and out of hospital over several years with her husband, Lesley saw first hand the numbers of people who were medically ready to leave hospital but had nowhere to go.

With the experience of care giving, liaising with health professionals and a home that had been adapted, Lesley wondered what to do next. That's when she applied to become a Shared Lives carer. Lesley particularly wanted to be able to use her skills and experience to support people coming out of hospital to provide a short stay before they were able to move home or on to an alternative setting.

Since becoming a Shared Lives carer, Lesley has supported several people including a gentleman who stayed for a few weeks after a hospital operation. During this time, Lesley was able to support his family carer to learn the new procedures that were needed to support with his healthcare needs so that she was confident when he moved back home.

This gentleman now visits Lesley's home for respite when his carer needs a break, both knowing that Lesley knows him well and can support his health and care needs: the alternative would be a nursing care home but both he and his carer are happier knowing he's going to a family home with Lesley.

Seeing people re-gain independence gives Lesley a sense of elation and a boost to know that she is making a difference to the people she supports which she finds deeply rewarding.

Other issues of the current provision of intermediate care and reablement which Shared Lives can address include:

- Users are often not actively involved in their reablement plans and are given poor information. The Shared Lives approach means that users are actively involved in the design and development of their plan with their Shared Lives carer and scheme.
- Reablement and intermediate care 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 can add to the menu of potential support offering to users an alternative to the traditional providers, especially for those on personal budgets
- 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 that they could benefit from in current provision. Shared Lives can help embed reablement and intermediate care 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 is in a unique position to offer on-going support to older people, particularly those with degenerative conditions, through day care and short breaks services
- Preventing people becoming institutionalised. For many people with learning disabilities, older people or people living with dementia it is difficult to differentiate between one institutional setting and another, whereas going to a Shared Lives carer's home would be a clearer transition back to a home environment.
- Shared Lives can be more flexible in responding to the individual's needs – it's not a one size fits all service.

Marjorie's story

Marjorie is in her early 80's. After being admitted to hospital with a period of ill health it was assessed she would be unable to safely return to her own home. Extra care housing was identified but was not available immediately. Instead of remaining in hospital or having a stay in residential care where the risk of deterioration and the need for long term care would be higher, Marjorie was discharged to Shared Lives. Marjorie was able to continue with her recovery and regain her independence. Marjorie continued to do the things she normally did in the community like visiting her hairdresser once a week. After 12 weeks Marjorie was able to move into her new home.

For Shared Lives schemes, there will be new challenges to working in intermediate care and reablement, which includes:

- Working directly with hospital teams in acute hospital trusts and engaging with 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.
- Working with local authority reablement teams: 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.
- Areas block purchasing services, therefore limiting resources available to commission new models of care.
- Training and supporting Shared Lives carers: 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 e.g. dressings changed etc. 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.

Statistics, NHS trusts and news stories clearly demonstrate the need to increase options for people being discharged from hospital. Shared Lives is a trusted model of support well known within social care. There needs to be a shift in how health care professionals and organisations think about what is on offer and recognise that Shared Lives is a positive and viable option for people. Shared Lives schemes are building stronger partnerships with NHS Trusts, CCG's and health professionals, bringing a deeper understanding of Shared Lives amongst health teams.

Comment from Social worker, South Staffordshire and Shropshire Healthcare NHS Foundation Trust, following hospital discharge.

'The Shared Lives Home from Hospital Scheme offers a person centred, gradual approach to reintegration into the community. We were extremely pleased with the personalised approach to recovery from a long term hospital stay. The shared lives carer enabled the individual to

regain confidence and identified areas of concern whilst feeding this back to both the shared lives team and their community team.

During the preparation to discharge, the individual was involved in all processes and central to all decisions. The shared lives carer offered a holistic approach to support identifying not only the individual's primary need of their mental health, but also supporting with their physical health.

This scheme offers a unique, personalised service that this individual considered as invaluable in their recovery. It's an excellent service that I would highly recommend.'

Financial case

Traditionally intermediate care is funded through the NHS, whereas reablement is usually funded through the social care budget, managed by local authorities. More recently initiatives have been introduced to support the objective of integration of health and social care, the Better Care Fund is one of these initiatives enabling areas to pool budgets. Intermediate care services most frequently become necessary when someone needs to be discharged from hospital, often after an acute health episode but cannot return to their own or a family members' home. This may be because their own accommodation is unsuitable, they need some assistance but not medical care or they are waiting for suitable long term accommodation to become available.

In some cases, intermediate care is provided in someone's own home by a Home from Hospital service such as RVS or Age UK. This is offered in some areas and may use volunteers who do not provide personal care. Alternatively, it may be provided by an independent home care service which visit a number of times during the day to provide the assessed support. If the person cannot return to their own home, they may go to a community hospital, thereby releasing the bed in the acute hospital setting or to a residential home.

Finding innovative and cost-effective solutions to help deliver good quality outcomes for people who require intermediate care or reablement services is increasingly important.

The following costs demonstrate that Shared Lives can offer financial savings as well as reducing the number of people staying in hospital when they no longer need to be there:

- The mean cost per occupied bed per excess bed stay per day is £303 (DOH, reference costs 2016).
- The mean cost per service user for bed based intermediate care is £5672 per episode with an average length of service 26.8 days (NAIC 2015)
- The mean cost per reablement episode reported by commissioners is £1,484 for 2014/15 with the average time of service 34.5 days (NAIC 2015).

Compared to this, the mean cost for a 24 hour stay with a Shared Lives carer is generally less than £100.

Reablement is usually commissioned and delivered through adult social care services and receive referrals either from the community or via hospital discharge. Reablement teams are usually based within local authority adult social care services, with services delivered by in-house council care teams or commissioned providers working in tandem with physiotherapists, occupational therapists and other health professionals.

By comparison Shared Lives carers are paid a modest amount to cover some of their time and expenses, but they are not paid by the hour and they do huge amounts without being paid: there is no clocking on and clocking off. Payments to Shared Lives carers usually comprise rent, a fixed amount to cover food, fuel etc. and a contribution to the service users' care and support needs, although for day care there is no payment towards rent. There is also sometimes a management fee for schemes that are independent of the local authority. Each Shared Lives scheme is responsible for setting the levels of payment for each of these features.

Shared Lives offers demonstrable saving on arrangements for people with learning disabilities and mental health issues saving local authorities £26,000 a year for a full-time arrangement for someone with learning disabilities and £8,000 for someone with mental health issues (Social Finance: Investing in Shared Lives 2013). Shared Lives has not yet developed the volume of services to older people to produce evidence of the financial savings that could be available and is new to offering Intermediate care and reablement. It has also been found that personalised, community approaches to adult social care can result in crisis prevention, avoid costs on community health services and avoid admissions into hospital or residential care, especially for older people (PSRRU 2008).

For people living with dementia and older people generally, staying in their own homes is very important. The Alzheimer's Society report 2009 found that people with dementia tended to stay in hospital for longer periods than other older people admitted with the same condition, and that a third of those admitted who were living in their own homes were discharged to a residential establishment. Many Shared Lives schemes who are developing to offer services to older people are considering also offering intermediate care and reablement services. Whilst this is still at an early stage, there could be considerable savings, not just in the immediate care the service user would receive upon discharge from hospital, but they would be enabled to return to their own homes rather than continue in residential care with the associated costs.

Tina's story

Tina is in her early 40's and was admitted to hospital following a stroke. Tina was in an acute ward for 2-3 months and then transferred to a rehabilitation unit for a further 2-3 months. Following the referral to Shared Lives the scheme matched Tina with a Shared Lives carer who had previous experience of working with people who had had a stroke.

The Shared Lives carer supported Tina to regain skills that she had forgotten. As Tina did not have all the distractions going on around her that she did in hospital she was able to focus more on her rehabilitation. Very quickly some of the activities of daily living improved and she began to visit her own flat. Tina began to learn how to cook again. The Shared Lives carer was able to support Tina with travel training so that Tina was able to travel independently by the time she returned home. Allied health professionals found they could reduce the amount of time they spent visiting Tina as the Shared Lives carer was able to continue the physio/OT throughout the day.

The health and social care team had predicted that Tina would require Shared Lives for around 3 months but due to the progress Tina made she was able to return home to her flat after just 7 weeks.

Tina's Shared Lives arrangement cost £400 per week. The cost of a hospital bed averages £300 per night therefore over the initial 6 weeks the savings to health were £10,200.

Social care had agreed a further 12 weeks funding but only 1 week of social care funded support was required so further savings were made.

Shared Lives does not just offer financial savings but improved outcomes for service users and family carers through a high degree of flexibility, trust and the opportunities to continue to be involved and engaged with family and the wider community.

Shared Lives schemes require sufficient staff capacity to deliver any planned expansion. Engaging with and developing partnerships with local NHS Trusts and CCGs takes time. Social care teams know and trust the Shared Lives model; this needs to be replicated with health commissioners and health professionals. Recruiting new Shared Lives carers increases the capacity to offer Shared Lives to more people being discharged from hospital. There are 9290 Shared Lives carers in England, an increase of 14% over five years. However, the number of full time scheme workers has fallen by around 70 showing a stretch in human resources. Replacing the 70 scheme workers lost since 2012/13 could enable Shared Lives carers to support 1750 more people. It is therefore worth looking at the capacity within the team, and how investment in staff hours could increase the opportunity for the scheme to develop and provide more arrangements.

Resources

The NICE Guidance Intermediate care including reablement was published in September 2017.

<https://www.nice.org.uk/guidance/NG74>

The Social Care Institute for excellence guide in July 2011

<https://www.scie.org.uk/files/prevention/independence/intermediate-care.pdf>

SCIE e-learning package for managers and care workers.

<https://www.scie.org.uk/publications/elearning/reablement/>

NHS England have produced an online quick guide for improving hospital discharge.

<https://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-Improving-hospital-discharge-into-the-care-sector.pdf>

SCIE maximising the potential of reablement

<https://www.scie.org.uk/publications/guides/guide49/files/guide49.pdf>

Age UK factsheet.

https://www.ageuk.org.uk/globalassets/age-uk/documents/factsheets/fs76_intermediate_care_and_reablement_fcs.pdf

Our documents

- Shared Lives quality framework
- Shared Lives Plus guidance
- Shared Lives Intermediate care business case
- Older people – health issues
- Dementia friendly environment guides
- NHS Jargon Buster
- Referral checklist
- Ambassador test - A charter for people who use Shared Lives
- Shared Lives charter
- A Shared Life is a Healthy Life - How the Shared Lives model of care can improve health outcomes and support the NHS
- Business Case for Shared Lives mental health support
- Mental health learning resource
- Complex needs risk assessment Shared Lives Plus guidance
- NDTi Cabinet Office Shared Lives Plus mental health evaluation report



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