Shared Lives Bradford - Compass Scheme

Overview

The Compass Scheme is rooted in the Shared Lives model of support and care, which means a regulated service in which a family, couple or single person include another individual in their family and community life. It allows individuals registered with the shared lives scheme to use their own home as base and a resource to support people to learn or maintain skills and access the community. It aims to provide a personalised day service, with flexibility and choice of trained and competent provider. Sessions are recorded in a meaningful way for each person using the service and this information informs the review process.

Sessions are structured to the individual's needs and wishes, the specific aims they wish to achieve and at times to suit them, including evenings, weekends or late starts. It is not tied to a traditional day service timing of 10am - 4 pm.

People using the service and carers are involved in the development of individual service plans and matched with a provider with similar interests and appropriate skills. Providers receive regular support and guidance from the scheme.

The pilot project ran over 12 months and is now being gradually rolled out to a wider audience - limited by lack of funding and capacity.

Initially one person from the Shared Lives team and one from the Time Out team met regularly with the admin worker and the manager. This was as part of their full time work. Now one worker has a dedicated 18.5 hours to the Compass Scheme. The manager continues to provide support and the admin worker provides approximately two hours per week. Payments were initially made
sessionally but are being adjusted to an hourly rate.

Local commissioners were involved at an early stage and received copies of the evaluation report. Key stakeholders, including providers of day services from the Care Trust were included at an early stage. Staff from the Compass Scheme met regularly with other projects to discuss what the benefits were. Verbal feedback was that the scheme was felt to be a very exciting and positive development.

Referrals from other teams increased whenever any promotional talk took place and there was a lot of interest in the project especially for people who struggle to access day services or did not want to do so.

The project won the Great British Care Awards regional heat in the category ‘Putting People First’ in November 2011 and was described by the judges as:

'A truly innovative approach to providing support and activities that is developing real solutions by actually putting people first.'
Outcomes
The outcomes for people involved in the Shared Lives Bradford service are:

- **People are less agitated** and looking forward to spending the day with their Compass person and were relaxed on return.
- **Clear record and memory** of what they done with the use of scrap books or photos.
- **Carers have confidence** and knew who the person and could be confident in what they were doing.
- **More productive use of time** - knowing that someone is being kept safe.
- **Overnight stays** achieved - with great benefit to the whole family and the service user.
- **Take up of service** by people who would not otherwise choose to accept or engage with services.
- **Able to choose** who they were matched with and to have clear plan of activities.
- **Enjoyed the flexibility** provided by a service that could respond to how they were feeling on the day.
- **Travelling** to places of interest, which involves building confidence, route planning, money work, social skills, presentation of self, time keeping, manners personal hygiene.
- **Learning to cook basic food, which** involves identifying likes and dislikes, shopping, planning, budgeting, getting to and from shops, using a kitchen, taking photos and creating a scrap book of pictures to record what has been made.
- **Playing two or three holes of golf, which** maintains links with old friends after onset of dementia; keeps some physical activity as part of life; builds in routine and yet accepts limitations imposed by poor health and changes in ability.
- **Planning walks to local shops to buy**
things, which builds confidence after an severe episode of mental ill health, skills in engaging with others, and to gain confidence in taking charge of small events.

- **Continuing to paint** and use artistic skills after the onset of Alzheimer's, which involves having space and time to do what can be done and not focus on the skills that have been lost.

One woman appreciated the fact that her husband, who had Alzheimer's, was introduced to the provider in a low key way so that he saw it as doing things with a friend, not having to go to 'a service'. Providers could pick people up at the time that suited them and this was a benefit.

Outcomes were measured by creating outcome focused plans at the start of the match and then reviewing at six-weekly intervals. Staff observed the matches and also asked questions of the service user, the provider and family members.
What Next?

The service would like to be able to take self funders or direct referrals or referrals from known agencies like the Alzheimer's Society. Currently, all have to come via care management services, which can cause delay. The service are working on this with other parts of the department.

They would also like to undertake further recruitment but are constrained by the budget. The debate about out sourcing is relevant as there would be pros and cons to being a completely independent organisation, or part of an organisation which is not statutory.

There is also limited availability for people who have mobility needs. The service would like to look at making some houses more accessible, for example by helping to put in a downstairs toilet / ramps/ handrails, however they currently do not have a budget to do this.
Key Learning Points

- **Planning and reviewing tools** need to be simplified and made more person-centered. Regular planning meetings need to take place at least every 12 weeks.
- **Transport** and transport costs to and from the providers home is an issue.
- **Need to target** promotion in relevant care management teams to ensure appropriate referrals.
- **Clear and specific aim** - Start each match with a very clear and specific aim to measure against.
- **Time to develop** without any increase in long term funding for staff time. Resolved by reorganising parts of the teams work so everyone started to work slightly differently.
- **Not to be overwhelmed with referrals** and they are unable to match.
- **Commissioners** have been sympathetic to what we are trying to achieve and supportive. They have not always had a good understanding of all the services and their potential but have been willing to listen and open to contact and discussion, which has been helpful.
- **Co-production** - we have worked closely with families and people using the services to tweak the way the service operates.