Improving Support for Greater Manchester's Unpaid Carers

Evaluating Impact and Learning from the Accelerating Reform Fund Programme

directors of adass
adult social services
Greater Manchester

Image: Centre for Ageing Better

Contents

1. Opening message

Greater Manchester has a strong track record in working together for our people. This has been demonstrated in over a decade of closer working under Greater Manchester's devolution deal in 2014, and our "whole system" approaches to collaborate together between the NHS, local government and Voluntary, Community and Social Enterprise (VCSE) sectors.

We share a clear ambition: to support people to live well, remain independent, and stay connected to their communities. Doing so in the context of rising demand and increasing complexity requires a system that works differently – more preventative, more joined-up, and more responsive to people's lives.

Jayne Ratcliffe,
Director of Adult Social Care,
Oldham Council and Greater Manchester Unpaid Carers Lead.

Our commitment to Carers in GM is to support the implementation of an integrated approach to the identification, assessment and meeting of carers' health and wellbeing needs. Through our living well at home transformation programme, we support embedding the Greater Manchester Carers Charter and Exemplar Model consistently across localities, with a focus on co-producing solutions to supporting carers who experience health inequalities and social injustices.

All local services and organisations, including adult services, third sector carers' centres, breaks schemes and other carer-specific services, have a vital role to play in supporting carers. Through better identification by the whole system, we can ensure that carers get the right help at the right time and stop them going into crisis.

The Department for Health & Social Care's Accelerating Reform Fund (ARF) provided an opportunity to innovate how we do this in practice. Through strong partnership between local government, the NHS and the voluntary, community and social enterprise sector, we have focused on two critical priorities: improving support for unpaid carers, particularly in hospital settings, and strengthening community-based alternatives such as Shared Lives. The programme was strategy-led, aligning with Greater Manchester's wider priorities around neighbourhood working, the Live Well agenda, and the shift towards prevention and community-based care.

By working collaboratively alongside carers, we have been able to develop more relational, practical forms of support that better reflect the realities people face.

In addition, the ARF programme is underpinned by Greater Manchester's Exemplar Model for Carer Support, which provides a shared, values-based framework for how carers should be identified, supported and recognised across the whole system.

Developed through extensive engagement with carers and VCSE partners, the model sets out a coherent approach spanning early identification, timely access to support, health and wellbeing, employment, support for young carers, and the recognition of carers as real and expert partners. Crucially, it balances system-wide consistency with local flexibility, offering a common direction while enabling place-based delivery reflecting the needs of communities across Greater Manchester. This longstanding framework has created strong foundations for partnership, shared language and practice, and a readiness to translate strategy into action.

It is not a standalone programme, but part of a broader transformation in how we support people and communities across our system. And it benefitted from the well-established communities, networks and commissioned offers across Greater Manchester's ten boroughs, and in particular the diverse and impactful range of Shared Lives and Unpaid Carer services.

What stood out was the strength of partnership and lived experience in shaping delivery. By working collaboratively alongside carers, we have been able to develop more relational, practical forms of support that better reflect the realities people face.

This report sets out the progress made and the learning generated so far. It also reinforces a clear direction for the future: sustaining what works, strengthening the evidence base, and continuing to work together to deliver earlier, more effective support for the people of Greater Manchester.

2. Executive summary

The Accelerating Reform Fund (ARF) programme in Greater Manchester represents a strategy-led, partnership-driven response to some of the most pressing challenges facing adult social care and the wider health system: rising demand, increasing complexity of need, and the critical role of unpaid carers in sustaining care at home.

Delivered through a GM-wide consortium spanning local authorities, NHS organisations and third sector partners, the programme has tested how targeted investment, aligned to both national reform priorities and Greater Manchester's own integrated care strategy, can accelerate practical system change. The success of the ARF programme depended heavily on the pre-existing services that are already in place across the ten boroughs, and involved strategic collaboration between the Shared Lives and Unpaid Carers teams in each.

The programme focused on two core priorities: strengthening support for unpaid carers – particularly at the point of hospital discharge – and expanding community-based Shared Lives provision, including preventative support for people living with dementia through the Live More initiative.

Across both priority areas, the programme demonstrates the value of working at scale across a devolved system. GM's established infrastructure for collaboration, shared strategy and neighbourhood-based delivery has enabled locally tailored innovation while maintaining a clear line of sight to system-wide priorities around prevention, community capacity and integration.

Early findings show credible and meaningful progress.

In hospital discharge pathways, the introduction of dedicated carer support roles has led to improved identification of carers, more consistent inclusion in discharge planning, and better access to practical and emotional support. Over 3,100 carers were identified and nearly 1,900 received personalised support, with overwhelmingly positive feedback on impact and experience.

Within Shared Lives, the programme has laid important foundations for growth. A GM-wide communications campaign, co-produced with people with lived experience, has begun to raise the profile of the model and support recruitment. At the same time, the Live More dementia pilots provide early evidence of demand for preventative, relationship-based support that enables people to remain connected to their communities while supporting family carers.

Several cross-cutting insights emerge:

- A strategy-driven approach, aligned to national reform and GM's own Live Well and neighbourhood agendas, has ensured coherence and relevance across diverse local delivery models
- Partnership working across statutory and VCSE sectors has been essential in bridging hospital and community support, and in developing Shared Lives capacity
- Dedicated capacity matters: targeted investment in roles and infrastructure has enabled activity that existing systems were not consistently able to deliver
- Relational, person-centred support drives the strongest early outcomes, particularly for carers navigating periods of crisis or transition
- Prevention and community-based models show clear potential, but require sustained investment and longer time horizons to fully evidence system impact

Image: Peter Kindersley via Centre for Ageing Better

Overall, the programme provides a compelling example of how a whole-system, partnership-based approach can begin to reshape support for carers and communities.

Overall, the GM ARF programme provides a compelling example of how a whole-system, partnership-based approach, grounded in lived experience and aligned to strategic priorities, can begin to reshape support for carers and communities. It offers both practical learning and a strong foundation for future reform across Greater Manchester and beyond.

Looking ahead, the programme leaves a strong strategic legacy through its alignment with Greater Manchester's Exemplar Model for Carer Support, the Live Well approach and other regional and strategic priorities.

ARF activity has reinforced and operationalised these key agendas for change and development, which set out whole-system approaches to identifying, supporting and valuing unpaid carers across health, local government, employers and the third sector.

By grounding delivery in shared principles – including early identification, strengths-based and relational support, and the recognition of carers as real and expert partners – the programme has helped translate Exemplar Model priorities from the page and into practice. This provides a clear platform for future system development, enabling Greater Manchester to build on proven approaches, sustain effective roles and partnerships, and strengthen consistency of support while maintaining local flexibility.

3. Introduction and context: the Accelerating Reform Fund

a. The Accelerating Reform Fund

The Accelerating Reform Fund (ARF) is a national programme funded by the Department of Health and Social Care (DHSC) to support innovation and improvement in adult social care in England. The programme focuses on developing person-centred approaches to care and strengthening support for unpaid carers amid increasing demand for adult social care.

Demand pressures reflect demographic change, including an ageing population and a growing number of people living with multiple long-term health conditions. The programme also aligns with wider national policy priorities to strengthen community-based care and improve coordination between health and social care services.

DHSC allocated £42.6 million to the programme across 2024/25 and 2025/26. Integrated Care Systems (ICSs) were required to establish local partnerships to deliver programme activity and to undertake local evaluation of impact. These evaluations are supported nationally by the Social Care Institute for Excellence (SCIE) and Ipsos, which provide development and evaluation support, respectively.

In Greater Manchester (GM), the programme is delivered through the GM ARF Consortium, led by the GM Adult Social Care Transformation team on behalf of GM Directors of Adult Social Services (GM ADASS). The consortium brings together the ten GM local authorities alongside NHS organisations, voluntary, community and social enterprise (VCSE) partners and other stakeholders across the health and social care system.

Greater Manchester received £1,997,195 in total ARF funding across the two-year programme period (£718,641 in 2024/25 and £1,278,554 in 2025/26). This funding was provided as Adult Social Care funding to support delivery of the programme across the GM system. Manchester City Council hosted the funding on behalf of GM ADASS, with responsibility for reporting back to DHSC on its utilisation.

Demand pressures reflect demographic change, including an ageing population and a growing number of people living with multiple long-term health conditions.

b. Policy and Strategic Context

GM has a population of approximately 2.9 million people (2,867,800 according to the 2021 Census) across ten local authority areas: Bolton, Bury, Manchester, Oldham, Rochdale, Salford, Stockport, Tameside, Trafford and Wigan. These areas collectively form both the G M Combined Authority (GMCA) and NHS GM (coterminous) areas. GM has an established history of cross-system collaboration and integrated strategic planning across health and social care.

At a national level, the Government's Fit for the Future: The 10 Year Health Plan for England (HM Government, 2025) sets out a proposed 'new model of care' designed to respond to demographic change and rising demand across the health and care system. The plan outlines three strategic shifts:

- a shift from hospital to community-based care, including the development of neighbourhood health services and multidisciplinary teams
- a shift from sickness to prevention, with greater emphasis on early intervention and population health
- a shift from analogue to digital systems, including improved information sharing and digital access to services.

Within GM, the regional strategy Putting Health at the Heart of GM: Improving Health and Care in GM 2023–2028 sets out priorities for improving population health through integrated working across health, social care and community services. Key priorities include:

- further development of integrated neighbourhood working
- strengthening the role of communities in improving health and wellbeing
- identifying and supporting unpaid carers
- continued development of the GM Care Record as part of improved information sharing across services.

The GM strategy places particular emphasis on community-led approaches to health and wellbeing. It commits to strengthening co-design and co-production with communities and people with lived experience, alongside a strengths-based approach to supporting people to remain well and independent.

This approach is also reflected in the Live Well programme in GM. Live Well aims to support people in remaining connected to their communities and accessing joined-up support for wellbeing, health and employment. The programme emphasises community-led approaches, with the development of local Live Well Centres designed to integrate wellbeing, health and employment support within neighbourhood settings.

These priorities and approaches are consistent with the national direction set out in ADASS's Time to Act: A Roadmap to Reform Care and Support in England. The roadmap calls for a shift towards prevention, community-based and relational models of care, stronger support for unpaid carers, improved integration across health, care and community services, and greater co-production with people and communities. It emphasises the role of local leadership in driving change and aligns closely with GM's focus on neighbourhood working, community capacity, and strengths-based approaches to supporting people to live well and independently.

c. The GM ARF Programme

The programme focused on two main priority areas of activity:

- improving support for unpaid carers during hospital discharge
- strengthening and expanding the Shared Lives model across GM.

Within Shared Lives, the Live More initiative was developed to test a preventative Shared Lives approach for people living with dementia and their families.

Hospital Discharge

The Hospital Discharge priority area focused on improving the identification and support of unpaid carers when someone they care for is admitted to, or discharged from, hospital. Projects were delivered across all ten GM localities through partnerships between local authorities, hospitals, carers' organisations and voluntary sector partners.

Activity centred on embedding carer support roles within hospital settings, strengthening referral pathways between hospitals and community-based carer support services, and increasing awareness of carers among health and care professionals.

Programme activity included identifying carers within hospital settings, providing personalised information and support, facilitating access to carers' assessments and support services, and delivering training and awareness-raising activity for hospital staff and volunteers. This aimed both to improve carers' experiences during hospital discharge and to strengthen the recognition of carers' needs within discharge planning processes.

Shared Lives Development

This focused on strengthening the development and visibility of the Shared Lives model across GM. Shared Lives provides community-based support in which approved carers share their home and family life with people who need support, offering flexible alternatives to traditional residential care.

As part of the programme, a GM-wide communications and development campaign was commissioned to raise awareness of Shared Lives and support the recruitment of new carers. The campaign sought to establish a more consistent regional identity for Shared Lives, strengthen communications across local areas, and increase understanding of the model among potential carers, partners and the wider public.

Work also included developing shared branding and communications resources, a regional website and social media channels, other digital offers, and coordinated outreach activity across the ten boroughs. The campaign was developed using a co-production approach involving carers, people supported through Shared Lives and system partners, alongside monitoring measures to track engagement and recruitment activity.

Live More: Shared Lives and Dementia

Within the Shared Lives priority area, the Live More initiative was developed as a test-and-learn programme to explore how Shared Lives could provide earlier support for people living with dementia and their families.

Live More offers people living with dementia opportunities for day support and short breaks through Shared Lives arrangements. The model aims to support people to remain active and connected to their communities while also providing practical and emotional support for family carers.

The initiative responds to evidence that many people receive limited support following a dementia diagnosis until needs escalate. Live More therefore focuses on earlier intervention, supporting individuals and families before they reach the threshold for more intensive social care services.

Launched in July 2025, the programme aimed to support around 100 people and families across GM through a six-month pilot. Delivery included co-production with people with lived experience, practical support for Shared Lives schemes and an evaluation framework designed to inform future development and potential scaling of the model.

Manchester City Council Digital Platform

The Manchester City Council (MCC) Digital Platform project is using a test and learn approach to delivering a digital support platform for Manchester Shared Lives carers. M CC have commissioned Carbon Creative to deliver this in partnership with them through coproduction values. This digital platform will be a Progressive Web App (PWA) i.e. it will have the look and feel of an app but be accessed via an internet browser. The aim is to populate the PWA with information about available support, events and other resources, based on the expressed needs of Manchester unpaid carers. MCC have aligned their design approach with Carbon Creative to the Shared Lives branding from the Passion4Social CIC campaign. This will ensure a cohesive feel across all projects developed as part of the GM ARF programme and make them more easily recognisable by carers. The learning and evaluation from this project will be used to assess whether this could be an impactful resource for carer across the other Greater Manchester boroughs.

Project activity to date has included coproduction workshops with unpaid carers and other system stakeholders, Coproduction and engagement with unpaid carers will continue throughout the design process. MCC are taking a phased approach starting with a community forum feature, with the potential expanding of the PWA in the future to include an event section and a resources page. The PWA is currently due to go live in June 2026.

The model aims to support people to remain active and connected to their communities while also providing practical and emotional support for family carers.

4. Development and Delivery: how the GM ARF programme has been running

Hospital discharge

Eight hospital discharge projects were implemented across GM, covering all boroughs and acute hospitals (Fairfield General (Bury), Manchester Royal Infirmary, North Manchester General Hospital, Salford Royal, Trafford General, Rochdale Infirmary, Royal Oldham, Royal Bolton, Stepping Hill (Stockport), Tameside General, Wythenshawe Hospital). These projects worked with a range of local authorities, carers' organisations and voluntary sector providers.

Delivery activity typically included:

- identifying unpaid carers within hospital settings
- providing personalised information, advice and practical support
- supporting access to carers' assessments and wider support services
- strengthening links between hospital teams and community-based support.

Shared Lives Development

This programme included several initiatives designed to support the development of Shared Lives capacity across the region. These included:

- an initial scoping exercise to assess opportunities for growth and diversification of Shared Lives schemes across GM
- a region-wide communications and recruitment campaign to raise awareness of Shared Lives and support the recruitment of new carers
- the development of a digital platform project to support Shared Lives carers.

Live More: Shared Lives and Dementia

Within the Shared Lives programme of work, the Live More initiative was developed to test a preventative Shared Lives approach for people living with dementia and their families.

Ten Live More pilot projects were developed across GM through local Shared Lives schemes. The programme was designed as a test-and-learn initiative to generate evidence about how Shared Lives approaches may support people earlier in their care journey and potentially delay or prevent the need for more intensive support.

Ten Live More pilot projects were developed across GM through local Shared Lives schemes.

Manchester City Council (MCC) – Digital Platform

The main objective of the MCC project is to ensure that the digital platform would be responsive to the lived experiences and practical needs of Manchester's Shared Lives carers. They recognised that for a solution to be effective and widely adopted, it must not only address the challenges carers face in their day-to-day roles but also be relevant to them and clearly designed with their input. To achieve this, they started the project by engaging directly with carers to gain a better understanding of their day to day lives and challenges they encounter.

Carbon Creative put together a proposal based on a high-level brief which was refined at a scoping session with GM colleagues in September 2025. The timescales and development schedule were revised due to some external and internal delays. The digital solution will initially be for Manchester Shared Lives Carers only. Based on the evaluation of the project, there may be wider GM conversations around whether other boroughs would find the approach useful. MCC sent out an expression of interest to GM carers to gauge interest in attending feedback sessions of the digital materials as they become available, and over twenty carers replied and took part in design sessions in February and March 2026. The level of response and engagement from GM carers to take part in the review and feedback sessions also indicate that this is something carers are interested in and would find very useful.

Co-production and Lived Experience

A cross-cutting workstream on co-production and lived experience was embedded across the GM ARF programme.

This workstream aimed to ensure that people with direct lived experience of caring roles could contribute to programme design, delivery and evaluation. The intention was to capture carers' perspectives and incorporate these insights into learning about what works and what may need to change within health and social care systems.

To support this work, a team of Peer Researchers with lived experience as carers was recruited. The Peer Researchers are supporting the development of the '100 Stories Project', which aims to collect and analyse qualitative accounts from unpaid carers across GM.

These stories are intended to complement programme monitoring data and provide deeper insight into carers' experiences of hospital discharge processes, community support and Shared Lives provision.

Gaddum led this workstream and recruited a Lived Experience Coordinator to support delivery. Interview transcripts from carers are currently being curated and analysed to identify emerging themes and learning for the programme evaluation. This will influence the future of the programmes, ensuring living experience is at the heart of services for people across Shared Lives and unpaid carer contexts.

Programme Funding and Distribution

The allocation of ARF funding across the programme reflects the distribution of local delivery projects and GM-wide programme activity.

Funding supported local authority delivery across the hospital discharge and Live More initiatives, alongside regional activity to support Shared Lives development, communications, programme coordination and infrastructure support.

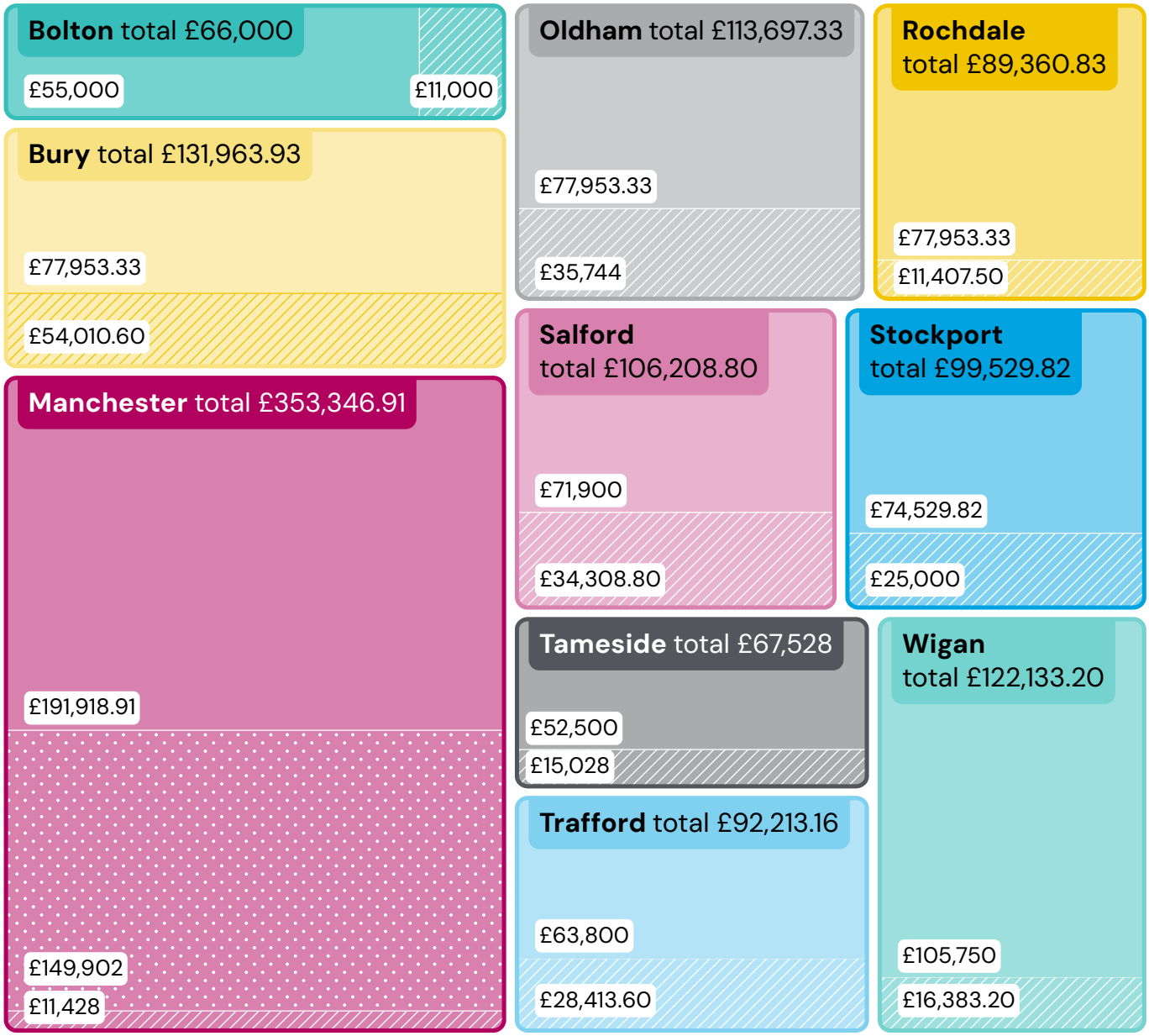
Figure 1: GM-ARF initiatives and finances*

Local authority total
Total across all: £1,241,981.98

Hospital Discharge projects
Total: £849,258.72

Manchester Shared Lives digital solution project
Total: £149,902

Shared Lives & Dementia projects
Total: £242,723.70



GM-wide project funding

Shared Lives Plus: initial research to scope potential for shared lives to grow and diversify across GM	**£49,660**
Shared lives: awareness raising and recruitment marketing-communications campaign (Passion4Social CIC)	**£249,800**
Shared Lives Plus: Shared Lives & Dementia infrastructure	**£191,400**
GM ASC transformation team project management support	**£61,231.02**
Whole-programme infrastructure support and co-production investment	**£203,122**
= Total	**= £755,213.02**
> = Grand total (£1,241,981.98 + £755,213.02)	**> = £1,997,195**

* Bury, Oldham & Rochdale combined Hospital Discharge project, £233,860

5. **Evaluation:** how we've measured the programme

a. Evaluation Focus

The evaluation was conducted within the context of the wider GM health and care system and incorporated qualitative insights from people with lived experience where available. It was designed to:

- assess how the GM-ARF programme was developed and implemented across the region
- examine early outcomes for people with care and support needs and their families, particularly unpaid carers
- identify wider system impacts and learning for partners across health, social care and VCSE organisations
- provide practical recommendations and future-facing implications for policy and service development.

b. Evaluation Questions

Impact and outcomes

- To what extent have ARF-funded projects improved outcomes for people with care and support needs and their families, particularly unpaid carers?
- What changes or benefits have been observed, and what factors have contributed to these outcomes?

Programme implementation and learning

- How effectively were the projects implemented across GM?
- What approaches were most effective in overcoming barriers to delivery, and what lessons can be drawn for other localities seeking to implement similar initiatives?

Economic and system value

- What potential economic or social value has been generated through the programme?

Evaluation Methods

The evaluation used a mixed-methods approach combining document analysis, stakeholder engagement and indicative economic analysis.

The main components of the evaluation included:

- Desk-based analysis of programme documentation and monitoring data provided by Gaddum between August 2025 and the conclusion of the programme.
- Engagement with programme leadership, including a series of face-to-face and virtual meetings with the ARF Senior Project Manager and Project Administrator.
- Analysis and synthesis of programme evidence, drawing together monitoring data, documentation and qualitative insights to identify key themes, outcomes and learning.

Approach to Analysis

Given the early stage of programme delivery, the evaluation focused primarily on implementation learning and early outcomes rather than long-term system impact.

While programme documentation included extensive material relating to governance arrangements and strategic alignment, the evaluation prioritised analysis of programme delivery in practice and the outcomes associated with funded activity. This approach aimed to ensure that the evaluation focused on the programme's practical implications for people, services and the wider system.

The evaluation focused primarily on implementation learning and early outcomes rather than long-term system impact.

Image: In-Press Photography via Centre for Ageing Better

6. Findings, analysis and learning

Overall, the evidence indicates that the programme has made early, credible progress in testing new approaches to carer support and community-based provision across GM.

The clearest evidence of impact has been found in the Hospital Discharge priority area, where projects have established new support roles, generated substantial activity and reported positive feedback from carers and staff. This is most likely explained by more embedded hospital service delivery in these areas when compared with the aims of Shared Lives and Live More being new programmes of influencing work.

Across Shared Lives, programmes of work are in a maturing phase. The Live More programme, in particular, demonstrates early evidence of demand for dementia-focused Shared Lives support and of the feasibility of this model across multiple localities.

Several cross-cutting findings emerge.

- Addressing unmet need: The programme addressed gaps in support. Evidence shows many carers and families had previously received little support, were unaware of available help, or had not been identified by services.
- Value of dedicated capacity: Introducing dedicated roles and development resource enabled activity that existing systems struggled to deliver consistently. This included improved carer identification and referral pathways in hospitals, and coordinated Shared Lives development and communications work across Greater Manchester.
- Importance of relational support: The strongest early benefits arose where support was person-centred, consistent and practical. This was evident in carer support during hospital discharge, Shared Lives approaches based on connection and shared interests, and the Live More model supporting people following a dementia diagnosis.
- Limits of short-term funding: Though much has been achieved, short timelines, recruitment challenges and local capacity constraints limit the pace of implementation and the extent to which outcomes can be demonstrated.Hospital Discharge

Intended outcomes

1. increased carer wellbeing, resilience, ability to continue caring effectively at home (reduction in carer breakdown)
2. increased ability of the person supported by the carer to continue to live well at home
3. specifically, reduced hospital readmissions (translating into potential savings against hospital admission/care costs)
4. reduced use of other formal health and social care services (translating into potential savings against the costs of these services).

Total ARF funding for Hospital Discharge was £849,258. Across the programme, funding was used primarily to establish new carer-focused roles embedded within hospital pathways and linked to community-based carers' organisations and support services.

Figure 2: **Hospital Discharge projects' ARF-funded new roles**

Bolton

ARF £55,000
Hospitals: 1

Carers Support Link Worker ('Caring for You Too' pilot in hospital-based discharge team, embedded within Age UK Bolton and delivered in partnership with Bolton Carers Support)

Bury, Oldham & Rochdale

ARF £233,860
Hospitals: 3

Carers Hospital & Community Healthcare Coordinators x 4 (3.5 FTE), Carers Information & Support Officers x 2

Manchester

ARF £191,918
Hospitals: 3
Carers Officers x 3 (hospital-based), Team Leader/Coordinator x 1

Salford

ARF £71,900
Hospitals: 2

Carers Hospital Pathway Development Worker, Shared Lives Development Worker

Stockport

ARF £74,529
Hospitals: 1

Carer Support Workers (hospital-based) x 3 (2.0 FTE)

Tameside

ARF £52,500
Hospitals: 1

Carer Community Engagement Worker (1.0 FTE), Health & Wellbeing Advisor (0.2 FTE)

Trafford

ARF £63,800
Hospitals: 2

[not specified]

Wigan

ARF £105,750
Hospitals: 3

Carers Liaison Coordinator (1.0 FTE), Carers Liaison Officer (part-time)

Totals = ARF £849,258 = Hospitals: 16

Although local delivery models varied, practice generally included a mix of casework, advocacy, information and signposting, training for staff, co-produced resources, and the development of referral routes between hospitals and carers' services.

Projects also introduced locality-specific innovations. These included practical post-discharge support in the home, carers' groups and courses, peer-led emotional support, staff awareness training, carer information resources, and mechanisms to gather carer feedback and inform service improvement.

Manchester carer impact story: a carer caring for her mum

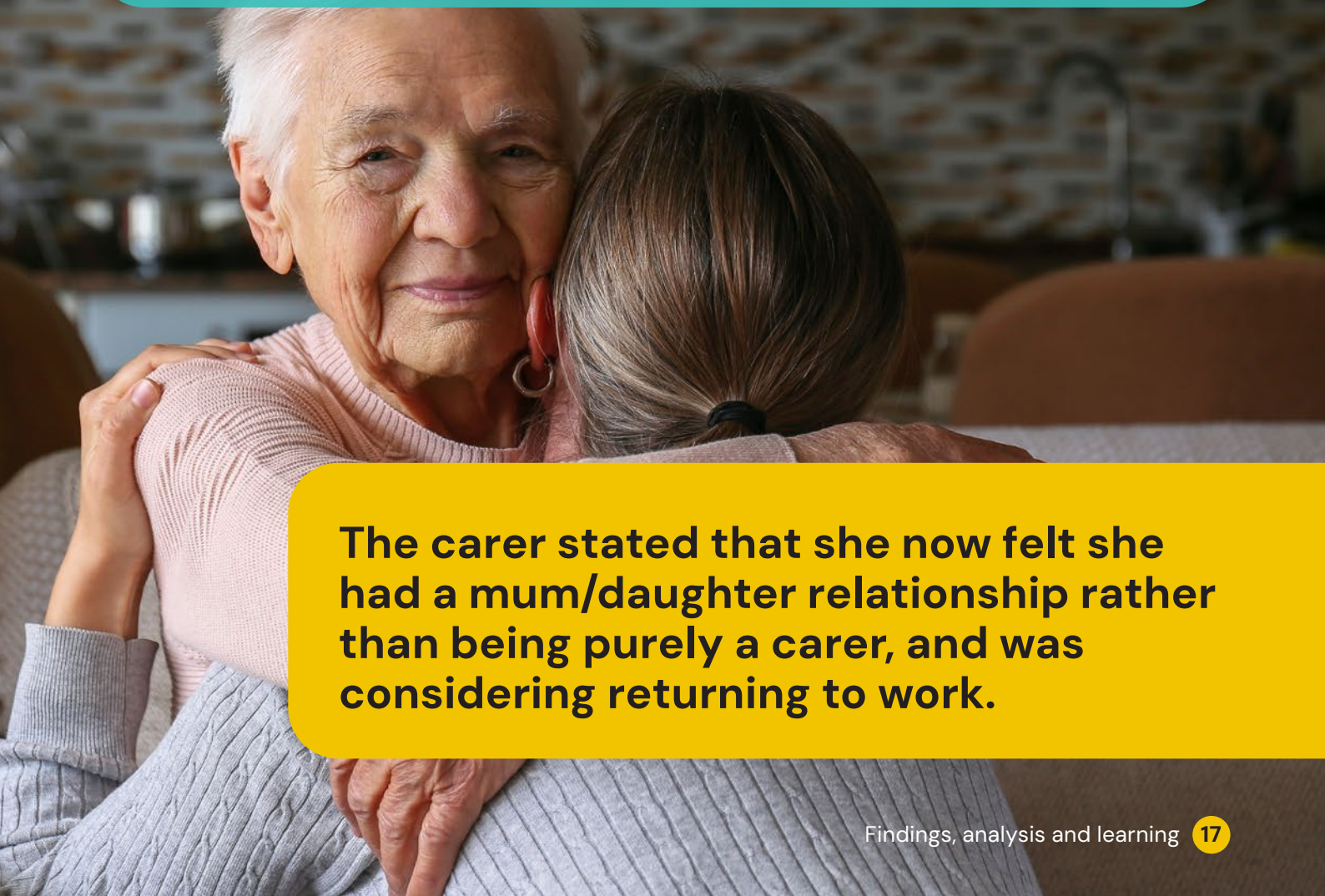
The carer is 40 years old and cares for her mum who has dementia. Prior to hospital admission, mum was living independently with support, and the carer had given up work to support her. Mum was admitted to hospital with Covid, and her dementia negatively progressed whilst in hospital.

The carer was anxious and stressed about her caring role, and in particular felt overwhelmed about an upcoming hospital-based Multi-Disciplinary Team (MDT) review. Consequently, the ARF-funded Caseworker talked with her about her concerns before the MDT meeting. The main concerns were that mum wouldn't cope even with an intensive home care package, due to fears around wandering and related safeguarding issues – accordingly, she preferred mum to be discharged to a local Residential Home, but was very anxious about being 'forced' to take mum home, and concerned that she may not get her wishes across clearly in the meeting.

The carer felt empowered after the above pre-MDT conversation with the Caseworker, and requested and received Caseworker advocacy support in the MDT meeting.

The outcome was that mum moved to a local Residential Home.

The carer stated that she now felt she had a mum/daughter relationship rather than being purely a carer, and was considering returning to work. The MDT Occupational Therapist commented on how useful it was to have an independent Caseworker in the MDT review.



The carer stated that she now felt she had a mum/daughter relationship rather than being purely a carer, and was considering returning to work.

Bolton carer impact story: a carer looking after her Mum, Jill

Jill is a 92-year-old woman who lives independently. She was referred to the Caring for You Too programme by the Home Hospital Team following her discharge from Bolton Hospital. Jill faces multiple health challenges, including visual impairment, arthritis, a stroke in 2020, and suspected but undiagnosed memory loss. Her daughter, who provides regular support, is also the primary carer for her husband. Managing two households, each with significant care needs, had become physically and emotionally exhausting, with tasks like cleaning her mother's home adding considerable pressure.

Jill was first introduced to the Home From Hospital service while in the Discharge Lounge. It quickly became clear that continued support at home was needed, prompting the Caring for You Too referral. Fortnightly domestic support was arranged, consisting of two hours every two weeks, totalling 12 hours over the initial period. Both Jill and her daughter warmly welcomed this help. A key success factor was the consistency of care, as the same Home Services Assistant (HSA) visited each time, reducing confusion and providing Jill with a familiar and reassuring presence. No significant barriers were encountered. The setup and delivery of support were smooth, with proactive communication and strong engagement from Jill's family throughout.

The introduction of cleaning support significantly lightened the daughter's workload, allowing her to move from a purely task-focused role to spending more meaningful time with her mother. As a result, Jill's home became a safer, cleaner, and more pleasant environment. Jill's daughter reported a marked reduction in stress and emotional burden. The regular and dependable support enabled her to manage dual caregiving responsibilities with greater ease and less isolation. Although Jill could not share her feedback directly due to memory difficulties, her daughter expressed heartfelt thanks. She described the service as having "lifted a weight off [my] shoulders", enabling her to reconnect with her mother in a more relaxed and emotionally fulfilling way.

Jill's home became a safer, cleaner, and more pleasant environment. Jill's daughter reported a marked reduction in stress and emotional burden

Jill continues to benefit from the regular domestic support and remains safely at home, surrounded by familiar routines and people. Her daughter is now better able to sustain her dual caring roles without becoming overwhelmed. This case highlights how even modest levels of practical support can lead to lasting, positive outcomes for both older adults and their caregivers. In particular, it underscores the value of continuity in service provision, especially for those with cognitive challenges and reinforces the critical role of post-hospital, integrated support in maintaining wellbeing and independence at home.

Hospital Discharge projects: example service improvements and innovations

Objective 1. To better identify carers in hospital settings

Manchester created a 'What is a Carer' presentation for hospital staff education, as part of its quest to identify carers who have not used carer support services before

Tameside and Trafford worked to identify and support hospital staff who themselves are carers for family members: Tameside worked collaboratively with the hospital HR team, promoted staff carer support on the hospital intranet and established a dedicated carers staff forum; staff carers in Trafford subsequently became wider carer advocates within their teams

Objective 2. To better support carers in practical ways through the hospital discharge process

Stockport provided carers with time and space, within the ward setting, to talk and to get support, through setting up a 'Serenity Lounge' carer drop-in provision at Stepping Hill Hospital – both the hospital and community-based Carer Support Workers hold weekly drop-ins there

Bolton supported carers during and after hospital stays by providing emotional, practical and respite support, and directly referred carers on to local carer support services as needed

3. To empower carers through the provision of carers groups, workshops and courses

Salford ran 'Empowered Carers' courses for carers as part of its 'Empowered Conversations Approach', engaging 15 carers to date (see figure 3 on page 26 for full details of carer engagement across all projects)

Salford ran therapeutic sessions for carers focusing on dementia (20 carers) and on older carers (10 older carers)

Wigan piloted a 6-week 'Caring Conversations' programme of peer-led emotional support for/with carers, in which volunteers phoned carers on a weekly basis (Sally's impact story on page 30 relates)

4. To train and support hospital frontline staff in identifying, communicating with and supporting carers

Bury/Oldham/Rochdale focused on upskilling hospital staff to ensure carers are identified and offered support

Manchester's 'What is a Carer' presentation (objective 1 above), to train and support hospital frontline staff

Salford piloted a 'Communicating with Carers' course with hospital-based therapy teams, which was well received by staff participants

Wigan worked with carers to co-design and co-create a carer-related training pack for hospital staff, to help staff to better identify and support carers

Tameside worked with carers to coproduce a carer registration form and associated staff training

5. To develop/use hospital-based provision of information, advice and signposting for carers

Salford established a Carers Focus Group and through this worked with carers on the Group to co-create information resources including audio materials

Wigan developed an information pack for carers to help them navigate available support

6. To better support carers during the vital first few weeks following discharge

Bolton: as part of its 'Home from Hospital' offer, Bolton has extended the scope of its 'Home Services Support for carers/Caring for You Too' six-week shopping and cleaning provision (delivered by Age UK Bolton) by making it free of charge, rather than previously paid for, and established strong referral pathways into this service

7. To embed co-production with carers at all stages of project development and implementation

Manchester established a Steering Group of carers with lived experience to underpin development of its project

8. To embed a continuous service improvement loop

Trafford developed a feedback questionnaire to capture carer experience of hospital discharge, to inform ongoing service improvement

Bury/HMR/Oldham: Cross boundary referrals & Out of Area referral were a focus of the project due to specialisms within hospital sites. There was collaborative working in all teams across the three Boroughs demonstrating wider system buy-in

9. To avoid hospital admission in the first place

Salford developed a Shared Lives Enhanced Response service, supporting the service user if his/her carer has an unplanned admission to hospital

10. To avoid re-admission to hospital wherever possible

...through all of the above objectives and examples

Bolton carer impact story: ‘LW’, a carer looking after her mother

LW is a woman in her late 60’s who is the primary carer for her elderly mother, who is bedbound and requires significant daily support. LW recently experienced several major life events in a short period of time. Her husband had passed away, and shortly afterwards, her mother had been discharged from hospital, returning home with increased care needs.

LW contacted the Caring for You Too service in a state of acute distress. She described feeling overwhelmed, emotionally exhausted, and in need of someone who would simply listen. She explained that she had not had the opportunity to grieve for her husband, as her caring responsibilities intensified immediately following her mother’s hospital discharge.

LW was managing all aspects of care alone, including personal care tasks, frequent bed changes, shopping, cleaning, and household management. She described feeling that she had become “a carer first and a daughter second”, which caused her significant guilt and emotional strain. She reported feeling close to breaking point and feared she would no longer be able to cope.

LW described the visits as a turning point, explaining that having reliable, practical help allowed her to breathe, feel valued, and regain a sense of herself beyond the caring role.

At the initial home visit, it was clear that LW was under immense pressure. She was providing full-time care with no regular respite and limited emotional or practical support. While deeply committed to her mother's wellbeing, she felt trapped by the demands of caring and resentful of how her own life had been consumed.

The Caring for You Too service recognised that LW's needs were as critical as those of the person she was caring for, particularly at this vulnerable point following hospital discharge. A person-centred support plan was agreed, focusing on reducing immediate pressure and preventing further deterioration in LW's wellbeing.

Weekly visits were arranged to support with changing bed linen and undertaking the majority of household cleaning. Although modest in scale, this intervention was carefully targeted to relieve the most physically and emotionally draining tasks.

LW engaged positively with the support from the outset. She described the visits as a turning point, explaining that having reliable, practical help allowed her to breathe, feel valued, and regain a sense of herself beyond the caring role. LW had the link with Bolton Carers Support for additional guidance and support when needed.

The impact of the support on LW has been significant. The practical assistance reduced her physical exhaustion, while the emotional reassurance of being supported helped stabilise her mental wellbeing at a time of profound vulnerability.

LW reported that the service gave her "a little bit of freedom" and, for the first time in months, the permission to prioritise her own needs alongside those of her mother. This included having time to rest, process her bereavement, and reconnect with life beyond caring. She expressed genuine gratitude for the immediacy of the response and the sensitivity of the support, particularly given her emotional state following both bereavement and her mother's hospital discharge.

As the Caring for You Too support draws to a close, discussions are underway about transitioning to longer-term Home Services support for LW's mother, ensuring continuity of care and ongoing stability for both mother and daughter.

Outputs and early outcomes

Across the programme period:

- projects identified 3,102 carers in hospital settings and provided 1,869 carers with personalised support and guidance.
- a total of 368 carers were referred for statutory carers' assessments, and 123 statutory assessments were completed by project staff.
- significant community development activity took place, including 877 public-facing engagement sessions, 9,863 conversations with members of the public about carer support, and 1,702 staff or volunteers trained in carer awareness.

Carer feedback is positive. Among carers who provided feedback, all reported that support had a positive impact on their wellbeing, and all said they would recommend the support. Reported inclusion in discharge planning also improved over time.

Co-production activity was a further notable output, with 319 activities involving people with lived experience reported across the programme period.

Tameside carer impact story: a carer caring for his wife

A carer came to our stall in the hospital visibly upset as he was caring for his wife who had dementia and she had been in hospital for a few days. He had reached a point of despair as he had no family. Both were in their 80s with no support. He explained how he felt isolated and, in his words, "on my own". The project worker chatted about possible dementia friendly day care at Wilshaw House [Ashton] to give him some time to breathe and take some time for himself. He said he would contact them to look around. He was also advised of all the activities we ran which he said he would love to attend to meet people. After the conversation the project worker took his details so we could follow up and arrange a carer's conversation in a little more depth. He was so appreciative that we had been at the right place, at the right time to offer him support.

He subsequently arranged a visit with his wife to Wilshaw House with a view to her attending two days a week, providing him with much needed respite. He said he felt a weight lifted knowing there were people that were capable and qualified to assist him looking for his wife and he could then begin to meet other carers at our activities for peer support, and to be less isolated.

Trafford carer impact story: June, a carer looking after her mum

June is a 63-year-old carer for her mum, aged 89, who has a number of long-term health needs including oedema, hypertension, psoriasis and high risk of falling. She was referred into Trafford Carers Centre by a nursing associate from the Trafford Crisis response team whilst at Trafford General Hospital. June is from a very small family unit and has taken on the care role for her mother with support from her husband.

June rang our helpline in a distressed state; she was overwhelmed with the multiple hospital admissions that her mother had recently encountered. The hospital caseworker visited her on the ward and was able to support at the discharge meeting and make sure she was confident in the package of care that was being put in place. June was provided with emotional support, and once her mother was discharged a month later, a full carers assessment was completed. Follow-up calls were also made to keep in contact with June.

June reported that she was able to cope with the hospital and discharge process much better with the support from Trafford Carers Centre. She became much calmer and felt supported with her mum's care. She managed to get some social life back into her own life – something which had been missing whilst her mum was unwell. June expressed that she was so grateful for our support.

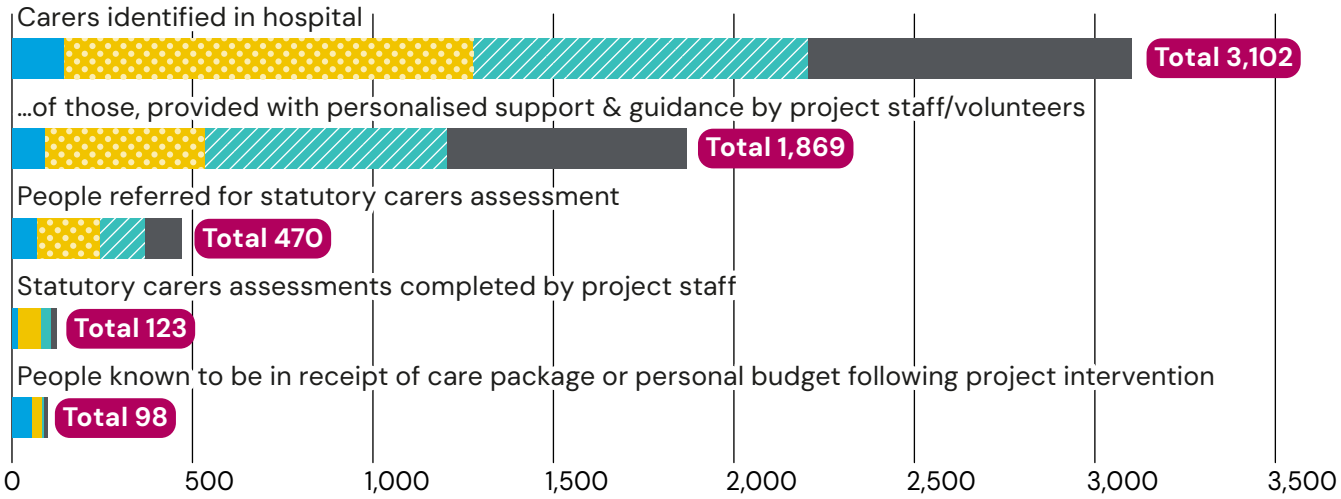
June reported that she was able to cope with the hospital and discharge process much better with the support from Trafford Carers Centre. She became much calmer and felt supported with her mum's care.

Figure 3: **Hospital Discharge carer quantitative outputs across the eight projects**

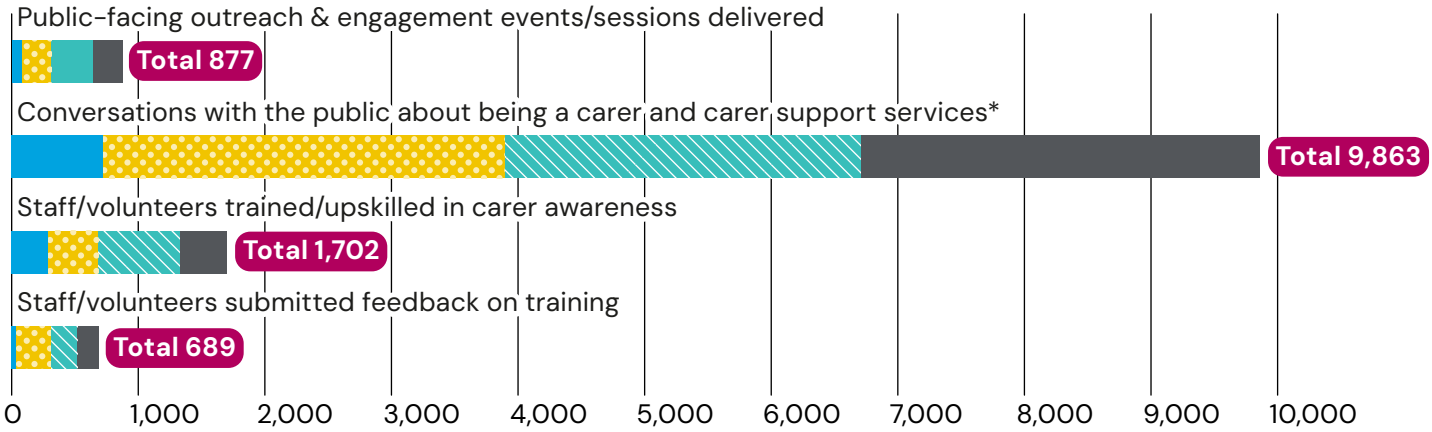
Legend:

Dec24-Mar25 | Apr25-Jun25 | Jul25-Sep25 | Oct25-Dec25 | Average/total

1. Carer intervention (carer identification & support):



2. Outreach/engagement/training:

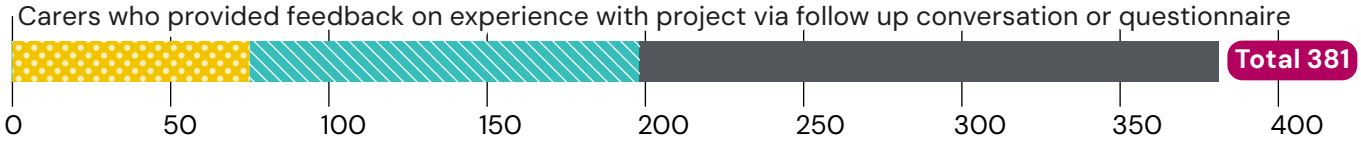


% of staff/volunteers in hospitals that are able to identify unpaid carers

...and % of staff with improved ability to assess unpaid carers' needs after having completed awareness training delivered by project

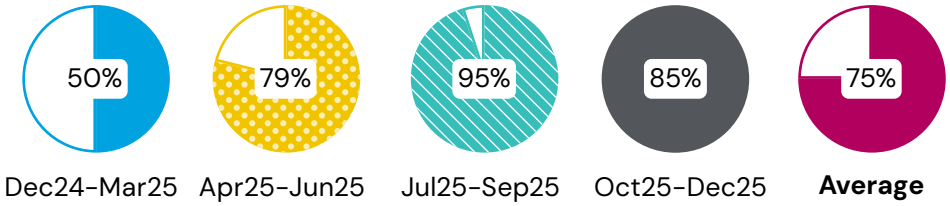
*as part of outreach & engagement activity (not discharge conversations)

3. Carer outcomes:

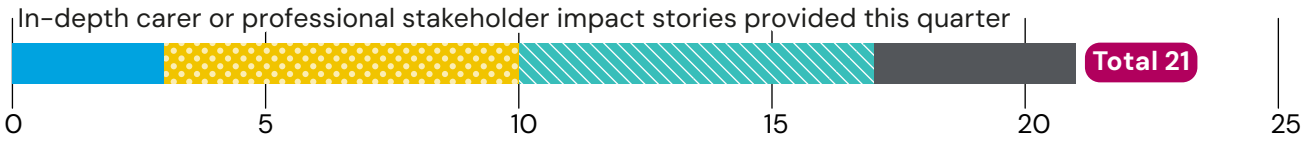


% of carers who report that the support they received had a positive impact on their wellbeing

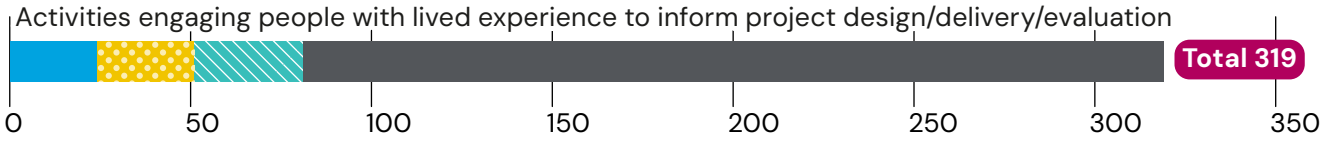
...and % of carers who felt included in the discharge planning process



...and % of carers who would recommend the support during discharge to friends/family



4. Coproduction:



The qualitative evidence broadly supports these findings. Across local projects, carers described feeling listened to, recognised and better supported during periods of significant stress. Staff feedback also suggests that the new roles added value by improving communication, supporting shared decision-making, and strengthening links between hospital and community services.

Overall, the available evidence suggests that the programme of work produced meaningful early benefits in three areas:

- improved carer recognition within hospital processes,
- better emotional and practical support for carers, and
- stronger links between discharge pathways and community-based support.

There is also some evidence that these changes may have contributed to smoother discharge processes and reduced crisis escalation, although this has not yet been consistently demonstrated by robust outcome data.

Analysis

The most significant achievement was the establishment of dedicated carer support capacity within hospital settings where this had previously been limited or absent. This appears to have enabled more systematic identification of carers and more focused support than had previously been possible within existing discharge arrangements.

A second important finding is that the intervention worked not only because support was available, but because it was relational. Across multiple projects, early success appears to have depended on staff having sufficient time to listen, explain, advocate and remain involved through the discharge process. The evidence suggests that carers often needed emotional reassurance and practical problem-solving before they were able to engage with wider services or longer-term planning.

This has implications for future service design: effective discharge support for carers is not solely an information function, but a relational and preventative one. It also demonstrates the importance of linking hospital-based support to community provision. In several areas, the benefit of the intervention extended beyond the hospital stay itself, particularly where carers were connected to practical help, peer support, statutory assessment, financial advice or wider carers' services. This suggests that the value of the model lies partly in its bridging function between hospital discharge and support in the community.

It is important to recognise that in many settings, projects were required first to establish basic recognition of carers within hospital systems before more advanced service development could take place. This helps explain why much of the reported activity relates to identification, awareness raising and initial pathway development. These are important achievements, but they also indicate that the programme has only begun to address longer-standing systemic weaknesses.

Salford carer impact story: a carer caring for his father-in-law and husband

This carer, in his late 60s, cares for both his father-in-law, who has Alzheimer's disease, and his husband, who has osteoarthritis. Alongside these responsibilities, he is managing his own recent prostate cancer diagnosis, which has affected his mobility and confidence. He regularly attends appointments at Salford Royal for his own treatment while supporting both cared-for individuals to attend theirs. He was referred to Gaddum by the Macmillan Cancer Care Team.

His journey began with a one-off appointment intended to address immediate concerns following his cancer diagnosis. He spoke openly about the impact of his symptoms on his mobility and the anxiety he felt when leaving the house, particularly around access to toilet facilities. This anxiety had been limiting his independence and affecting his ability to carry out his caring role.

During the appointment, he was able to discuss issues he had previously been embarrassed to raise, especially in the context of balancing his own health needs with his caring responsibilities.

He received practical support that directly addressed the barriers he was facing. He was signposted to apply for a Disability Badge, referred for a Disability Toilet Key, and connected with Adult Social Care for a shower stool to reduce the risk of falls. These interventions improved his confidence, mobility, and sense of safety.

He also joined the Salford Carers Service newsletter and requested to be placed on the waiting list for further support – something he had not initially intended. He left the appointment feeling more informed, more supported, and more capable of managing both his own health and his caring responsibilities.

This story highlights the importance of proactive identification of carers within hospital settings. He did not self-identify as a carer, yet the referral enabled him to access support that significantly improved his wellbeing and confidence. His experience demonstrates the value of sensitive, practical conversations that address both emotional and physical barriers to caring.

He did not self-identify as a carer, yet the referral enabled him to access support that significantly improved his wellbeing and confidence.

Wigan carer impact story: Sally, a carer caring for her partner, Dave

Sally cares for her partner, Dave, who has heart failure. She has been in this unpaid carer role for the past 10 years, and has her own physical health challenges. She received no post-discharge support from the hospital: "There has been no after support from the hospital once we arrived back home. I have just been left to get on with it".

Support from Wigan & Leigh Carers Centre, via the ARF-funded Caring Conversations programme, has been very beneficial: "I can't believe I've found someone I can truly talk to... The support has been excellent... I realise that I finally have someone there for me. I no longer feel completely on my own, like I have for the past 10 years. Caring alone for so long has been incredibly hard, but knowing that Wigan & Leigh Carers Centre are there makes a huge difference. It helps me feel calmer and reassured, and it reminds me that I'm not alone anymore".

"The support has been excellent... I realise that I finally have someone there for me."

Challenges and limitations

Several common challenges affected delivery:

- System complexity: Hospital discharge across GM involves multiple organisations, pathways and governance arrangements. Embedding new roles required extensive relationship-building and local negotiation, which slowed implementation.
- Short delivery timescale: Delays to mobilisation meant projects became operational at different times, leaving limited opportunity for initiatives to mature or demonstrate longer-term outcomes.
- Operational barriers: Projects reported recruitment challenges, uneven ward engagement, governance delays, lack of private space to speak with carers, and the ongoing difficulty that many people with caring responsibilities do not identify as carers.
- Limited outcome data: While activity levels and qualitative feedback are strong, there is currently limited quantitative evidence on impacts such as reduced readmissions, avoided service use or cost savings. This constrains conclusions about system-level impact at this stage.

Learning and implications

Several early lessons emerge from this programme of work:

- First, dedicated hospital-based carer support resource appears to be important. Where staff had time and visibility within hospital pathways, carers were more likely to be identified, supported and included in discharge planning.
- Second, support was most effective when it combined emotional support, practical help and advocacy. Carers often needed immediate reassurance and help to stabilise their situation before they could engage with further services.
- Third, practical support after discharge can be highly valuable. The evidence from local examples suggests that relatively low-level interventions, such as help with cleaning, shopping or follow-up contact, may make a material difference to carers' ability to cope at home.
- Fourth, workforce development matters. Projects that worked with hospital staff to improve carer awareness and recognition appear to have strengthened the wider culture of support, rather than relying only on the presence of project staff.
- Finally, the importance of sustainability: the evidence suggests that these roles filled a real gap in existing pathways, but their longer-term value will depend on whether local systems can retain or mainstream key elements of the model beyond the ARF period.

Where staff had time and visibility within hospital pathways, carers were more likely to be identified, supported and included in discharge planning.

a. Shared Lives (promotion and development of Shared Lives)

Shared Lives desired outputs and outcomes

1. output: increase in the number and diversity of Shared Lives carers offering day support/respite provision (along with attracting and recruiting an increased diversity of carers, notably through reaching and engaging BAME communities and younger people)
2. output: enhanced profile/awareness of the 10 GM Shared Lives schemes and their day support/respite offers
3. output: increased referrals into Shared Lives schemes
4. in turn to generate five principal sets of outcomes: (1) enhanced social connection and resilience for supported people; (2) family carers being able to continue caring for longer; (3) Shared Lives carers benefit from enhanced connection, emotional wellbeing and income; (4) for the wider system, a reduction in unplanned/crisis health and social care usage; (5) a case for longer-term investment in the Shared Lives day support model.

This programme of work formed part of longer-term ambitions to refresh the GM Shared Lives strategy, develop a shared digital presence for the schemes, and strengthen collaboration and consistency across the ten boroughs.

The commissions and programme activity

Three principal commissions were delivered as part of the Shared Lives priority area.

Table 1: Shared Lives commissions

Commission	Contracted provider	ARF £
1. Scoping of potential for Shared Lives to grow and diversify across GM	Shared Lives Plus	49,660
2. Shared Lives marketing and communications campaign	Passion4Social CIC	199,800
3. Shared Lives digital platform/tool/ app project	Manchester City Council	149,902

The first commission involved a scoping exercise led by Shared Lives Plus to assess the potential for Shared Lives to grow and diversify across GM. The resulting report highlighted several key features of the existing landscape. Provision was predominantly focused on working-age adults with learning disabilities, with comparatively limited provision for older people, people with physical disabilities or those with mental health needs. In addition, a significant proportion of arrangements were still focused on live-in placements rather than day support.

The analysis also highlighted strong demand for expanded day support provision, particularly for older people and those living with dementia. However, it identified several barriers to growth, including low day support fees, limited recruitment of Shared Lives carers, and relatively low public awareness of the Shared Lives offer. These findings informed the subsequent development of a GM-wide marketing and communications campaign.

In practice, many local schemes had already begun broadening their client groups and increasing their day support provision prior to ARF funding. For example, Wigan had already increased day support to around 60% of its overall provision and played a leadership role in sharing learning across the GM network of schemes.

Two main development initiatives were subsequently supported through ARF funding.

- The first was a GM-wide marketing and communications campaign, designed to increase awareness of Shared Lives and recruit a more diverse range of carers. The campaign sought to reposition Shared Lives as a recognised care and support option rather than a relatively hidden service. It aimed to develop a shared brand identity, create centralised digital resources, and use authentic lived-experience storytelling to communicate the value of the model.
  The campaign was delivered by Passion4Social CIC, working alongside a Shared Lives Lived Experience Advisory Group. Workshops and focus groups with carers, supported people and professionals were used to shape the messaging and ensure that promotional material reflected genuine lived experience.
- The second initiative was a digital platform project led by Manchester City Council. The intention was to develop a digital tool to support sessional Shared Lives carers by providing centralised resources, information and peer communication features. The platform was also intended to support cross-borough working and potentially provide a basis for wider GM adoption in the future.

A contingency budget of £50,000 was also retained within the programme.

Outputs, outcomes

The marketing and communications campaign has seen exponential outputs since a soft launch in the third quarter of 2025-26. Notable milestones include developing a shared GM brand identity for Shared Lives, creating a centralised website as a gateway to local schemes, and setting up social media channels to raise public awareness and direct potential carers and families to local services.

Fully launched in January 2026, the campaign established a set of performance indicators and developed shared documentation resources for schemes across GM. The Manchester digital platform project has made progress in its mobilisation phase also, with the maturation of this being after the point of publishing this evaluation.

Learning: challenges

Several challenges emerged during implementation:

- First, Shared Lives has historically had a relatively low public profile. The model is not widely understood by the general public, and even within health and social care systems awareness can be inconsistent. This lack of visibility was a key driver behind the decision to prioritise a marketing and communications campaign.
- Second, expanding day support provision represents a structural shift within Shared Lives schemes that have traditionally focused more heavily on live-in arrangements. Broadening the model to serve a wider range of client groups also requires adjustments in recruitment, training and operational practice.
- Third, capacity constraints within local schemes present a practical limitation. Some schemes already operate close to capacity in terms of staffing and approved carers, which can limit their ability to absorb new referrals or recruit additional carers generated through awareness campaigns.
- Fourth, financial viability remains a challenge. Payment rates for Shared Lives carers vary significantly across local schemes and are often relatively low. This may discourage participation from potential carers who cannot afford to take on the role, particularly in lower-income communities. However, aligning pay to a single-remuneration framework across GM is also not the answer.
- Finally, the short delivery timescale of the ARF programme has limited the ability to implement and evaluate longer-term changes. As with other activity of the programme, the compressed timeframe has constrained the development of measurable outcomes.

A further practical challenge relates to the digital platform project, where documentation to date provides limited clarity regarding the intended functionality, implementation progress and future role of the tool.

Learning: early success factors and future potential

Several learning points have been identified through the programme's early successes:

- The co-produced nature of the marketing campaign is a significant strength. By grounding the campaign in the lived experiences of Shared Lives carers and supported people, the programme has developed communications that are more authentic and relatable than traditional promotional approaches.
- The development of a shared GM brand identity, website and social media presence also provides a platform for more coordinated promotion of Shared Lives across boroughs. Over time, these tools may help increase public understanding of the model and support recruitment of a more diverse carer workforce.
- More broadly, the Shared Lives day support model offers considerable potential to strengthen social connection, support family carers, and enable people to remain active in their communities. If awareness increases and recruitment challenges can be addressed, the model could represent a valuable component of the wider GM "Living Well at Home" agenda.

Alongside these early successes, activity should also be understood as laying the groundwork for future development, as the campaign continues to mature.

b. Shared Lives Marketing Campaign

Outputs, outcomes

There are two headline objectives of the Shared Lives Marketing Campaign. First, to raise awareness of Shared Lives schemes. Second, to increase recruitment of Shared Lives carers across Greater Manchester.

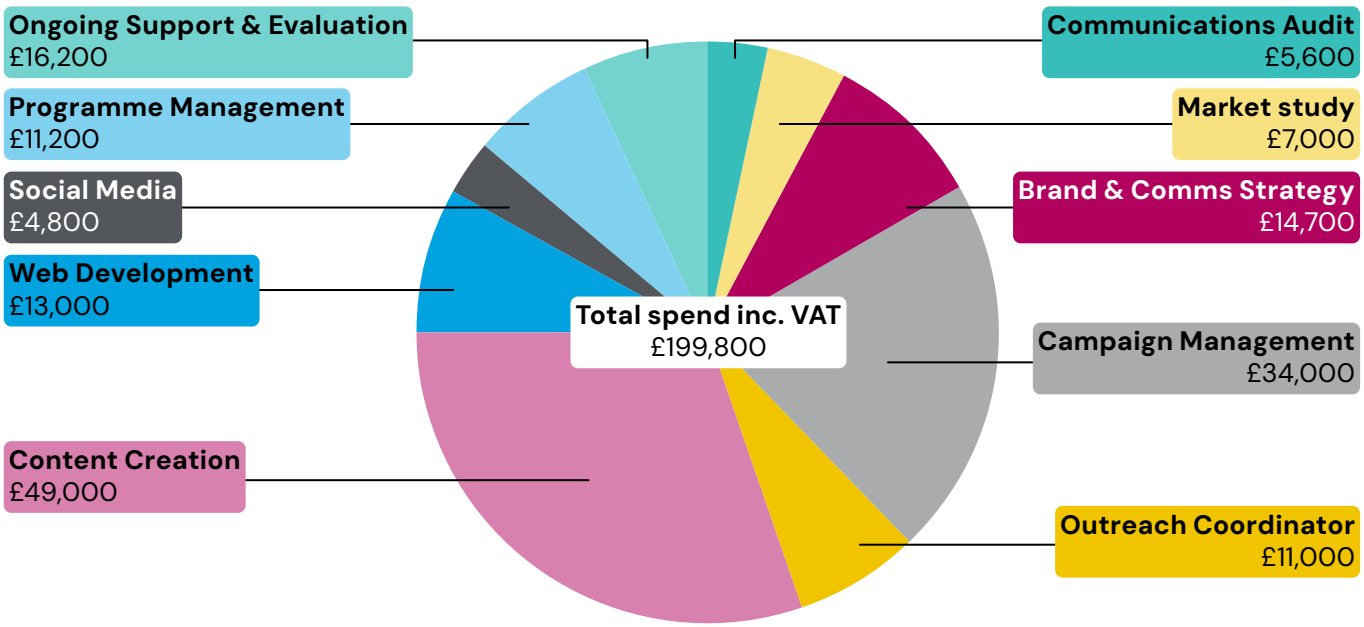
During the discovery stage, a communications audit was carried out which discovered inconsistent visuals an messaging across boroughs, a lack of a unified identity, design issues of existing messaging regarding layout, spacing and hierarchy. There was a need for clearer, centralised messaging. Feedback from lived experience user groups gave us clear feedback that the existing national website not meeting their needs. The recommendations from the communications audit were for:

- GM-wide Brand Toolkit
- Unified logo, colours, tone of voice
- Central website hub with borough signposting
- Shared social channels (Facebook & Instagram)
- Quarterly referral/engagement dashboards and cross-borough comms training

Significant outputs to date have included:

- The creation of Greater Manchester Shared Lives branded campaign, developed through coproduction
- Website and social media channels (Facebook, Instagram and LinkedIn)
- Creation of a KPI framework agreed with Borough Leads to measure the impact of the campaign e.g. number of enquiries and referrals, conversion rates of referrals, improved quality of life for supported people

Figure 4: Passion4Social CIC – Shared Lives Campaign funding (by project workstream)



Learning: challenges

- The main challenge has been the short programme duration, especially working with over 80 stakeholders across Greater Manchester
- The campaign involves proposing a significant change for system stakeholders – a shift from individual borough identities to a shared GM wide identity for Shared Lives. For reasons including capacity, adoption has occurred at varying paces.
- A key learning is that working truly collectively and collaboratively takes longer than you ever anticipate at the outset. But the end result is well worth it: a campaign that people hopefully feel ownership of and can be proud of.

Learning: early success factors and future potential

- The benefits of continuing are clear: we have started building momentum with the campaign and increasing visibility for Shared Lives. Boroughs are now adopting the branding and suggested approaches, with our support. This creates more consistency and ease for potential carers and supported people navigating an already complex system.
- The outreach provided rich insights into the importance of local connections and visibility in community settings, as well as how to build referral pathways
- Passion4Social CIC will continue supporting the network until June. Beyond that, we hope the ecosystem will continue to collaborate closely to maintain Shared Lives shared identity across GM.
- Passion4Social CIC will train some of the NHS team to continue updating social media channels and the central website, leaving many assets for the network to use. We hope that this will leave a legacy of collectively created, professional and engaging content that the network can use for some time to attract new carers to Shared Lives.

c. Shared Lives and Dementia ('Live More' programme)

Introduction and aims

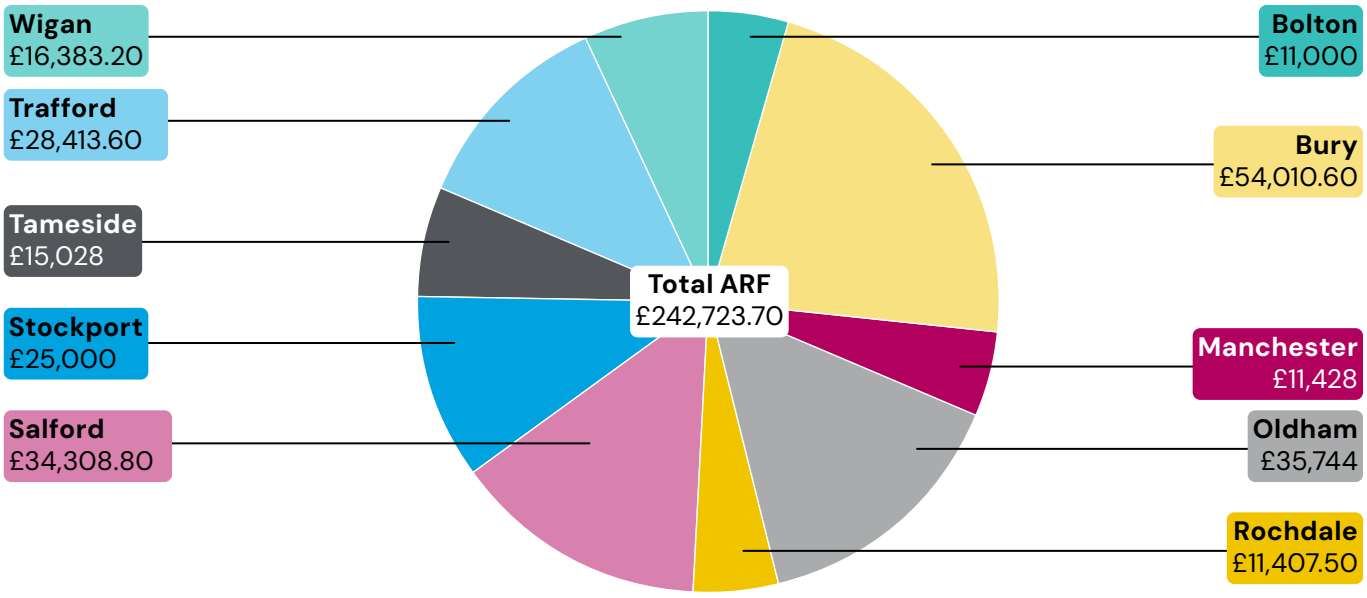
Shared Lives and Dementia desired outcomes

1. increased number of people with early dementia able to stay connected, well, and living at home
2. increase in family carers' wellbeing and thereby ability to continue caring at home (reduction in carer breakdown)
3. decrease in unplanned health/social care usage (offering potential savings against 'conventional care' budgets).

The pilot schemes and programme structure

Ten pilot schemes were established across GM, one in each local authority area. Together, the pilots aimed to support approximately 100 people living with early-stage dementia for at least six months through Shared Lives day support.

Figure 5: Shared Lives and Dementia funding



Shared Lives Plus:
Shared Lives & Dementia infrastructure
£191,400

Delivery of the pilot schemes was supported through ARF funding of £242,723, with additional programme infrastructure and evaluation support provided by Shared Lives Plus. The organisation has led the overall test-and-learn programme, helping schemes develop consistent processes, share learning and capture evidence of impact.

An interim evaluation report was published in January 2026, with a final evaluation expected later in 2026.

Shared Lives and Dementia strand impact stories

Liz, with Elaine:

In Stockport, Shared Lives companion Elaine has been supporting Liz, who loves shopping for bargains and baking. They have visited local charity shops together. Baking is particularly meaningful to Liz, as she used to bake for her whole family, so when she was feeling a bit low recently, she and Elaine made brownies and took some to the Shared Lives office. Liz loved meeting new people and having a chat, and Elaine noticed how happy Liz was when baking. Elaine is also helping Liz join activities at The Meadows [NHS mental health and specialist care service for older people], including the allotment group and a monthly pub club, which is helping her build confidence and feel more connected in her community.

[Source: 'Live More' Bi-Monthly Report, December 2025].

Don, with Eddie:

Shared Lives Oldham recently matched Don, a retired Physics teacher who is living with dementia, with his new Shared Lives companion, retired Engineer, Eddie. Don loves walking, so the two of them have been heading out to their local park together and stopping for a coffee along the way. It is quickly becoming a regular outing that both Don and Eddie really enjoy.

[Source: 'Live More' Bi-Monthly Report, December 2025].

A highlight self-reported by one of the schemes:

"Seeing [a woman with dementia] so happy at the prospect of getting out and independently shopping, going for coffee and cake with a carer that she really gets on with, reducing the need to rely on her family who all work full time".

Elaine is also helping Liz join activities at The Meadows, which is helping her build confidence and feel more connected in her community.

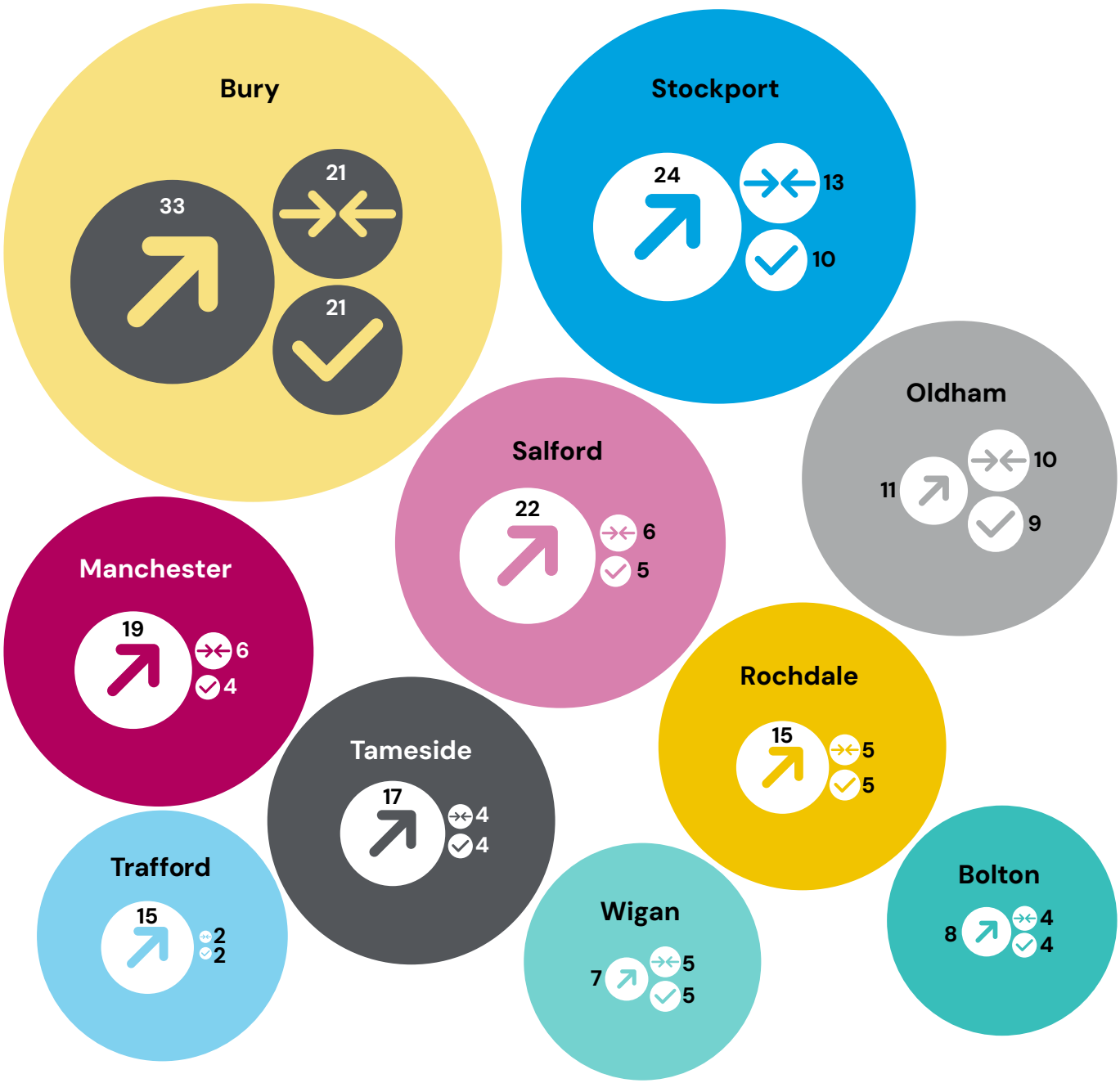
Outputs, outcomes

Across the ten pilot schemes, the programme has generated measurable early activity. To date, schemes have established referral pathways, recruited participating carers, and begun delivering new day support arrangements.

The programme has generated 171 referrals, resulting in 76 successful matches between individuals with early-stage dementia and Shared Lives carers, and the establishment of 69 active day support arrangements.

Figure 6: Shared Lives and Dementia, breakdown of referrals, matches and support arrangements by scheme

Source: 'GM Live More Programme: April Report', Shared Lives Plus



Through these arrangements, people living with dementia have been supported to participate in everyday activities such as shopping, social visits, exercise and creative pursuits, while family carers have been able to take a break from caring responsibilities.

Learning: challenges

A number of implementation challenges emerged during the pilot phase.

- **Cultural shift:** Many Shared Lives schemes had traditionally focused on adults with learning disabilities, so expanding provision to people with dementia required new knowledge, training and confidence among staff and carers.
- **Capacity constraints:** Many existing Shared Lives carers were already supporting others, limiting the pool available for the pilot.
- **Referral challenges:** Some referrals involved people whose dementia had progressed beyond the programme's early-stage focus, highlighting the difficulty of identifying people at the right stage for preventative support.
- **Family engagement:** Families affected by early-stage dementia are often new to adult social care and may require additional reassurance and guidance to engage with services.
- **Operational complexity:** Converting referrals into active arrangements proved time-consuming, with recruitment challenges, carer withdrawals and matching processes affecting progress.
- **Short timeframe:** The limited ARF delivery period constrained implementation, as with the activity in other ARF priority areas.

Learning: early success factors and future potential

Although still early, the Live More programme has shown clear promise. The core idea is straightforward: helping people with early-stage dementia stay active, connected and involved in everyday life rather than waiting until needs escalate before support appears. Feedback suggests that regular, relationship-based support can make a real difference for both the person with dementia and their family carers, who gain valuable breathing space.

Schemes that progressed at pace built on existing strengths and relationships. For example, areas with strong existing relationships with memory services and community partners generated higher referral volumes. A focus on referral processes was also vital. All schemes simplified their referral processes and revised them to be shorter, more conversational and strengths-based. In several areas, schemes also streamlined assessment and support planning ensuring the focus remained on people's interests, routines and relationships rather than formal care thresholds.

The wider Shared Lives communications work has also helped raise awareness and give the model a clearer identity.

Looking ahead, demand for preventative, community-based support for people living with dementia is likely to grow. If sustained and expanded, Live More could play a useful role in helping people remain connected to their communities while delaying the need for more intensive forms of care.

Manchester City Council – Digital Platform

Due to the timelines of the MCC project, findings and analysis are at an earlier stage than the rest of the GM ARF Programme. However, there have been key learning points around successes and challenges to date. The main objective continues to be to ensure that the developed platform will be responsive to the lived experiences and practical needs of our Shared Lives carers. The project recognises that for a solution to be effective and widely adopted, it must not only address the challenges carers face in their day-to-day roles but also be relevant to them and clearly designed with their input.

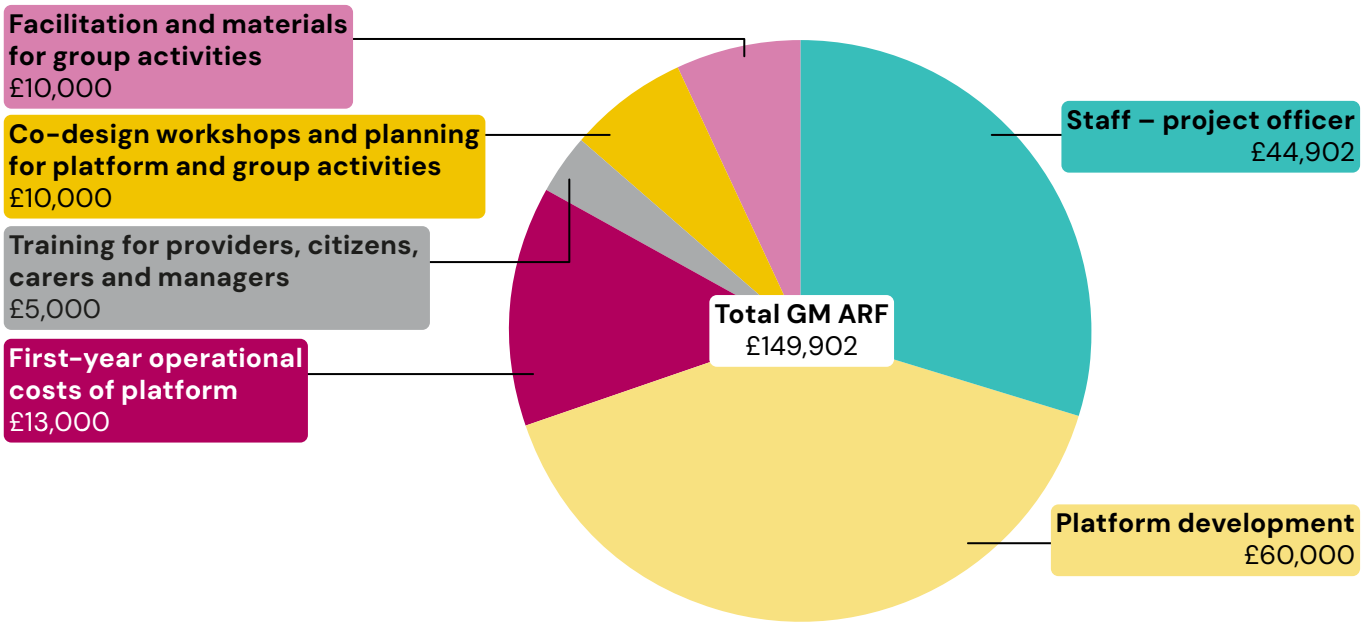
Successes:

- Collaborative approach with Passion4Social CIC to ensure all products from this ARF workstream are aligned in terms of branding and hosting. This should enable one consistent feel across all work and make the different platforms easily identifiable.
- There is now a clear, detailed delivery plan for the phase 1 of the web-app.
- Positive engagement and feedback from carers to be involved in the development of the web-app. This will ensure that the final product has been co-designed with end users and that it meets their needs.

Challenges and Barriers:

- Due to the internal and external delays, the project is being delivered in a phased approach. The first phase is the development and implementation of the Shared Lives Carers community forum. This will be for Manchester Shared Lives Carers only to begin with. The digital agency (Carbon Creative) has indicated that the go-live date for the launch of phase 1 of the Progressive Web App will be June 2026.
- Engaging effectively with GM colleagues and carers has proven difficult due to tight timescales that limit flexibility for meaningful collaboration. Some colleagues are stretched across several ARF projects alongside their day-to-day operational tasks, which further constrains availability. To address this, MCC have engaged with the GM A RF monthly sub-group meetings chaired by Gaddum as a touchpoint to share updates.
- The project has experienced some delays confirming who will host the digital platform and are now considering costs and options to host with the provider

Figure 7: Shared Lives and Dementia funding (by cost category)



7. Recommendations

Evidence and evaluation

From the outset, it is recognised that many of the outcomes associated with complex, preventative and system-change programmes take longer to fully materialise and to be robustly measured. However, in Greater Manchester, we are confident that the outcomes from project activity across the priority areas have demonstrated meaningful signs of transformation that will see better outcomes for carers and those they support.

Across both Priority Areas (Hospital Discharge and Shared Lives), several important conclusions emerge.

- Strategic alignment: The programme's innovations – hospital-based carer support roles and expanded Shared Lives support, including for early dementia – align closely with the local, regional and national strategic drivers.
- Lived experience at the centre: Development was strongly informed by the voices and experiences of carers and people receiving support.
- Preventative potential: Early evidence points to benefits in preventing or delaying more intensive health and social care interventions, particularly as demand rises with an ageing population and increasing complexity of need.

Recommendations set out below are based on learning to date, drawing on the quantitative and qualitative evidence currently available but it must be recognised that much of the long-lasting impact will be realised after the point of publishing this evaluation.

This will include, over time, more developed quantitative measures relating to system and population outcomes, alongside richer qualitative evidence, including lived experience accounts. The outputs from The 100 Stories Project, which collected qualitative insights from carers across all project themes, will be used to inform system learning and the recommendation in this evaluation report.

Implications for identifying carers in hospital settings

The programme has demonstrated the value of embedding dedicated carer support roles within hospital teams. These roles play an important part in identifying carers, providing timely information and advice, and supporting carers at key pressure points such as hospital admission, discharge and care transitions. Several implications and recommendations follow.

The outputs from The 100 Stories Project, which collected qualitative insights from carers across all project themes, will be used to inform system learning and the recommendation in this evaluation report.

Sustain

Hospital based carer support roles should be maintained with longer term funding, recognising the ongoing need for dedicated capacity to support carers and to strengthen links between acute services and community-based carer support.

Invest preventatively

Future investment should take an invest-to-save approach, recognising the potential for effective carer support to reduce downstream system pressures, including avoidable admissions, delayed discharges and increased reliance on statutory services. Where possible, this should be supported by an agreed and transparent methodology for capturing system impacts and avoided costs associated with preventative investment.

Allow realistic timelines

Meaningful improvement in outcomes for carers requires longer delivery and embedding periods than those typically available through short-term funding programmes such as ARF. Future initiatives should build in realistic timescales for workforce development, relationship building and outcome realisation.

Strengthen systematic identification of carers

Future developments should further embed proactive and routine identification of carers across hospital, primary care and community pathways, particularly at key transition points. This should be supported by consistent recording, clear referral routes and shared responsibility across organisations.

Improve navigation and continuity of support

Building on ARF learning, future models should strengthen the role of carer support workers as navigators, helping carers access assessments, breaks, social prescribing and voluntary sector support, and ensuring continuity beyond acute episodes of care.

Embed carers as partners in service design and delivery

Future developments should ensure carers are involved not only in individual care decisions but also in the design, commissioning and evaluation of services that affect them. Embedding coproduction with carers and carers' organisations can help ensure support is accessible, relevant and responsive to diverse caring experiences.

Prioritise carer wellbeing and sustainability

Future work should continue to recognise carers as individuals with their own health, employment and wellbeing needs. This includes improving access to carers' assessments, meaningful breaks, emotional support and flexible support options, all of which are critical to sustaining caring relationships and reducing the risk of carer breakdown.

Implications for Shared Lives

The Shared Lives developments demonstrate clear alignment with both national and Greater Manchester policy priorities relating to community connection, prevention and supporting people to live well at home.

The Shared Lives day support model, including the Live More dementia pilot, shows considerable promise in enabling people to remain socially connected and active within their communities, while also providing family carers with valuable respite. These benefits are inherently preventative and may help delay the need for more intensive forms of care, particularly for people living with dementia and their carers.

A key enabler of the Shared Lives model during the ARF programme has been the implementation of a coordinated marketing and communications campaign across Greater Manchester. Delivered through the GM ARF Shared Lives Marketing and Communications Project, the campaign was designed to raise awareness of Shared Lives, improve public understanding of the range of support offered (including day support and short breaks), and boost the recruitment and diversity of Shared Lives carers. Core elements of this work included the development of a unified GM communications strategy, a centralised digital landing site, tailored digital and offline content, and targeted social media activity, alongside an emphasis on real-life storytelling and coproduction with people with lived experience.

This marketing activity provides a strong platform for increasing visibility of the Shared Lives offer and for supporting longer-term growth of the model. Importantly, the campaign was also designed with sustainability in mind, with materials and digital assets intended to be adaptable and usable by local Shared Lives schemes beyond the end of the ARF funding period. Ongoing monitoring of campaign reach, engagement and conversion metrics will be important to understand its contribution to awareness, referrals and carer recruitment over time.

However, achieving the full potential of both the Shared Lives model and the associated marketing campaign will depend on sufficient capacity within local Shared Lives schemes. This includes adequate staffing, infrastructure and the ability to recruit, train and support new Shared Lives carers. Without this capacity, there is a risk that increased awareness, interest and referrals generated through marketing activity cannot be fully translated into new arrangements and sustained support.

In relation to the 100 Stories Project, while this work was intended to contribute rich qualitative evidence and lived experience insight, the timing of its completion means it has not been possible to incorporate its outputs into this evaluation. The project remains a valuable asset for future learning, communications and service development, and could play an important role in supporting both ongoing marketing activity and future evaluation of Shared Lives approaches.

8. Closing statement: thanks and what comes next

Firstly, a huge THANK YOU to everyone who has contributed to the GM ARF Programme and supported the vision to improve the lives of unpaid carers.

Every contribution is hugely valuable as we look to the future. You may have been directly employed on the programme or you may have been one of our partners advocating for and driving the improvements needed. You may have been one of the vast numbers of carers who have given their time for workshops, interviews, meetings and surveys giving invaluable ideas and feedback on your experience of services and of being a carer. Some of you have contributed in multiple ways. This evaluation is not about simply looking back at what has been achieved, it is about reflecting on the work and learning to date to inform how we carry on into the future.

The GM ARF programme has shone a light on something that has long been known but too rarely addressed: unpaid carers, families and communities are navigating health and care systems without timely support. This programme has shown that relatively modest interventions – when designed around relationships, lived experience and community connection – can begin to change that. As the funded programme draws to a close it is important that we re-affirm the Greater Manchester commitment to our unpaid carers. This evaluation gives us clear insights and evidence around what works and what is needed for unpaid carers in terms of improving the timeliness and impact of the right support at the right time. The GM ARF Programme, and the evaluation of the huge amount of work completed provides us with a knowledge base and springboard to continue that work.

So, what happens next and how can you continue to contribute and keep up to date with developments? There are lots of ways to do this. In the first instance, please add our NHS GM internet page to your favourites to keep abreast of the work Carers | Greater Manchester Integrated Care Partnership. Secondly, please feel free to reach out to the team directly with any ideas or feedback at gmhscp.gmasctransformation@nhs.net. At the evaluation event being held on 16th April we will have a pledges board where you will be able to say how you will continue to advocate for carers and drive real change. If you are not attending the event please use the email address to let us know what you are going to do.

For Greater Manchester, the ARF programme should not be seen as an end point. It is an early step in a much longer journey – one that will require continued partnership, stronger evidence and sustained commitment. But the direction of travel is clear: supporting carers, strengthening communities and investing earlier are not optional extras. They are essential if the system is to remain sustainable in the face of growing demand. More broadly, the programme reinforces the importance of relationship-based support: time to listen, trusted local connections, and help that focuses on people's everyday lives rather than only on services. These are precisely the ingredients needed to support people to live well at home and to sustain caring relationships for longer.

Thank you!

Greater Manchester's commitment to unpaid carers has been made possible by a values driven and passionate partnership across our diverse region, and we'd like to acknowledge the following:

directors of

adass

adult social services

Greater Manchester