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A problem shared...

... is a problem halved? **Clare Connell** and **Ryan Perrott** analyse whether the Shared Lives scheme is the most effective method for moving more care into the community

Shared Lives has been touted as a more cost-effective, person centred support option that empowers individuals and acts as a road to independence in the community. To date, however, Shared Lives schemes are struggling to make a meaningful commercial impact in the adult social care market, posing limited threat to more traditional models of care.

Shared Lives is a community-based care service that could be an answer to the financial and commissioning challenges local authorities (LAs) are facing. There are over 120 Shared Lives schemes in England, provided by councils, independent and third sector care organisations. In a typical Shared Lives placement, an adult with care needs would be matched with an approved carer. That carer shares their home, family and community life with the person that is placed with them and supports their care needs in this setting. The schemes can work in one of three ways. The first type of arrangement involves an individual moving into the home of their Shared Lives carer, in a similar way to a children's fostering placement, where they live with their carer's family and are supported over the long-term. The second arrangement works in the same way, but the individual would be supported on a short-term basis such as a respite placement. The third type of arrangement involves Shared Lives carers sharing their home, family, or community life with an adult for day support.

As of 2016, there were nearly 12,000 people supported by a Shared Lives placement in England (figure 1), in categories of care ranging from learning disability and autism to dementia, physical impairment and substance misuse. Just over half of arrangements are long-term, with remaining placements for short breaks and day care. Some LAs, such as Southampton, have made good use of the schemes, with 10% of their learning disability population (known to social services) in a Shared Lives arrangement. In light of council budgetary pressures and the more personalised commissioning landscape, Shared Lives could be seen as an attractive option for LAs.

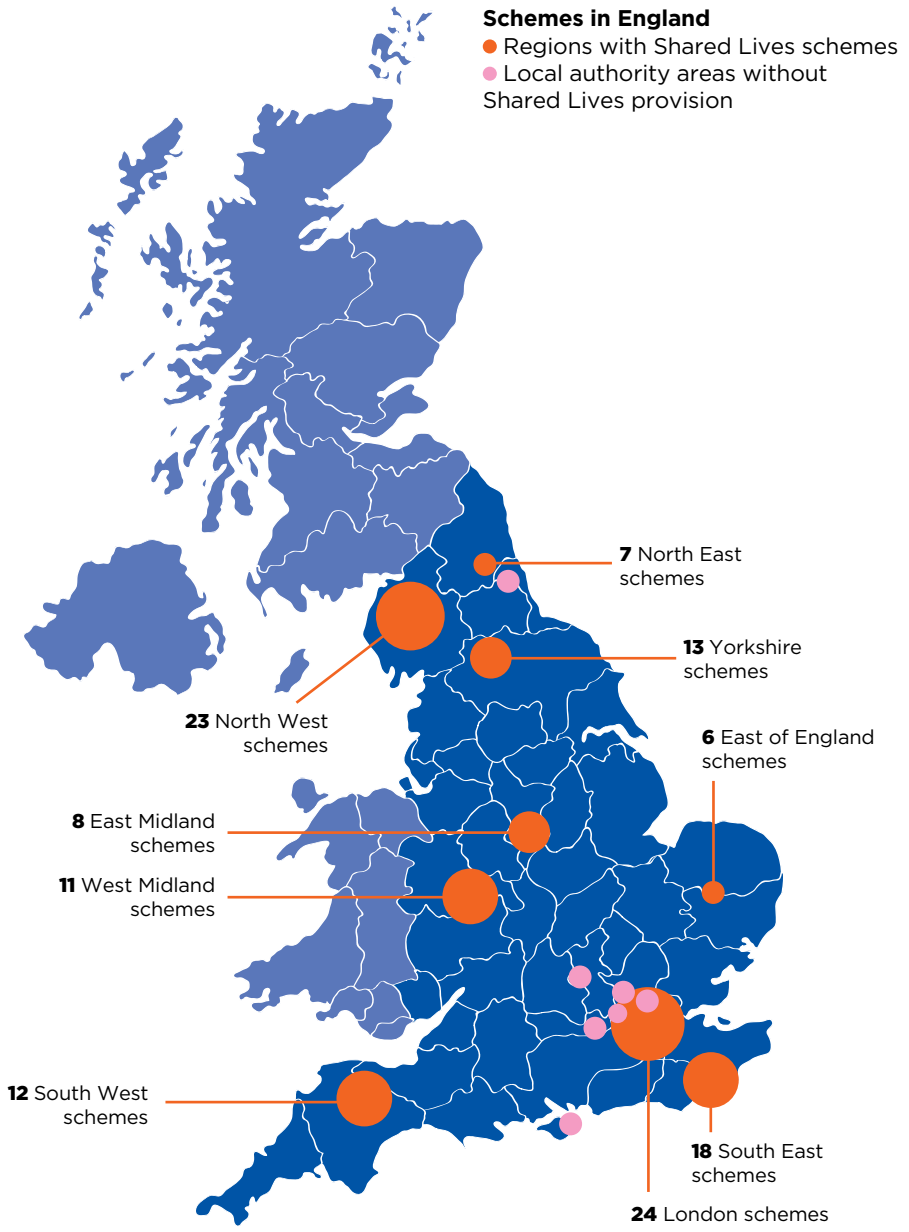
Indeed, with the rising demand and increased complexity of needs, the issue of social care funding continues to cause a headache for policymakers. In the 2016-17 financial year, the annual cost of social care to LAs increased by £556 million, a 3.3% increase to £17.5 billion and the first real terms spending increase since 2009-10. There is little sign that expenditure on social care will decrease either, with an ageing and growing population, of which nearly 1.2 million people are estimated to have a dementia diagnosis by 2025.

With this on-going budgetary squeeze, the need for commissioners to consider cost-effective care options and value for money is therefore paramount. In this context, Shared Lives has positioned itself as a cheaper market alternative to traditional care models. Shared Lives Plus (figure 2), the UK's network for Shared Lives carers and home care schemes, claims that Shared Lives can be on average £26,000 per year cheaper for people with learning disabilities when compared to other care provisions, and £8,000 per year cheaper for people with a mental health diagnosis. The reduced costs largely come as a result of avoiding stays in more expensive care homes and further creates less reliance on hospitals, GPs, and other community care services.

In making their business case for Shared Lives working for older people, they also point to a four week stay with a Shared Lives carer catering for dementia, costing £1,800 in total compared to an average of £2,800 at a dementia specialist care home over the same four-week period. An independent study into Shared Lives for older people also concluded that day care and respite costs under Shared Lives were "broadly in line with, and in some cases more affordable" than traditional models of care.

As well as providing a potentially cheaper alternative, Shared Lives schemes also look to deliver personalised care that achieves positive outcomes for service users and allows them to maintain their independence. Advocates argue that being part of a family and having needs catered for in this environment has allowed individuals to engage with the community in a way that they would otherwise not be able to in a more traditional care setting, such as a residential home. Being part of a Shared Lives scheme has seen users take their first holiday, enter the world of work for the first time, join clubs and go out into the local community by themselves. Carers have empowered people to take control of their own lives in areas such as medication storage, money management and preparing their own meals. In many cases, this has been seen to be very successful and has been met with considerable praise. Croydon Shared Lives, which has been rated 'Outstanding' by CQC, has been described by local health and social care professionals as an excellent model of care, where

FIGURE 1: SHARED LIVES PLUS



- Shared Lives Plus is the UK network for Shared Lives and Homeshare
- There are 122 Shared Lives schemes in England, operating across nine regions
- Shared Lives operates in the majority of local authority areas with a responsibility for adult social care, bar Barnet, Bracknell, Camden, Hartlepool, the Isle of Wight, Milton Keynes, Tower Hamlets and Wokingham
- There is significant variation across regions in terms of the number and size of Shared Lives schemes
- Whilst the North West, South West and London have all experienced significant growth, the South East and the East of England have seen a reduction in the number of people using Shared Lives.

people are able to lead the lives they want and are supported to develop and build in confidence.

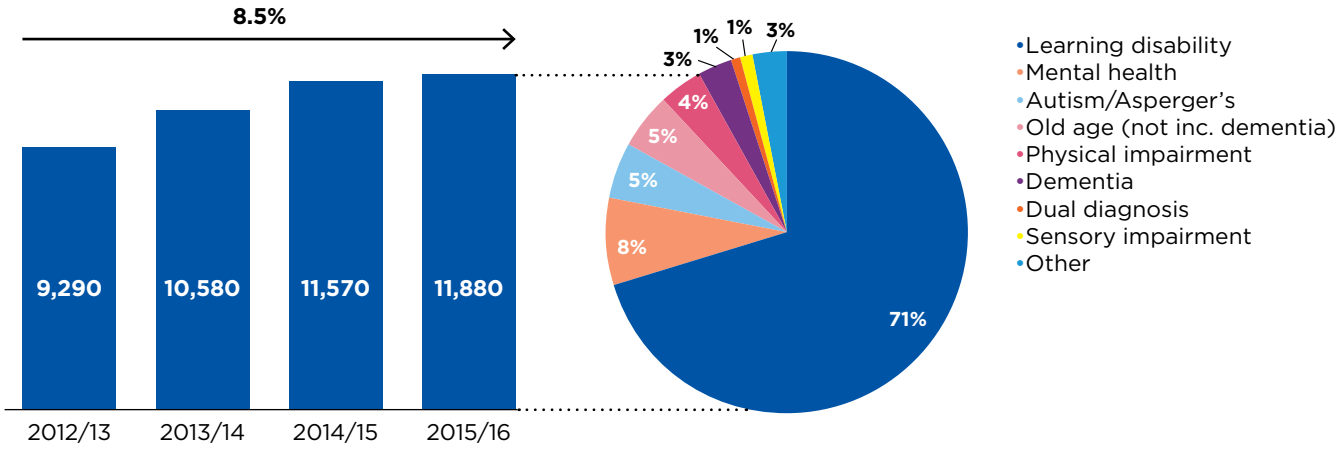
On the face of it, especially with social care policy being directed towards care in the community and personalisation, Shared Lives offers a cost-effective option that is very much in line with current commissioning objectives. Despite these clearly advantageous characteristics, however, Shared Lives has not yet materialised into a strong commercial contender within the adult social care market. In fact, growth in the number of Shared Lives placements has started to slow down. The number of people using one of the schemes grew by less than 3% in 2015-16, compared to 9% the previous year and 14% in 2013-14. The number of people using the schemes for short breaks and respite actually decreased by 3%, while recruitment of Shared Lives carers has also started to slow.

Over 90% of Shared Lives schemes are rated as being 'Good' or 'Outstanding' by CQC. So, what then could be preventing Shared Lives from achieving a stronger foothold in the adult social care market? The first reason is that thus far, Shared Lives has not yet proven itself of being entirely diverse and flexible in the types of needs it can support. Of the 11,880 Shared Lives service users in England, 71% have a learning disability as their primary care category, while less than 8% have a mental health diagnosis. Only 5% have an autistic spectrum disorder, 4% have a physical impairment, 3% have dementia and 1% have a dual diagnosis of learning disability and mental health (figure 1). If this lack of diversity in care provision continues, Shared Lives will not mount a significant commercial challenge to traditional models of care, such as residential homes.

In particular, the prevalence of dementia is increasing, and Shared Lives does not look to be offering much capacity to cater for dementia needs. This makes it harder for Shared Lives to evidence a more cost-effective option for ▶

FIGURE 2: SHARED LIVES PLACEMENTS

Number of Shared Lives placements (2012-13 - 2015/16) and placements by care category (2015-16)



commissioners when it comes to EMI care for the elderly. The needs of older people are also increasing in complexity as a result of dementia; perhaps indicating that these needs will be best met by well-resourced dementia specialist care homes rather than family/home settings. This means that increasing complexity among over 65s might be a better commercial opportunity for traditional residential and nursing homes, rather than Shared Lives schemes.

The same is also true when it comes to dual diagnosis. Provision for people with learning disabilities is fairly well supplied but there is a shortfall in provision for people with both a learning disability and mental health diagnosis, a gap which Shared Lives looks unable to move into at the moment, with only 140 Shared Lives placements being for dual diagnosis in England. Unless Shared Lives is able to show it can provide for needs in categories of care other than learning disabilities and mental health, and cater for increasing complexity, it will not pose much threat to traditional care providers in the adult social care market. In a survey released in September 2017, 55% of Shared Lives schemes reported challenges in their attempts to diversify; with several schemes experiencing a lack of awareness among social work teams of what Shared Lives could offer different client groups.

This relates to the next key challenge for Shared Lives - raising awareness among commissioners and social workers. While awareness surrounding the schemes is fairly prominent among learning disabilities professionals, knowledge about Shared Lives among professionals in other care categories – particularly those who work in mental health, remains low. There is a minimal understanding with regards to the concept of Shared Lives and what it can offer, which is not helped by budget cuts at local councils, restructures, and high turnover of social work staff. There are several LAs across England – including Tower Hamlets, Milton Keynes, and Hartlepool that are yet to have any Shared Lives schemes, either independent or council-run.

Shared Lives also faces the challenge shared by their children's counterpart in fostering provision – recruitment.

There can be no doubt that Shared Lives needs to be more flexible in the types and complexity of needs it can cater for. But perhaps the key to increasing commissioner awareness will also come from increased flexibility of a different kind – referral routes, funding options and arrangement types. As well as positioning itself as a primary option for adult placements, schemes are beginning to offer both children's fostering placements and Shared Lives schemes for adults in transition. Conversely, perhaps Independent fostering agencies could expand their commercial appeal, and revenue streams, by offering Shared Lives for adults transitioning from their fostering placements. Or Shared Lives schemes could position themselves as a step-down from traditional settings, and a bridge between traditional models of care and the community. For this to be successful, however, the flexibility will need to be effectively communicated to commissioners and demonstrated on a much wider scale, rather than individual cases.

Shared Lives could also take advantage of new funding mechanisms such as personal budgets and direct payments, which place funding in the hands of service users and their families and allow them to decide on care spending. This would enable the schemes to widen their appeal to potential referrers.

Shared Lives schemes clearly face significant barriers to their future commercial growth in a market place where commissioners are far more familiar with traditional models of care. How they overcome these moving forward, very much depends on how flexible the schemes can be and how they evidence this to commissioners. Until then, there will be no real impact on the traditional providers of care that they pitch their services against. ■

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