

Scaling up community-based models of care in Northern Ireland



Northern Ireland has a rapidly ageing population and growing demand for care. Both policymakers and practitioners have recognised that reforming the adult social care system is critical to ensuring the strain on primary and secondary health services does not become unsustainable. However, the collapse of the Northern Ireland Assembly in early 2017 has prevented the implementation of an ambitious reform programme led by the Department of Health.

Several community-based care and support models have developed locally in recent years, and offer hope and choice to older people and their families in the absence of political momentum. This Highlights briefing aims to contribute to discussion and debate around scaling up promising third sector innovation and good practice in the adult social care sector in Northern Ireland by exploring some of these models in more detail.

In this briefing, we describe five promising models of person-centred care and support that we believe have the potential to grow. We also describe some of the changes we feel will help in supporting the growth of these kinds of care and support models. Finally, we provide links to useful resources, including the Social Care Innovation Network which we are running in England exploring how we scale innovative models of care and support.

“Community-based care and support models are essential in putting power into the hands of people and creating the dynamic that will drive innovation. But to succeed they need acknowledgement, support and encouragement.”

John Kennedy, member of Expert Advisory Panel for ‘Power to the People: proposals to reboot adult care and support in NI’

Key messages

- The collapse of the Northern Ireland Assembly has stalled proposed reforms of an adult social care system struggling to meet rising demand.
- A culture of innovation is needed to scale up person-centred models of care and support which meet older people’s needs. Good models exist but there is no clear mechanism for resourcing and scaling these up to become mainstream services.
- Greater collaboration between statutory, community and voluntary providers sharing and maximising assets to deliver better outcomes for older people. This is critical where care and support services are seen as a shared responsibility across a range of bodies.
- Older people should be empowered through education and information to live healthier lives and access opportunities to stay connected and active in their communities. This views older people as an asset and co-partner in managing their own health.
- Co-production with older people is critical to designing services that people need and want. Co-produced services enable people to live fuller, healthier and more independent lives.
- Providers of new innovative services need to work closely with commissioners to design evaluation systems that produce clear and useful data.

Policy context

Recognition that system needs to be reshaped – how?

Transforming your care (Department of Health, NI); Health and wellbeing 2026 (Bengoa)

Power to People report – adult social care (2017)

Self-directed support: community-based, person-centred, co-produced, choice

The care system in Northern Ireland is under strain. In addition to the increasing demand for social care precipitated by an ageing population and budget cuts, the Chief Social Worker for Northern Ireland, Sean Holland, cites the fragility of the residential care home market (especially in rural areas); the quality of home care; and difficulties recruiting enough care workers (a situation which is likely to be exacerbated by Brexit) as major concerns for the Department of Health. Self-directed support and co-production with people who use services are growing but remain limited.

The reform of health and social care has faced several challenges in Northern Ireland. The fall of the Northern Ireland Assembly took place in the context of several reports setting out a vision for a transformed health and care system. These included [Health and wellbeing 2026: delivering together](#) (Department of Health, 2016) and [Power to People: proposals to reboot adult care and support in NI](#) (Expert Advisory Panel on Adult Care and Support, 2017). The Department of Health continues to build momentum around investment and new thinking about social care in the absence of a Health Minister and Executive. This includes developing a policy paper and action plan for public consultation. This will help to inform a future Health Minister but key decisions cannot be made until an Executive is re-established. Introducing and scaling up more person-centred care services will be a huge challenge in the context of an uncertain political environment and a health and care system under strain, but as the examples in this briefing show, it is possible to

provide better care even in a difficult climate. Community-based care and support models such as those outlined in this briefing provide a welcome alternative for older people and their families, and represent a first step towards introducing greater innovation to a system currently struggling to cope with increasing demand.





Evidence of need

An ageing population

- The population aged 65 and over is projected to increase by 65.1 per cent to 491,700 people from mid-2016 to mid-2041.¹
- The population aged 85 and over is projected to increase by 127.2 per cent to reach 82,800 people over the same period.¹
- Rates of disability increase dramatically for those aged 85 and over (by 67 per cent) compared to 5 per cent among young adults.²
- People aged 65 and over living alone will represent 86.6 per cent of the projected increase in people living alone between 2012 and 2037 (36,900 people).³
- A need for an additional 4,050 care packages was projected from 2017–2020 (15 per cent increase) and an additional 20,101 care packages by 2037 (68 per cent increase).⁴

Delayed discharge from hospital

- Delayed discharge in Northern Ireland is costing £1.5 million a month to keep people in hospital who could be discharged if a suitable care package was in place. Many of these people are aged 65+.⁵

Short-break support for carers

- Health trust provision of short-break support in Northern Ireland was almost 1 million hours in each quarter in 2015/16 but more than half of this was in an institutional setting rather than community based.⁶

Dementia care

- The number of people living with dementia in Northern Ireland is projected to increase to 60,000 by 2051.⁷
- Health and social care expenditure for people with dementia in Northern Ireland was projected to double from 2011 to 2031.⁷

Summary of innovative models of care and support

Promising models	Primary characteristics of target population	Existing beneficiaries	Potential beneficiaries	Potential barriers to expansion	Key enablers for implementation	Outcomes/savings
Supporting older people and other vulnerable groups to remain independent and connected						
CLARE	Isolated and frail older people	139 older people supported (2017)	Dependent on volunteers/staff capacity	Managing risks associated with supporting older people with complex needs	Recruitment of volunteers and community capacity	Older people supported to remain at home. 1,000 hours of volunteering and 2,200 staff contacts in 2017
SPRING Social Prescribing	Wide range of vulnerable adults e.g. mental health, older people, low level health conditions	Piloted in 2015–18 in Derry. (332 people aged 65+ supported 17/18) Expansion with Big Lottery support across Northern Ireland and Scotland (2018–21)	Target = 13,300 vulnerable people supported across Northern Ireland and Scotland	Coordinating 30 delivery partners across Scotland/NI and gaining wider support from Health and Social Care	Good communication and coordination	Potential to reduce GP attendance by 28% = 2 fewer GP appointments a year (saving £83 per person)
MEAAP	Older people	Year 1–174 people supported	Older people	Identifying potential service users/unsuitable referrals	Raising awareness with potential beneficiaries	Every £1 invested in Impact Agewell = £2.80 saving
New community-based models of social care, practical support and accommodation for older people						
Shared Lives (referred to as adult placement in Northern Ireland)	Adults with a learning disability but increasingly older people and other groups	221 adults with a learning disability in NI	Older people, adults with mental health issues, ex-substance users, physical disability etc	Expanding from learning disability to older persons care directorates/recruiting more carers	Current Health & Social Care Board led project to support Health Trusts in NI to expand the model	£26,000 a year cheaper for adults with learning disabilities; £8,000 a year cheaper for adults with mental health problems
Homeshare	Older people living on their own	Department for Communities commissioned Homeshare NI feasibility report in 2018. 350 older people supported in rest of UK	Older people in NI who need practical support to stay in their own homes.	Concept new in NI, Recruiting Householders and Homesharers.	Many schemes need start-up grants for first 2–3 years until established	Potential to be self-funded after 2–3 years depending on number of matches supported



CLARE (Creative Local Action, Responses and Engagement)

CLARE's key objective is to empower older people to maintain their independence and reduce feelings of isolation and loneliness. The model adopts a strengths-based approach, valuing the assets of the individual and the community that they live in. Co-production is central to the work of CLARE. It supports innovative thinking, ensuring that it is user-led and not service-led, working in partnership with the older person and their community.

Each older person referred meets with the CLARE Community Social Worker to engage in an initial guided conversation in which they are viewed as expert in their experience and in identifying what actions and supports will work for them. CLARE delivers its services with a mix of staff and volunteers known as Community Champion volunteers. Support includes connecting older people to health and social support services and community resources, practical assistance based on individual needs (such as accompanying older people to the bank, shops or activities) and purposeful befriending.

CLARE works closely with the Public Health Agency and Belfast Health and Social Care Trust. The service will take referrals from a wide range of sources including self-referrals.

Current users and outcomes

In 2017, CLARE:

- supported 139 isolated older people and delivered over 1,000 hours of volunteering and 2,200 staff contacts
- reported 83 per cent of its clients said they felt better able to keep in touch
- reported 67 per cent of its clients said they felt increased feelings of positivity.

Estimated financial benefits

As a community-based early intervention model, CLARE helps to ensure older people can remain in their community for longer with personalised, effective support. This has the potential to result in savings in terms of reduced hospital and nursing home admissions and better uptake of health care appointments. CLARE is keen to find evaluation partners to measure cost avoidance and savings.

Potential benefits

- Can support a frailer older population with a range of services beyond signposting
- Supports older people living on their own
- Strengthening communities e.g. recruiting local volunteers to support individuals
- Empowering older people to shape and design what good support should look like through continuous learning and co-production

Barriers and enablers for expansion

CLARE wants to contribute to systemic change in the way health and social care is designed by working with older people, their communities and the organisations involved in the commissioning and delivery of services. CLARE is currently talking with isolated older people whose opinions are not usually heard in other areas of Belfast, identifying what support they want to improve wellbeing and whether CLARE could help. Any expansion of CLARE requires extensive community consultations and endorsement as well as partnership working. CLARE is keen to share the model and learning but this will not lead to a simple scaling up or replication as each community must consider how it can dovetail with and add value to their existing assets.

Coordination

CLARE is a member of Belfast City Council Healthy Ageing Strategic Partnership where voluntary and community and statutory organisations can share information and coordinate approaches to tackling loneliness and improving wellbeing for older people. CLARE is also a member of the Social Work Strategy Local Engagement Partnership for co-production and Belfast Health and Social Care Self-Directed Support Implementation Group.

Case study: CLARE

Service-user

Freda is 94 years old, lives on her own and had become lonelier in recent years. She copes with a range of medical conditions – a stroke, glaucoma, arthritis, occasional falls and memory problems. She was also finding it hard to attend medical appointments and access her money and pay bills at the local bank because of the impact of decreased mobility, visual impairment and memory problems.

Support provided

CLARE has provided person-centred support tailored to Freda's needs including help with accessing Direct Payments which has enabled her to get out to more activities with the help of a personal assistant. She has also been assisted to access support from a range of health professionals through CLARE staff and volunteers.

Outcomes

Greater independence and support to live at home by enabling real connections to health and social care support and the assets of CLARE volunteers in her local community.



IMPACT AGEWELL®

IMPACTAgewell® aims to improve quality of life for older people by connecting them to their community. It goes beyond the traditional signposting model, instead building in a funding stream to actually invest in the community-based, often volunteer-led, organisations which deliver these services (commonly referred to as 'social prescriptions') such as befriending, transport, luncheon clubs and handyman services.

Older people who are eligible to take part in the programme can submit an expression of interest or be referred to the programme by their GP. (Participants must be aged 65 years or older; have a long-term health condition; live alone or with another person over 60; registered with one of six GP practices in Mid and East Antrim area.) An IMPACTAgewell® Project Officer will arrange an initial home visit to meet the older person where they are given support to co-produce their personalised health and wellbeing action plan.

The Project Officer will try to connect the older person with a range of community/voluntary organisations that have signed up to the programme and help them to identify goals and actions that will keep them connected in the community over a six-month period.

The model – which is led by local charity the Mid and East Antrim Agewell Partnership (MEAAP) – has been co-produced and is being delivered in collaboration with health care practitioners thanks to funding support from Dunhill Medical Trust.

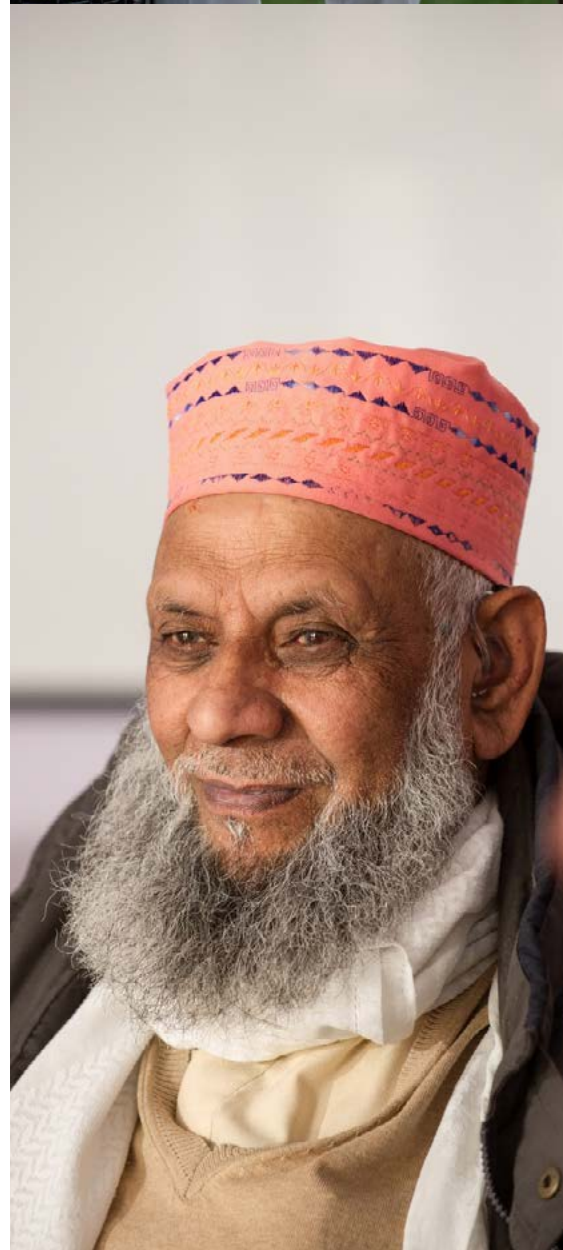
“In many cases we are de-medicalising the problems that have been labelled as clinical, problems like depression, medicine adherence, health literacy, and instead are freeing up patients to be people again, and to find the solutions within themselves or with their neighbours – recognising their assets as opposed to their liabilities.”

Deidre McCloskey, Project Coordinator, IMPACTAgewell®

Current users and outcomes

In Year 1, IMPACTAgewell®:

- supported 174 service users out of 391 referrals (45 per cent) for which 68 have formally completed their period of support
- Established and conducted 72 locality hub meetings involving local council, integrated care partnerships, community pharmacy, primary and secondary care colleagues and commissioners
- created and established 14 community partnership agreements for local community/voluntary sector groups who have agreed to provide 'social prescriptions' in return for a small financial contribution.



Estimated financial benefits

An initial cost-benefit analysis has been undertaken on baseline data, this found that the potential fiscal return on investment (FROI) at the end of year 1 was 2.8. That is, for every £1 spent on IMPACTAgewell® there is a potential cost saving of £2.80 through things such as reductions in visits to GP services, reduced need for community care and for prescriptions.

Barriers and enablers for expansion

IMPACTAgewell® has expanded the pilot area beyond the original six GP practices to help increase the level of uptake of referrals, and already has five new GP practices signed up, with a bi-monthly IMPACTAgewell® locality hub approach now being trialled.

The referral criteria is also being reviewed, with the potential of introducing 'frailty', which is deemed to be either 'mild' or 'recoverable' as a long-term health condition for referral purposes. This has been difficult to date as there is no agreed method within primary care in terms of measuring or grading 'frailty'.

IMPACTAgewell® has struggled to identify potential service users, with 191 (49 per cent) either declining the offer of support following referral stating 'enough support', or considered unsuitable for the programme. There are no central service user records with basic health information and very little information on living circumstances and family support unless the older person has been seen by a social work team.

IMPACTAgewell® also recently launched a short film featuring two clients talking about their experience of being involved in the programme. Four local events were also held in summer 2018 as part of the NHS 70th Birthday Celebrations to encourage peer-to-peer networking.

Getting community and voluntary organisations to sign up to the partnership has also been a challenge. Many of the community/voluntary groups locally have low capacity hence are wary of taking 'unrestricted funds'.

Coordination

Many of the partners involved in the project have spent much time networking and disseminating information. MEAAP has had a very active Twitter presence (@meapni #IMPACTAgewell) and have been using this social media tool to network far and wide. Presentations by partners have most recently included the 1st International Social Prescribing Research Conference in June 2018, the Big Lottery Fund UK in September 2018 and the WHO International Healthy Cities Conference in October 2018.

PACT Community Pharmacy also won their first award from the Ulster Chemists Association for their population health model utilised and first piloted as part of IMPACTAgewell® in January 2018 and were shortlisted for Pharmacy Team of the Year at the UK Chemist and Druggist Awards hosted in London in July 2018.

As noted above, MEAAP and many of the partners involved in the IMPACTAgewell® Programme have taken every opportunity to interact and influence similar organisations/projects involved in multidisciplinary team approaches, in social prescribing, in co-design and co-production, as well as innovation and quality improvement.

Case study: IMPACTAgewell®

Service-user

Emily, 89, lives alone in her own home. She was referred by her GP as she has several long-term health conditions including heart failure and hypertension, as well as having hearing problems and using a walking stick. She wanted to get out more to attend local activities, but did not have access to transport

Support provided

The IMPACTAgewell® Project Officer supported her to attend a local luncheon club making use of a local community transport scheme. She was also referred to a hearing clinic and other health services.

Outcomes

Emily is more active in her local community and less lonely.





SPRING Social Prescribing

This social prescribing service is a way to link medical care to (typically) non-clinical, locally delivered care intervention services to reduce the stress on GP/ NHS services. Medical professionals can refer their patients to a range of activities and services, recognising that a social model of health contributes to the wellbeing of patients. The Social Prescribing Project aims to empower patients and communities, supports greater independence, reduces reliance on primary healthcare, and ultimately delivers better health outcomes for people and society.

SPRING Social Prescribing follows on from a pilot project delivered by Bogside and Brandywell Health Forum (BBHF) in the Derry/ Londonderry region between 2015 and 2018. Northern Ireland's Healthy Living Centre Alliance (HLCA) and Scottish Communities for Health and Wellbeing (SCHW) have come together as a partnership to scale up the pilot, which is the largest coordinated project of its kind. SCHW and HCLA each represents a network of community-led health organisations working to deliver better health and wellbeing outcomes with and for local people. The Social Prescribing Project will build on their experience, as well as on many years of accumulated knowledge working with local people and in local contexts. The project is funded by Big Lottery UK and will synthesise learning from across two regions, initially for a three-year period.

The project is structured with 10 delivery partners in Scotland including rural and urban areas. There are five partners in Northern Ireland, one in each trust area representing a total of 20 delivery organisations.

Current users and outcomes

The pilot programme delivered by BBHF between 2015 and 2018 supported a total of 607 people aged 65+. Based on this pilot, the people who will most benefit from a social prescription are likely to experience one or more of the following:

- low level mental health issues
- poor social support mechanisms, social isolation, loneliness or a carer
- risk of Type 2 diabetes
- physical inactivity
- frequent attendance at primary care services
- dissatisfaction with results, referral or discharge from secondary care
- poor results with mainstream treatments
- vague or unexplained symptoms or inconclusive diagnoses
- history of alcohol/drug misuse/dependence
- chronic illnesses.

GPs and stakeholders will also benefit as the project may reduce the number of repeat visits to GP surgeries, and improve the quality of patients' lives.

Estimated financial benefits

The substantial range of health issues from obesity and diabetes, to depression and loneliness makes it difficult to measure financial savings to the health service. Health interventions range from a small number of expensive counselling sessions, to a relatively inexpensive placement in a walking group.

Social prescribing has the potential to reduce GP attendance by 28 per

cent (Polley et al. 2017).⁸ Median attendance to GP practices from social prescribing users is 8.3 per year (Carnes et al, 2015).⁹ Twenty-eight per cent reduction is 2.3 fewer GP consultations per year which adds up to £83 saved per person. For 1,000 people, the saving would be £83,000 over one year. Given that a social prescribing worker costs on average £30K, the service would almost pay for itself just on the basis of savings on GP attendance.

There could also be:

- savings on benefits
- reduction in hospital admissions
- quicker hospital discharge
- delay in admission to nursing care.

The new project has a cost-saving analysis tool built into the software.

Implementation issues

The main cultural change will be the shift from the traditional medical model of health to the social model of health. Many people who present at primary care require support that is beyond a strictly medical intervention. For example, health professionals may encounter patients suffering because of isolation, stress, or low mood. These patients need more than medicine to improve their lives.

At a time when the NHS is under increasing pressure, social prescribing is coming to the fore as an effective way to deliver quality health outcomes. Social prescribing is attracting a high level of political support, but further work needs to be carried out in order to move it from a series of isolated local projects to an integral part of the way healthcare is delivered nationally.

To achieve long-term cultural change, the SPRING Social Prescribing Project will work closely with all levels of government – especially those with responsibility for health.

Barriers and enablers for expansion

There is significant synergy between the HLCA, SCHW, and their members. It was realised very quickly that something very significant could come of a partnership approach to social prescribing.

Scaling up the Social Prescribing Project across Northern Ireland and Scotland has huge potential economic benefits in terms of saving the NHS money. For example, improvements in wellbeing, reducing hospital admissions and the need for other medical intervention.

The project will have many quantitative benefits such as sharing best practice across multiple community-led health organisations.

The project will be able to record the numbers of people attending activities and the specific impact that the activities are having on their health and wellbeing. The project will also be able to measure the impact on the quality of life of participants in the project over time.

The main challenges to scaling up are:

- the geographical distance among 30 delivery partners
- cultural, social and economic differences across communities in Northern Ireland and Scotland
- delivery partners offering different social interventions in response to cultural needs in Northern Ireland and Scotland
- different levels of support from health care professionals in Northern Ireland and Scotland
- different funding depending on council areas and health trust areas.

Coordination

Information will be shared across the Healthy Living Centre Alliance and Scottish Communities for Health and Wellbeing using Elemental Software and internal reporting systems.

Case study: Social Prescribing

Service-user

Ena is 77 and regularly attended her GP in Derry having dealt with several health conditions including cancer, diabetes, angina and back pain after surgery. She needed help with improving her mobility and reducing her loneliness and depression.

Support provided

The Social Prescribing Co-ordinator helped Ena to join a local fitness class which she attends a twice a week.

Outcomes

Reduced social isolation, greater confidence and wider social network through the fitness classes. She also feels fitter evidenced through lower blood sugar levels. Ena now attends fewer GP appointments.





Homeshare

Homeshare enables two unrelated people to share a home for mutual benefit. Typically, an older Householder living in their own home with a room to spare will be carefully matched through a local Homeshare organisation with a younger adult (such as a recent graduate). The potential Homesharer typically provides 8-10 hours of practical support per week in exchange for low-cost accommodation. There is no element of personal care or regulated activity involved. The type of support provided could include help with cleaning; shopping; gardening; overnight security; and companionship. The younger adult saves money by accessing good quality accommodation at below market rent which is often close to work or in large towns/cities. The Homeshare organisation provides ongoing support to both the older Householder and Homesharer including regular monitoring and advice. Homeshare has experienced rapid growth in England and recently the Republic of Ireland with potential for organisations to be established in Northern Ireland.

In 2018, the Department for Communities commissioned a feasibility report from Shared Lives Plus into the potential of Homeshare to support older people in Northern Ireland. Shared Lives Plus does not deliver Homeshare directly but provides support and advice to organisations who would like to set up a service including access to quality standards. It also engages with policy-makers keen to develop innovative sustainable community-based services that tackle loneliness and help older people to maintain their independence and stay in their own homes. In Northern Ireland, Homeshare organisations could be established by a range of third sector providers already working with older people and where Homeshare could complement and add to existing services. Organisations are responsible for the recruitment and vetting of participants, matching and introductions and monitoring Homeshare arrangements. Key recommendations from the NI feasibility report include:

- Identifying and supporting third sector organisations to pilot Homeshare
- Establish a Homeshare steering group with key stakeholders across community, health and housing

Current users and outcomes

- Twenty-three Homeshare organisations in the UK and Ireland supporting over 350 older people
- Addresses gaps in practical support to help older people stay in their own homes
- Reduces fear among older householders living on their own with an overnight presence in the house
- Reduces social isolation

Estimated current financial benefits

- Older householder pays from £20 per week and homesharer from £40 per week to the organisation – covering running costs and salaries
- Organisations can become sustainable with as few as 26 arrangements

Potential benefits

- Supports older people to live independently
- Supports those with low-level social support needs below eligibility thresholds for statutory social care
- Reduces demand for social housing and makes best use of existing housing stock
- Offers companionship combating social isolation
- Potential to support other groups beyond older people
- Reduce and delay health trust spending on social care and new housing stock for older people
- Providing good-quality, low-cost homes for key low-paid workers and other groups who need affordable housing
- Supporting early discharge from hospital

Implementation issues

- Homeshare model is relatively unknown in Northern Ireland
- Some scepticism about the potential for compatibility between older and younger people in a Homeshare arrangement
- Adequate investment to start and sustain a service until it is self-funding
- Reassuring participants about safeguarding
- Needs of older householder escalating over time making Homeshare arrangement untenable
- No current dedicated infrastructure support for Homeshare in Northern Ireland
- Older people may be reluctant to pay a small fee for the service
- Potential impact on older householder in receipt of benefits

Case study: UK Homeshare

Service user

Andy is 68 and had lived alone for more than 14 years after an active career that took him around the world. He recognised that he was becoming increasingly lonely and unsure how to address this.

Support provided

Andy was referred to the local PossAbilities Homeshare organisation in Greater Manchester. They matched George who was from Romania and coming to work in Greater Manchester. They undertook police checks, vetting and introductions. George provides 10 hours practical support a week as well as providing an overnight presence for at least five nights a week.

Outcomes

Andy is less lonely enjoying a range of social activities with George. He is also reassured at having an overnight presence in the home. The Homeshare arrangement has also helped George to settle in well to a new life in England and he enjoys the friendship he has with Andy.

“It’s given me a new perspective on life and even though I hate to admit it, I do need a bit of extra help round the house – I’m not getting any younger!”
Householder, London

“It’s just really reassuring knowing that someone is looking out for mum.”
Daughter of a householder, London





Shared Lives (Adult Placement)

Shared Lives Plus is the UK charity that promotes and develops both the Shared Lives and Homeshare models and provides support to member schemes and carers. Shared Lives is better known as adult placement in Northern Ireland and is a unique type of social care regulated by RQIA. Four adult placement schemes were established by a number of legacy health and social care trusts in the 1990s. They have focused exclusively since then on supporting adults with a learning disability. They offer day support, short breaks or longer-term care arrangements in the homes of approved carers in the community. Local schemes have a successful track record in building their services over many years pioneering the drive for more person-centred and community-based care models. Schemes offer people the chance to stay in the community being looked after in a more normal environment and as an alternative to institutions and day centres. With support from the Big Lottery, Shared Lives Plus has been working with key stakeholders in Northern Ireland to expand the adult placement model to support other groups and in particular older people. This work reflects how the model has expanded in the rest of the UK to support a broader range of vulnerable adults. This expansion project is being supported with Department of Health transformation funding and is being led by the Health & Social Care Board in conjunction with the five health and social care trusts.

Current users and outcomes (Northern Ireland)

- 221 adults with a learning disability supported, 214 carers
- Schemes running in four out of five health and social care trusts
- 50 per cent of care provided is short breaks
- 25 per cent of adults being supported are in care arrangements that last 4+ weeks

Estimated current financial benefits per year

- £26,000 savings a year for people with learning disabilities compared to institutional care (Social Finance)
- £8,000 savings a year for people with mental health needs compared to institutional care (Social Finance)
- £2,351 savings a week on delayed discharge from hospital (Welsh example) – £413 a bed night in hospital compared to £540 a week in Shared Lives placement

Potential benefits

- Developing this model of care as an additional option available through self-directed support (SDS)
- The adult placement model is well established in Northern Ireland over 20 years providing safe person-centred care
- It offers an alternative to institutional care when family carers need to organise respite care for an older loved one
- It could be developed as a step-down support option from hospital or provide intermediate care in the community
- Provides continuity of care for older people who receive care from the same carers in the community
- Combats social isolation – older people benefit from inclusion in the carers wider family networks
- Potential to support older people in the early stages of dementia with a familiar respite option enabling their family carer to get a break
- Health trusts can avoid costly out-of-area placements in residential settings

Implementation issues

- Expanding beyond learning disability directorates within health and social care trusts
- Addressing low awareness levels about the model and its benefits
- Reviewing and updating carer payment rates to ensure consistency across Northern Ireland
- Developing a consistent regional approach sharing learning and good practice from both Northern Ireland and across the UK
- Can take 12–18 months to establish new schemes
- Embedding alongside other more traditional models of care as part of the scaling-up process

Case study: Older persons (Scotland)

Service-user

Ian was diagnosed with dementia several years ago with symptoms including macular degeneration and subsequent gradual loss of sight and short-term memory loss. His independence was reduced, and his wife struggled to care for him without a break.

Support provided

Ian was referred to his local Shared Lives scheme in Moray, Scotland. He was matched with a local Shared Lives carer taking into account his needs and preferences. Care and support have grown steadily in line with his needs from two hours weekly with the Shared Lives carer to overnight respite in the Shared Lives carer home.

Outcomes

Shared Lives carer support has enabled Ian to remain living at home and in the community. His wife can now access regular respite that enables her to continue caring for Ian.



Conclusions and recommendations

Transformation work across health and social care is being supported in Northern Ireland despite the lack of a local Assembly in recent years. This is being led by the Department of Health in conjunction with the Health and Social Care Board, GPs, health trusts and other health agencies. Broad objectives for health transformation were laid out in health strategies published towards the end of 2016 and early 2017. In addition, the publication of the *Power to People* report in late 2017 recognised the importance of reforming an adult social care system that cannot meet growing demand in its current form, especially with a growing ageing population.

Many innovative models of care and support exist already in Northern Ireland. Some of these are already delivered by health trusts or community and voluntary providers. The challenge is scaling up proven models of person-centred care beyond specific geographical areas or specialisms of care and embedding co-production at all stages.

Key recommendations include:

- **Develop key broad shared objectives and targets across government departments and public bodies** in relation to supporting innovation around care and support models. This will mean greater collaboration and shared resources between bodies responsible for health education, housing, council services and tackling poverty and income issues.
- **Develop Northern Ireland-wide evaluation tools for wellbeing and social connection.** This will create opportunities for gathering evidence and data across different providers which can be used by commissioners to support further investment in innovation and prevention services.

- **Establish an innovation scaling fund in Northern Ireland** to test new approaches and evaluate if they can deliver better outcomes and more person-centred care especially for older people. A clear mechanism for scaling up innovation will be critical to develop the capacity in the system to transition away from less person-centred models of care.
- **Bring together the evidence base on innovative models** of health, care and support into a single 'what works' information source, perhaps building on the SCIE Northern Ireland social work and social care hub. This can be shared with all stakeholders interested in transformation and innovation across Northern Ireland.
- Discussions around investment in innovation often focus on 'new money' but **commissioners also need to tackle the issue of transferring resources away from existing low-quality outcome approaches** to more person-centred sustainable care and support services. This can be difficult for existing commissioners especially when they have funded services for many years. Existing care providers also need to be supported to innovate and transform services where possible.

- **Commissioners need to embed co-production in all new services** to ensure buy-in and support from service users and their families. It will also allay fears about moving away from more traditional care services to new models which can deliver better outcomes. Service users become partners in this process co-producing solutions and actively managing their own health.
- **Commissioners should pay care and support providers on the basis that they improve resilience, independence, self-care and social connections.** These outcomes will be critical in meeting the demands of an ageing population and delivering more sustainable services in the medium to longer term. There will need to be a transition away from paying providers to provide set tasks and only supporting those who have reached a critical threshold in relation to care needs.



Further information

References and resources

1. [NISRA Statistical Bulletin: 2016-based population projections](#). NISRA, 26 October 2017
2. [Transforming your care](#). Health and Social Care Board, December 2011
3. [A profile of older people in Northern Ireland – Annual update](#). page 24, OFMDFM, 2015
4. Systems, Not Structures: Changing Health & Social Care – Expert Panel Report – DHSSPS, 2016
5. Analysis of H&SCB statistics, IHCP, March 2017
6. [Commissioning Plan 2015–16](#). page 69, Health and Social Care Board/Public Health Agency, 2015
7. [Improving dementia services in Northern Ireland – a regional strategy](#). DHSSPS, November 2011
8. [Searching for Real-World Effectiveness of Health Care Innovations: Scoping Study of Social Prescribing for Diabetes](#). Journal of Medical Internet Research, February 2017
9. [City and Hackney Social Prescribing Service: Evaluation Report](#). Researchgate, 2015

[Northern Ireland social work and social care hub](#). SCIE

[Social Care Innovation Network](#). SCIE, TLAP and Shared Lives Plus

About SCIE

The Social Care Institute for Excellence improves the lives of people of all ages by co-producing, sharing, and supporting the use of the best available knowledge and evidence about what works in practice.

We are a leading improvement support agency and an independent charity working with organisations that support adults, families and children across the UK. We also work closely with related services such as health care and housing.

www.scie.org.uk

Shared Lives Plus

Shared Lives Plus is the UK network for family-based and small-scale ways of supporting adults. Our members are Shared Lives carers and workers, and Homeshare programmes. Shared Lives used to be known as Adult Placement.

www.sharedlivesplus.org.uk

Contact us

For information on individual organisations featured in this Highlights briefing, please use the contact details below. If you would like to discuss any other aspect of this briefing, please contact ewan.king@scie.org.uk.



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