Housing Learning and Improvement Network

Housing LIN

Care and Support in Extra Care Housing

This document is a replacement for the Housing Learning and Improvement Network's 2005 Technical Brief no.1, "Care in Extra Care Housing". It has been updated to reflect recent policy changes and developments, including personalisation. Information on the regulatory framework has also been brought up to date and extended. "Care and Support in Extra Care Housing" is relevant to both commissioners and providers.

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CARE AND SUPPORT IN EXTRA CARE HOUSING

INDEX

Glossary of Abbreviations

CLG	Department of Communities and Local Government
CQC	Care Quality Commission
CRB	Criminal Records Bureau
CSCI	Commission for Social Care Inspection
DH	Department of Health
ECH	Extra Care Housing
ECHR	Extra Care housing for rent
ECHS	Extra Care housing for sale
FACS	Fair Access to Care Services
ISA	Independent Safeguarding Authority
LIN	Learning and Improvement Network
PCT	Primary Care Trust
POVA	Protection of vulnerable adults
PPF	Putting People First
RSL	Registered social landlord
SAP	Single Assessment Process
SP	Supporting People
SPAA	Supporting People Administrative Authority
SSD	Social Services Department
TSA	Tenant Services Authority

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CARE AND SUPPORT IN EXTRA CARE HOUSING – A TECHNICAL BRIEF

PREFACE

This "Care and Support in Extra Care Technical Brief" is a replacement for the Housing Learning and Improvement Network's 2005 Technical Brief no.1, "Care in Extra Care Housing". "Support" has been added for two reasons. In the context of personalisation and self-directed support, the term support is used to encompass personal care and other forms of support. Secondly, this Brief will contain a little more consideration of housing-related support as it links in with the provision of care and more general support in Extra Care Housing (ECH).

More than four years has elapsed since the publication of the original Technical Brief. In this period, a number of important policy and contextual changes have taken place. These include:

- Putting People First (PPF) and the "personalisation" agenda – in particular the introduction of personal/individual budgets, increased choice and control amongst service users, and an increased emphasis on personally tailored, outcome-focused services
- The Health and Social Care Act 2008 which saw the creation of the Care Quality Commission and a new framework for registering and regulating "regulated activities" under the Act, including personal care
- The removal of the Supporting People ring-fence and placement of expenditure on housing-related support within the remit of Local Area Agreements
- A growing trend towards commissioning care and housing-related support in ECH from a single provider and the Turnbull Judgement *(See page 20)*
- Tightening of budgets, rising thresholds of eligibility for care under Fair Access to Care Services (FACS) and the new "Guidance on Eligibility Criteria for Adult Social Care" introduced in February 2010
- The Mental Capacity Act 2005 and changes in regulation regarding consent to Direct Payments by those who lack capacity to give it
- The Safeguarding Vulnerable Groups Act 2006 and the creation of the Independent Safeguarding Authority
- An increase in the number of mixed-tenure scheme developments

All of these have important implications for the way in which care and support are commissioned, funded, regulated, configured and delivered in extra care settings.

Extra Care Housing does not have its own unique classification and its own regulatory framework. It is a hybrid with a range of housing-related and community care legislation and regulation applying to it. Within the increasingly complex social care and supported housing landscape, commissioners and providers need to navigate a complex array of rules and regulations, some of which are not complementary, in order to develop models which are compliant, but which at the same time are cost effective and provide good outcomes for the people who live there.

In 2005, when the first Technical Brief was written, the sheer variety of approaches was notable. Five years on, with many more Extra Care schemes in existence, and with growing experience and confidence, the variations are even greater with commissioners and providers becoming increasingly innovative and adventurous. As approaches diverge increasingly from the earlier, relatively straight-forward models,

some may be riskier in the face of the legislative and regulatory framework, even though they may offer certain benefits.

For that reason, this revised Technical Brief includes more information on the regulatory framework. However, this is not written by a lawyer and legal opinion may in any case differ. Commissioners and providers would be advised to get legal advice if they are new to this field.

So, how has this revision been tackled?

- There is a new section on personalisation and Extra Care Housing *(p22)*
- Nine new case studies have been added *(p42)*
- The original text has been brought up to date throughout

This is a rapidly evolving area, and the Brief can only include examples which currently exist and have been drawn to our notice. Thus, the case studies should not be seen as a blueprint for future development.

Apart from any changes in policy direction following the 2010 general election, there are other potentially important social policy developments in the pipeline which are likely to have an impact on Extra Care Housing in the future. These include:

- The government's Green Paper *Shaping the Future of Care Together*[1] and the White Paper *Building the National Care service*[2]
- The Personal Care at Home Bill
- The Law Commission's proposals on tidying up community care legislation

As these are not yet at the point of being implemented they will not receive detailed consideration in this Brief.

INTRODUCTION

A defining feature of Extra Care Housing (ECH) is the scheme-based availability of round-the-clock care. However, there is great diversity in the way this care is commissioned, managed, configured and delivered. Despite the variety, there are also common features and key principles which are universally applicable. For example, although care is part of the overall service, ECH is fundamentally a housing provision. People live in their own homes and the care delivered is essentially personal care not "accommodation and nursing or personal care together".[i]

The main focus of the Brief is on care services which are eligible for funding primarily from Adult Social Services, as distinct from, for example, housing-related support services funded by Supporting People and/or occupants. It is directed at commissioners of the care service as well as care and housing providers.

The Brief concentrates on care provision in social sector ECH – rented and mixed tenure – although there is a small amount of coverage of the private sector.

It is set out as follows:

Characteristics of care and support in Extra Care Housing (p10)

Section 1 covers the characteristics of care and support in extra care housing. It defines how the terms care and support are used in this document, and outlines legislation and regulation which is relevant to care and support in Extra Care Housing. This includes the new social care regulations and avoiding registration as "accommodation for persons who require nursing or personal care"; Supporting People Services; Vetting and Barring; the Mental Capacity Act 2005; Changes to Direct Payments regulations; and eligibility criteria.

Section 1 goes on to identify some of the distinctive features of care in Extra Care Housing including 24-hour cover, flexible and responsive service provision, independence promotion, team work and holistic care.

Commissioning care and support in Extra Care Housing (p20)

Section 2 is devoted to commissioning care and support in social sector extra care housing. It highlights two key changes in the commissioning landscape. The first relates to changes in commissioning housing-related support, in particular, the growing trend towards commissioning both the care and support from a domiciliary care provider, and the removal of the Supporting People ring fence.

The second is the advent of Putting People First and the personalisation agenda. A number of commissioning models and their pros and cons are outlined, current trends are noted, and future changes are considered, before turning to aspects of care procurement in the context of Extra Care Housing, and the potential for added value if health funding is invested in Extra Care Housing.

This section is concluded by 9 case studies which illustrate the commissioning models outlined, as well as drawing out other features including the approach to charging for care and support, and progress with elements of self-directed support.

[i] For further information on Extra Care Housing, see *The Extra Care Housing Toolkit*[3] and *Factsheet 1:Extra Care Housing: What is it?*[4]

Revenue and charging arrangements (p64)

The main focus of Section 3 is on charging for care and support in ECH. It reminds readers of the policy framework – Fairer Charging guidance, entitlement to assessment and ordinary residence rules – before suggesting some pointers for developing charging policies in the future. It considers the issues in relation to charging for round-the-clock cover, and the position when somebody seeks to move from a private arrangement to one which is state-subsidised. It finishes off with a brief resumé of charging for Supporting People services.

Legal Relationships (p73)

Section 4 is devoted to the legal relationships between local authorities, providers and service users in different scenarios, and uses simple diagrams to illustrate these. It considers both the social and private housing sectors.

Care Delivery (p81)

Section 5 looks briefly at who the providers of care may be in an extra care setting, and the pros and cons of integrated v separate housing and care management. In the light of recent dialogue with the Care Quality Commission, a caveat regarding the risk of registration as a care home applies to this topic.

How much care? (p85)

The 6th section considers the factors which should be taken into account when deciding how much care should be collectively available in a scheme – the commissioning model, the number of properties, purpose of the scheme, who the scheme is targeting, staffing variables, commissioner priorities and provider confidence – and goes on to outline what optimal cover may include.

It then considers ways of quantifying the level of care needed, important points about costing the service, and various other operational matters.

This section ends with a number of the original 2005 case studies whose template was slightly different from the one used in 2010 and has a slightly more operational focus, covering, for example, staffing structures and distribution of care hours. The content has been updated.

SECTION 1

CHARACTERISTICS OF CARE AND SUPPORT IN EXTRA CARE

1. DEFINITIONS

1.1 Care and support in Extra Care can be broadly defined to cover a wide range of supportive services delivered in a holistic and cohesive manner. However, the primary focus of this Brief is on the provision of "personal care" in Extra Care Housing (ECH).

1.2 *The Care Standards Act 2000* has been amended by the *Health and Social Care Act 2008.* This Act introduces the concept of "regulated activities" one of which is "personal care". This is defined in the Act as "physical assistance given to a person in connection with—

(i) eating or drinking (including the administration of parenteral nutrition),
(ii) toileting (including in relation to the process of menstruation),
(iii) washing or bathing,
(iv) dressing,
(v) oral care, or
(vi) the care of skin, hair and nails (with the exception of nail care provided by a chiropodist or podiatrist); or

the prompting, together with supervision, of a person, in relation to the performance of any of the activities listed [above], where that person is unable to make a decision for themselves in relation to performing such an activity without such prompting and supervision."[5]

1.3 Personal care thus defined, together with less intimate forms of care and support, as well as housing-related support, are all commonly provided in Extra Care schemes.

1.4 "The primary purpose of housing-related support is to develop and sustain an individual's capacity to live independently in their accommodation. Some examples of housing-related support services include enabling individuals to access their correct benefit entitlement, ensuring they have the correct skills to maintain a tenancy, advising on home improvements and accessing a community service alarm."[6] Supporting People services are those that support the most independent living arrangements and are not general health or personal care services. Following the absorption of the Supporting People funding into Area Based Grants from April 2010, and the commensurate loss of a protected identity, these services will enter a state of flux, and current definitions and eligibility may no longer apply.

1.5 In this Brief, terms will be used in the following way:

- "Housing-related support" or "Supporting People services" will be used when referring specifically to services currently seen as eligible for Supporting People funding.
- "Support" will be used more loosely to cover general support which may encompass personal care, housing-related support and the areas in-between which do not fall neatly into either category. If used in the context of personalisation and "self-directed support", the term "support" will encompass any type of service which can be included in a "support plan"; care is likely to be one component.
- "Care" will be used when referring to services regulated under the Health and Social Care Act by the Care Quality Commission and traditionally

commissioned by Adult Social Services Departments as community care services.

1.6 In this Brief, the term Extra Care Housing (ECH) is interchangeable with "very sheltered" housing, also referred to by some as "housing with care".

2. REGULATION

2.1 New Social Care Regulations

2.1.1 The care provided in Extra Care Housing is delivered to people in their own homes. Occupants have security of tenure afforded either by an assured tenancy or a range of home ownership arrangements.

2.1.2 The new regulations covering personal care are the Health and Social Care Act 2008 (Regulated Activities) Regulations 2009 and the Care Quality Commission (Registration) Regulations 2009[5]. These are in the process of being rolled out and further guidance is still being developed in key areas, so this Technical Brief does not cover the registration requirements in detail. Commissioners and providers are strongly advised to acquaint themselves with, and keep abreast of, developments in this area.

2.1.3 The new regulations cover a wider range of activities than the Care Standards Act, including care and treatment, and aim to focus on outcomes rather than processes. The two categories of regulated activities particularly relevant in the context of ECH are personal care, defined earlier, and "accommodation for persons who require nursing or personal care: the provision of residential accommodation, together with nursing or personal care."[5]

2.1.4 Subject to some defined exceptions, the "provision of personal care for persons who, by reason of old age, illness or disability are unable to provide it for themselves, and which is provided in a place where those persons are living at the time the care is provided"[1] needs to be registered with the care Quality Commission (CQC). Care providers are expected to register with CQC to "carry on the regulated activity" from October 2010.

2.1.5 "An activity which is ancillary to, or is carried on wholly or mainly in relation to, a regulated activity shall be treated as part of that activity."[5]

2.1.6 The new Guidance[7] describes a number of service types. Under the heading "Community Social Care", four are listed of which domiciliary care is one, and Extra Care Housing is another. Certain outcomes apply to all service types, while others apply selectively.

2.1.7 There are two areas where ECH may now find that it comes under the umbrella of these regulations:

2.1.8 Regulation 15 (Outcome 10) is about safety and suitability of premises. "The term premises where a regulated activity is carried out does not include a service user's own home"[1]. However, "the registered person [carrying out personal care] must ensure that service users and others having access to premises where a regulated activity is carried on are protected against the risks associated with unsafe or unsuitable premises"[7]. This may for example apply to assisted bathrooms or treatment rooms in ECH.

2.1.9 Regulation 16 (Outcome 11) refers to the safety, availability and suitability of equipment used in carrying out the regulated activity. The care provider has a responsibility for ensuring any equipment used complies. This may for example extend to the baths in assisted bathrooms.

2.1.10 The guidance can be found at the following link: http://www.cqcguidanceaboutcompliance.org.uk/

2.2 Avoiding registration as a care home

2.2.1 Critical to Extra Care Housing is that the regulated activity which takes place there is defined by CQC as personal care, and not "accommodation and personal care provided together" and therefore registrable as such. If Extra Care scheme were to be registered as a care home, some undesirable consequences would follow, including:

- Occupants would no longer be living in their own homes with associated rights
- Their homes, and the scheme as a whole, would be subject to inspection as "establishments"
- The revenue funding streams (e.g. housing benefit) would no longer be available
- HCA could require reimbursement of capital subsidies

2.2.2 The new legislation and regulations have not so far sought to define what constitutes "the provision of residential accommodation, together with nursing or personal care." CQC reproduced the 2008 CSCI guidance[8] in its own name and this is what currently applies. CQC says that new guidance on these issues is likely to be published soon, but that the thrust of the guidance is likely to be the same.

2.2.3 The guidance identifies a number of "factors to be taken into consideration when making a judgement" and suggests these should be taken together as indicative of the whole picture rather than any one being taken as conclusive in its own right.

2.2.4 The degree of inter-dependence between the accommodation and care provider is an important consideration. The question over whether it is necessary for the accommodation and care to be delivered by separate providers, or separate arms of an organisation and separate management, in order to demonstrate that the two functions are not inter-dependent, remain thorny issues. Although "on the ground", schemes exist with each of these arrangements and are registered with CSCI as domiciliary not residential care providers, CQC interpret the guidance as saying that there should be a separation between providers of accommodation and care. They advise against the two functions being provided by the same company. They say that if the two functions are provided by the same company, there must be clear and distinct separation between the care element and the housing element for it not to be considered accommodation and care together.

2.2.5 The Guidance for Regulation Managers and Inspectors[8] makes clear that if the care and accommodation are provided by the same organisation then the degree of separation between the two functions needs to be looked at. Whilst co-operation is accepted as important, "mutual reliance" between the two functions would be seen as the two being provided together. A case being heard in July may shed further light on this issue.

2.2.6 Other important principles include:

- The occupant needs to be living in his/her own home. This can be demonstrated by having an assured tenancy or lease and being able to:
  - "deny entry to others in relation to parts of the accommodation where they have exclusive possession"[8]
  - remain in the accommodation even if they no longer require a care service
  - assign the accommodation to another

- The tenancy or lease needs to be demonstrably valid. If it could be shown to have been signed by someone who could not possibly have had the capacity to understand and agree to the basics in it, when they apparently signed it, or by someone who did not have the legal authority to sign it on behalf of the occupant, there is a risk that the regulators would consider the tenancy as questionable, or as belonging to the person who signed it. They may therefore look at whether the apparent distinction between the tenancy arrangement and the care provision arrangement was a sham. If the residual background arrangements amounted to an integrated arrangement for care and accommodation together, interdependently, the registration rules for the regulated activity of "accommodation for persons who require nursing or personal care" may be regarded as triggered.

- Receiving anything that could be seen as personal care from the on-site provider should not be made a condition of tenancy or lease, nor be tantamount to a condition of occupancy. This means receiving care should not be mandatory and that ECH occupants:
  - must have a separate agreement covering their care
  - should have a genuine choice in who provides their care
  - can refuse to receive or pay for care without their occupancy being put at risk
  - can, if they have a direct payment or personal budget, choose to spend it elsewhere than on the on-site provider

2.2.7 There may also be some good practice pointers, although their legal relevance is unclear:

- Allocation procedures not mimicking residential placement procedures
- Ensuring the proper involvement and powers of the housing provider and /or housing authority in allocation of properties
- Charging polices following the non-residential care charging guidance
- Maximising choice; minimising what is made a condition of tenancy or lease
- Guarding against a dependence culture and an institutional feel

2.2.8 The position regarding the 24/7 availability of domiciliary care and housing-related services in an emergency situation only, as a condition of tenancy or lease, is also not clear. (*For further consideration of this issue, see p69)*

2.2.9 This is an area where legal advice should be sought when setting up new schemes with untried arrangements, and commissioners and providers should keep a look-out for the new Guidance due out shortly, and any subsequent case law.

2.3 Supporting People Services

2.3.1 There is not a regulatory framework as such for Supporting People (SP) services. Supporting People Administering Authorities (SPAA) have contracts with providers, who must comply with the terms and conditions in the contract. Many SP commissioning teams currently use the Quality Assessment Framework to monitor the services but this is not mandatory. (For more information on the QAF see Sitra's publication *Understanding the QAF refresh* [9] at the link below. http://www.sitra.org/fileadmin/sitra_user/2009/QAF/Understanding_the_QAF_refresh_150110.pdf)

2.3.2 From April 2010 the Supporting People funding was due to be included in Area Based Grants, with local strategic partnerships deciding how to commission and monitor services. CLG generated frameworks may be retained in some areas and adapted or dispensed with in others.

2.4 Vetting and Barring

2.4.1 The *Safeguarding Vulnerable Groups Act 2006* set up the Independent Safeguarding Authority (ISA). Together with the Criminal Records Bureau (CRB), it will implement the new vetting and barring scheme to help protect vulnerable adults and children from abuse. The ISA will make decisions about who will be barred from working with vulnerable groups, and keep a combined list of people barred from working with these groups. The ISA is a mandatory addition to current safeguarding systems such as CRB checks which continue to be required.

2.4.2 A Regulated Activity under **this** Act is broader than under the *Health and Social Care Act 2008,* above. The concept, here, covers "any activity which involves contact with children or vulnerable adults and is of a specified nature"[10]. Care, housing and support staff in an Extra Care setting fall within this definition. The terms of this Act are being phased in and place duties and responsibilities on both employers and individuals. Some of these include:

- Employers *must* refer information to the ISA in certain circumstances and *may* refer in others
- An employer must not engage in Regulated Activity a barred person or a person who is not ISA-registered
- Once the scheme is fully implemented, to undertake a Regulated activity, an individual must be ISA-registered.
- A barred individual must not undertake a Regulated activity
- An employer who counts as a Regulated Activity Provider must check that a prospective employee who is in a Regulated activity is ISA-registered
- Personal and family relationships are not included.

2.4.3 From November 2010, it will be mandatory for new entrants and job movers in the social care sector to have ISA registration before they start their new posts. Members of the existing workforce will be phased in between April 2011 and July 31st 2015. Registration of staff providing housing management and SP services to vulnerable adults only have to start registering in 2013. For more information go to www.isa-gov.org

2.5 The Mental Capacity Act 2005

2.5.1 In February 2009, the national dementia strategy *"Living Well with dementia"*[11] was launched. Objective 10 is "considering the potential for housing support, housing-related services and telecare to support people with dementia and their carers". Increasingly Extra Care housing is being seen as an option for supporting people to "live well with dementia"[11].

2.5.2 It is very important that all services are commissioned and delivered in accordance with the Mental Capacity Act, should an occupant's capacity to make a particular decision be in doubt. The five key principles of the Act are:

- **A presumption of capacity –** every adult has the right to make his or her own decisions and must be assumed to have capacity to do so, unless it is proved otherwise
- **Supporting individuals to make their own decisions** – a person must be given all practicable help before anyone treats them as not being able to make their own decisions
- **Unwise decisions** – just because an individual makes what might be seen as an unwise decision, they should not be assumed to lack capacity to make that decision
- **Best Interests** – an act done or decision made under the Act for or on behalf of a person who lacks capacity must be done in their best interests
- **Least restrictive option** – anything done for or on behalf of a person who lacks capacity should only be done after considering if there is another option that is less restrictive of their basic rights and freedoms

2.5.3 For more information on the Mental Capacity Act in the context of housing, see Housing LIN Factsheet 20 entitled *Housing Provision and the Mental Capacity Act* 2005[12]
http://www.dhcarenetworks.org.uk/_library/Resources/Housing/Support_materials/Factsheets/Mca_factsheet_20.pdf

2.6 Changes to Direct Payment regulations

2.6.1 Since November 2009, all councils must offer direct payments to certain eligible adults who lack the capacity to consent to receive them. Direct payments can now be made to a willing and appropriate 'suitable person' such as a family member or friend, who receives and manages the payments on behalf of the person who lacks capacity. Further information can be found at
www.dh.gov.uk/en/SocialCare/Socialcarereform/Personalisation/Directpayments/DH_076522 [13]

2.7 Eligibility Criteria

2.7.1 In the social housing sector, eligibility criteria for ECH (as distinct from eligibility for community care services specifically), are commonly developed jointly by those investing, or with an interest, in the provision. These typically include the housing provider, social services and housing authority. Each stakeholder will seek to ensure that their statutory and legitimate interests are reflected in the criteria. The basis for planning consent will also define parameters.

2.7.2 Thus, while receiving and paying for care should not be written in as a condition of occupancy, being in need of care is commonly included as one of the criteria for being offered a property in Extra Care Housing.

2.7.3 It is a matter of debate how much ECH should be considered a direct replacement for residential care. Many leading providers take the view that if a large number of lettings at the outset are taken by people already in need of residential care this undermines the ability of extra care to provide something qualitatively different or better. They argue for a mix of need levels. A whole host of variations exist. There are schemes at one end of the spectrum which focus primarily on those with high need levels, while at the other end, commonly the larger village developments, there may be a wider range which includes a majority with no care or support needs at all.

2.7.4 In recent times there seems to have been a growing pattern of tying scheme eligibility criteria to the local FACS thresholds, commonly set at substantial or critical. In February 2010, the Department of Health issued new guidance on eligibility criteria for adult social care in England which replaces the 2003 guidance. Called *Prioritising need in the context of Putting People First : A whole system approach to eligibility for social care*[14], it encourages councils to think about "prevention and early intervention beyond just adult social care services"..."Councils should have both a strong focus on the overall well-being of their communities and a recognition that people should be helped in a way that may prevent, reduce or delay their need for social care support."[14]

2.7.5 The document describes three categories of resources and services: universal services; targeted interventions; and care and support. Supported and extra care housing are included as examples of services providing targeted intervention to support individuals at increased risk, with a view to supporting "people to maintain their independence and wellbeing and reduce or delay the need for more targeted social care interventions."[14]

2.7.6 The full Guidance[14] may be found at the following link
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113154
Social Care Institute for Excellence (SCIE) have developed a 2010 FACS training module
http://www.scie.org.uk/publications/elearning/facs/index.asp

2.7.7 For more information on applications and allocations in ECH, see *Assessment and Allocation in Extra Care Housing*[15], the Housing LIN report at the following link
http://www.dhcarenetworks.org.uk/_library/Resources/Housing/Support_materials/Reports/Assessment_Allocation_in_ECH.pdf and
Factsheet 25 *Nomination Arrangements in Extra Care Housing*[16]
http://www.dhcarenetworks.org.uk/_library/Resources/Housing/Support_materials/Factsheets/Factsheet25.pdf

3. DISTINCTIVE FEATURES OF CARE IN EXTRA CARE HOUSING

Care in Extra Care takes place in people's own homes, and in that sense is domiciliary care, but ideally, it has also had certain distinctive features:

3.1 24-hour Cover

3.1.1 The general consensus of opinion is that an important defining feature of Extra Care housing, as distinct from other forms of sheltered housing, is the round the clock presence of a care, or combined care and support, provider. Ideally, a dedicated team of staff delivers the care, even if the scheme is also used as a base to provide domiciliary care to people living in the surrounding community. In other words, the scheme is never left without at least one member of care staff on site.

3.1.2 This is one of the main features which distinguishes Extra Care Housing from domiciliary care provided to people dispersed throughout the community. In many areas of the country, 24-hour cover is not available to them, and where it does exist, it is likely to be less immediate.

3.2 Flexibility and Responsiveness

3.2.1 Whilst care is delivered on the basis of care plans, in order to maximise the unique benefits of Extra Care housing, flexibility should be built in to enable care staff to respond flexibly to temporary and unpredictable fluctuations in need, as well as to emergencies.

3.2.2 An outcome-based approach to care planning (service commissioning at an individual level) will facilitate this. "Having agreed the outcomes and appropriate budget the aim should be for the service provider to negotiate the day to day details with the service user and to have sufficient autonomy to respond flexibly to the user's needs and preferences."[17] The personalisation agenda reinforces and extends service users' choice and control.

3.2.3 Any significant long-term changes in need will usually result in an alteration of the individual's care plan. During the scheme commissioning process, the triggers and arrangements for this should be agreed between social services, care and housing provider(s). The less restrictive, onerous and bureaucratic the process, the better for all concerned.

3.3 Independence Promotion

3.3.1 Supporting independence is central to Extra Care Housing. This means supporting people to do things for themselves rather than simply (and sometimes more easily) doing things for people. The way in which care is delivered is critical to achieving this. Staff should be trained to support independent living, and care/support plans should be written in such a way as to enable this approach. Allowing too little time or being overly prescriptive undermines achievement of this objective. With the advent of self-directed support planning and the emphasis on personalisation, rigid task or time-based care plans should be a thing of the past.

3.3.2 Extra care can successfully house people who have previously been in residential care. Often these applicants will require a period of re-ablement to enable them to re-adjust to independent living. In areas where residential care homes are being closed down and replaced by Extra Care Housing, and the

same care staff are intended to deliver the service, staff need to be given appropriate induction and training in care delivery in an Extra Care setting. They should not transfer a dependence culture across to the scheme(s). It is good practice for at least one or two senior members of staff to be experienced in independent supported living so they can lead and reinforce different working practices, values and culture. For further details on workforce development, download the Housing LIN factsheet number 9 on W*orkforce Issues in ECH*[18] .

3.3.4 From the outset when developing the scheme, staffing structures and levels, management, organisation, training and what, in practice, it means to achieve independence need to be properly considered. To give an example:

3.3.5 Restaurants are common to Extra Care Housing schemes and may be useful in ensuring levels of nutrition and social contact. However, if all meals are provided this will tend to de-skill occupants and create dependency. Are occupants supported to make at least some meals themselves if they wish? How will this be done? Who will do this? Does it imply a large number of part-time staff (or volunteers) at key times? Will younger staff of a different generation actually have the domestic skills to help prepare the meals requested? What training may be required? Are staff available with the knowledge to support people from specific ethnic backgrounds with particular dietary preferences? [ii]

3.4 Team Work

3.4.1 The care service is just one aspect of the Extra Care Housing service configuration. Care providers are often part of a bigger team, with delivery of a quality cohesive service to occupants being the common uniting goal.

3.4.2 Effective team-working is essential in an Extra Care Housing scheme, especially if the housing and care management structures are separate. The relationship between the care team leader and scheme manager is pivotal; there has to be very close co-operation and communication between them. The relationship should be characterised by a degree of give-and-take, and clarity of roles should be complemented by some flexibility at the edges. For example in some Extra Care Housing schemes, care staff will assist at meal times by serving meals in lieu of preparing meals for individual tenants. Or they may help with activities by assisting occupants to take part, and being available to meet the personal care needs.

3.4.3 The personalisation agenda potentially introduces greater complexity. Communication and teamwork become all the more important if there is a range of providers commissioned by individuals to provide support. Assuming people remain entitled to emergency cover, there needs to be communication between the emergency provider and planned provider. Effective co-ordination at an individual level is needed, as well as clarity regarding the duty of care of the on-site provider towards occupants whose arrangements fail.

3.5 Holistic Care

3.5.1 This guide focuses on direct personal care in the way commonly considered and perceived by commissioners and specialist care providers. However, in

[ii] For more information on catering in ECH see Factsheet 22, *Catering Arrangements for ECH*[19]

the context of Extra Care Housing the (limited) research available tells us it is the culture of the organisation and staff and how care is provided that makes a difference to feelings of well-being, quality of life and mental health.

3.5.2 The best Extra Care Housing schemes will see social and leisure activities, encouraging independence, healthy living and life styles as all part of an overall approach to care and what good care really means. Furthermore, there will not be rigid demarcation between the different services at the point of delivery.

3.5.3 Whilst commissioners need to know what they are getting for their money, excessive micro-analysis, control and task definition may diminish the quality of the service for occupants and result in a less cost-effective service overall.

CHARACTERISTICS OF CARE IN EXTRA CARE HOUSING - KEY POINTS

- Care in Extra Care is domiciliary care, not residential care.
- The care provider must register with CQC as a domiciliary care provider.
- Staff who have contact with occupants in ECH will need to register with the Independent Safeguarding Authority.
- An occupant's property needs to be demonstrably their own home, there must not be an interdependence between accommodation and care, and care should not be a condition of tenancy or lease.
- Where an individual's capacity to make particular decisions is in doubt, the Mental Capacity Act 2005 comes into play.
- Care and support should be available on site round the clock.
- The service should be flexibly delivered.
- It should be delivered in such a way as to promote independence, choice and control.
- Close collaborative working with other staff on site is fundamental.
- Care is only one aspect of an overall approach which facilitates a sense of well-being.

SECTION 2

COMMISSIONING CARE AND SUPPORT IN EXTRA CARE HOUSING – SOCIAL HOUSING SECTOR

1. INTRODUCTION

1.1 Over the past few years in most Extra Care Housing schemes for rent, including many mixed tenure schemes and care villages, care has been procured by social services, or the authority which had adult social services functions, such as a PCT or Care Trust. Very often, it has been procured at a "macro" level through a block contract rather than being spot-purchased for each individual separately. This has tended to be the most common arrangement, irrespective of who has provided the care, and whether the block has been made up of hours or an agreed number of packages in pre-determined bands.

1.2 Housing-related support has been procured by the Supporting People Administering Authority (SPAA), usually from the housing provider in the form of a block subsidy contract.

1.3 We are now seeing significant changes to commissioning and procurement approaches in these two areas.[iii]

2. PROCURING BOTH CARE AND HOUSING-RELATED SUPPORT FROM A DOMICILIARY CARE PROVIDER

2.1 A RECENT TREND

2.1.1 As Supporting People Administering Authorities have sought to disaggregate housing-related support services from accommodation based provision, and SPAAs have become part of adult social care departments, housing-related support in many areas has been de-coupled from housing management.

2.1.2 In Extra Care there has been an increasing trend towards the local authority procuring the care and housing-related support from the care provider, leaving the housing provider to deliver housing and facilities management only, or, in some cases, a small amount of housing-related support as well. There are benefits and disadvantages to this approach.

2.2 ADVANTAGES

2.2.1 If the care and support are provided by a single provider, then Supporting People (SP) money can contribute to the cost of combined care and support round-the-clock cover. While adult social care and SP budgets were separate, this saved adult social care expenditure.

[iii] "**Commissioning** can be seen as a series of interlinked processes, based on a robust analysis of needs in a defined area, that enable the purchasing of services that vulnerable people need....." "It involves developing policy, service models and delivery capability to meet the identified needs in the most appropriate way....." "Within the context of a broader commissioning plan, **procurement** is the process involved in identifying and selecting a provider of goods or services."[20]

2.2.2 Advocates of the approach argue that it also enables a more flexible and responsive service, with a multi-skilled assistant able to provide whatever is needed. In practice this appears not always to have been the case, with inflexible service specifications and separate monitoring arrangements militating against front-line flexibility.

2.2.3 In 2009/10, the ring fence was removed from SP funding although it was still a named grant. From April 2010, SP money will be included in the Area Based Grant and decision-making for expenditure on these services will move into the Local Area Agreement framework. With the removal of the SP ring fence, there should be the opportunity for greater flexibility over the use of the funds, a more integrated service specification and delivery, and more streamlined monitoring processes. Nevertheless, it remains important that personal care does not masquerade as housing-related support because of the registration risk, and also that the independence-promoting and preventative focus in ECH enabled by SP does not get subsumed into spending on the more intensive services.

2.3 DISADVANTAGES INCLUDING TURNBULL JUDGEMENT

2.3.1 While it is valid to argue that care and housing-related support need to dovetail with one another, housing management and housing-related support are also very closely linked, and it is equally valid to argue for the combination of these two functions. Specialist sheltered and supported housing providers see the support element as intrinsic to the service they offer and have concerns with performing landlord functions only. In the same way that there are grey areas between care and housing-related support, there are grey areas between housing-related support and more intensive housing management.

2.3.2 Care providers may have little understanding of housing-related support issues, for example information and advice about tenancies, benefits etc. Where the housing provider also provides the care and support, all three functions may be more effectively dovetailed, although there may also be lack of transparency, and other issues of concern *(See pros and cons of integrated management p81 and registration issues p12).*

2.3.3 However, of overriding concern in this context is the issue highlighted by the Turnbull Judgement:

2.3.4 The housing benefit system for private tenancies restricts how much rent can be paid. Registered Social Landlords (RSLs) normally operate outside these restrictions. They are classed as providing “excluded accommodation” – as long as rents are not hugely unreasonable, local authorities do not have to refer rents to the Rent Officer, and Housing Benefit (HB) can be paid on the full amount. However, Extra Care gross rents (rent and accommodation-related services charges) tend to be on the high side because of extensive communal facilities whose costs need to be met. If a local authority considered the rents to be unreasonably high, they could – although it is very unusual – refer the rents to the Rent Officer. If this were to happen, the Rent Officer would need to be satisfied that the accommodation qualified as “exempt” from the normal rules that limit HB to a figure set by the Rent Officer.

2.3.5 “Exempt accommodation” is defined in Housing Benefit Regulation as “accommodation which is provided by a non-metropolitan county council in

England, a housing association, a registered charity or voluntary organisation where that body or person acting on its behalf also provides the claimant with care, support or supervision"[21]

2.3.6 "The amount of care, support or supervision provided by the landlord can vary considerably but it must be more than minimal"...it must go "beyond that which is normally provided by a housing provider."[21]

2.3.7 "Commissioner Turnbull argues that 'on behalf of' should be taken to mean that the care, support or supervision if not provided by the landlord should be provided for them. There should be 'some form of interposition' for the landlord in providing these services."[21]

2.3.8 "If the care, support or supervision is not **directly** provided by the landlord or someone acting on their behalf, for example if all the care, support and supervision are independently commissioned by Social Services, then *'exempt accommodation'* status will not apply."[21]

2.3.9 If the accommodation is not classified as exempt, then the Rent Officer can restrict housing benefit to the local reference rent rather than covering the full rent at the scheme.

2.3.10 It would be safer therefore for the landlord either to provide some or all of the housing-related support directly, or to sub-contract it out to the care provider rather than it being commissioned directly by the local authority. There are models in which both the care and the housing provider deliver an element of support *(See case study 7 p57).* This can work well although attention needs to be paid to the contractual, payment flow and charging arrangements.

2.3.11 It is not advisable for the RSL, or indeed a private/independent sector landlord/accommodation provider, to directly provide care on its own behalf because of the other regulatory risk of being seen to be providing accommodation and care together and therefore registrable as a care home. *(See p12 on registration issues)*

3. PERSONALISATION AND EXTRA CARE

3.1 PUTTING PEOPLE FIRST

3.1.1 Signed by 19 key government and voluntary sector stakeholders, Putting People First (PPF) is a "shared vision and commitment to the transformation of Adult Social care"[22] "through personalisation, prevention and early intervention"[23]

3.1.2 "In the future, we want people to have maximum choice, control and power over the support services they receive."[22]

3.1.3 "Agreed and shared outcomes which should ensure people, irrespective of illness or disability, are supported to:

- live independently
- stay healthy and recover quickly from illness
- exercise maximum control over their own life and where appropriate the lives of their family members
- participate as active and equal citizens, both economically and socially
- have the best possible quality of life, irrespective of illness or disability

- retain maximum dignity and respect"[22]

3.1.4 The four main themes at the heart of Putting People First are[24]

- Facilitating access to universal services
- Building social capital within local communities – i.e. developing and utilising the strengths and resources within a community for the common good
- Making a strategic shift towards prevention and early intervention
- Ensuring people have greater choice and control over meeting their needs
    - o includes greater emphasis on self-assessment
    - o person centred planning and self-directed support becoming mainstream
    - o tailoring services to an individual's needs
    - o personalised budgets for everyone eligible for publicly funded adult social care support other than in an emergency

3.1.5 "By 2011 all 152 councils will be expected to have made significant steps towards redesign and reshaping their adult social care services (in the light of their Joint Strategic Needs Assessments), and have most of the core components in place" [25] One of these core components reads:

3.1.6 "For people eligible to receive council-funded support:

- Person-centred planning and self-directed support to become mainstream, with individuals having choice and control over how best to meet their needs, including through routine access to telecare
- A simple, straightforward personal budget system, which will lead to maximum choice and control being in the hands of people who use services as well as support to increase the uptake of direct payments, where people choose to take their personal budget as cash....."[25]

3.1.7 The Local Authority Circular LAC (DH)(2010) on *Transforming Adult Social Care*[26] gives local authorities information on the use of the final tranche of the Social care Reform Grants and reinforces these messages.

3.1.8 All of the above is commonly referred to as "the personalisation agenda".

3.2 FUNDING ASPECTS

3.2.1 Terminology in this document will be used in the following way:

- Personalisation - the ethos of making services more person-centred, incorporating the concept of self-directed support to allow people more choice and control both generally and financially.

- Individual budgets (IBs) – "An indicative amount of money that can combine several funding sources that you can use to purchase services from the public, private or voluntary sector."[23] In other words, it is the unit of currency for apportioning resources, rather than being defined in service terms, tasks or hours, and may combine more than one funding stream.

- Personal budgets (PBs) - an individual budget but limited to adult social care funding. "A personal budget is the amount of money that a council decides is necessary to spend in order to meet an individual's assessed needs. The

budget can be allocated as a direct payment or the council can retain direct control of the budget"[27]

- Direct payments - one form of individual or personal budget in which the service user is given the money directly to spend and which is covered by Direct Payment Regulations[28]. There are other mechanisms for implementing personal budgets. Direct payments are personal budgets, but not all personal budgets are direct payments.

- Micro- and macro-commissioning - not official terms but micro- used to refer to services being commissioned on an individual basis by, or on behalf of, an individual, while macro- refers to block or cost-and-volume type contracts.

3.2.2 By March 2011 the vast majority of service users are expected to have personal budgets.[25,26] They are seen as an important way of meeting the personalisation agenda by transferring control and choice to service users over how their needs are met.

3.2.3 Important features of personal budgets are that:

- they are a transparent, up-front allocation
- the individual can choose what it is spent on to meet the outcomes in the support plan
- they are portable – they are not tied in to a particular type of service or provider

3.3 EXTRA CARE HOUSING AND THE PERSONALISATION AGENDA

3.3.1 As mentioned earlier, there is no universally accepted definition of Extra Care Housing. Two features of ECH which are commonly accepted as fundamental and defining are particularly relevant to this Technical Brief. These are:

(i) the availability of care and support around the clock, and
(ii) opportunities for social activities and interaction

Without these two elements, Extra Care Housing would have difficulty attracting applicants in need of round-the-clock care, and delivering the well-being benefits of ECH identified in research. Service provision in ECH would be no different from other forms of sheltered housing, and could not serve as an alternative to residential care. Many Extra Care Housing schemes provide a cohesive and well co-ordinated service which enables flexibility and responsiveness, as well as a much valued sense of safety and security. This unique synergy helps to achieve improved well-being amongst ECH occupants.

3.3.2 Key challenges therefore for those developing ECH in the context of a move to personal budgets are:

- How to maximise choice and control while keeping key benefits of the model intact, and
- How to maximise opportunities for individual choice without jeopardising services which need a critical mass of purchasers to make them viable

3.3.3 These issues are explored more fully in the discussion paper *The 'Putting People First' Agenda and Care and Support Provision in Extra Care Housing*[29].

3.3.4 Other opportunities and challenges for ECH in the context of personalisation are explored in the *Building Choices* work undertaken by Housing 21[30], SITRA's *Personalisation, Prevention and Partnership: Transforming Housing*

and Supported Living [31], SCIE's *At a Glance 08* [32] and Housing LIN's February 2010 briefing[33]. The general issues will not be addressed in this Technical brief. (At the time of writing, ADASS is producing a more general housing briefing).

3.4 MODELS FOR COMMISSIONING[iv] CARE AND SUPPORT IN ECH

This Brief is based on the premise that care, or care and support, should be available at an Extra Care scheme around the clock, however this is commissioned and funded, however extensive or minimal it may be, and irrespective of where any risk in providing it may fall.

There are at least six possible models for commissioning round-the-clock care and support. These are not always totally distinct – for example, some authorities are adopting approaches which do not fit neatly into either of the first two models but are hybrids of the two. Within each model there are myriad variations. The models vary in the extent to which the services are based upon individual purchasing decisions, and how much they enable choice and control, in addition to participation, for individuals or occupants working collectively.

3.4.1 Option A: Spot-purchasing

3.4.1.1 The provider agrees to take on the risk of providing round-the-clock cover and relies on sufficient take-up of on-site provision by private purchasers, personal budget-holders or local authority spot-purchases, possibly under a framework agreement with the council. This is more likely to work where the development is very large, enabling economies of scale, and where some aspects of the cover (e.g. support not care elements) are subject to a fixed charge by the provider *(see section on charging p 64)*. This model is not uncommon in retirement villages where the majority of occupants have private arrangements with the provider. It may also apply to already established schemes where demand is clear. It may become more common as confidence grows *(see case study 8 on p 59).*

3.4.1.2 An approach like this is unlikely to work if simply imposed by the local authority. Both provider and council need to have confidence in the level of likely demand. Excellent partnership working, a relationship characterised by trust, and an appreciation of one another's legitimate concerns are fundamental.

3.4.1.3 If a compulsory charge is made for the round-the-clock cover by the provider, this approach may be seen as a variation on Option B. The same advantages and disadvantages outlined for the core and add-on approach (Option B) apply to this model. In addition:

Advantages

- Maximises freedom of choice in use of personal budgets (assuming that Social Services FACS eligible individuals are free to move to the scheme, even if they choose not to use the on-site care provision to deliver their care/support plan) while still ensuring round the clock cover

[iv] The term "commissioning" will be used in this context although a key manifestation of a models will be the procurement approach, because of the wider strategic and policy framework implied by the word "commissioning"

- From the council's perspective, this minimises the amount of money tied up in block contracts

Disadvantages

- May challenge provider's ability to staff sufficiently to provide a flexible and responsive service
- Many providers, particularly of smaller schemes may be unable to take the risk *(See pump-priming model (Option F) as an alternative)*

For examples which largely or entirely fall into this category, see case study 1 p44 and 6B p56

3.4.2 Option B: Core and add-on

3.4.2.1 This approach involves the council commissioning what is seen as the fundamental core service, usually a minimum cover of round-the-clock on-site care and support, and possibly also other elements of support such as activity facilitation. Planned care or support can be purchased either from the on-site provider or an off-site alternative, using Personal Budgets (PBs). This model may vary in the extent to which the cost of the core is covered by the council, how much of it is expected to be available for planned care and support, and in the charging arrangements.

3.4.2.2 A decision needs to be made on whether to define the core service as:

- care (funded from the from care budget only), or a combination of care and support, funded through the local authority care and SP budgets, or
- general care and support funded in the form of a grant, or
- whether to treat it primarily as housing-related support, and make it a condition of occupancy.

3.4.2.3 The first option ensures that, insofar as the service could be defined as care, care and accommodation are contractually separate. However, if the Registered Social Landlord (RSL), i.e. housing association, provides no element of support or supervision, or no-one provides any on the landlord's behalf, there is a small risk of falling foul of housing benefit regulations, resulting in full rents and service charges not being covered by housing benefi*t. (See Turnbull Judgement p 21)*

3.4.2.4 While a grant is a safe approach, there is no mechanism for the council to collect charges. (*For further consideration of the charging issues in the context of the core, see p68)*

3.4.2.5 If the core service is a condition of tenancy, and the cover includes personal care in an emergency rather than general support only, the scheme may become exposed to a risk of registration as a care home. *(See p70)*

3.4.2.6 However it is defined, the 24/7 cover should ideally be provided by someone registered to provide personal care so that the possibility exists of purchasing care and support from the on-site provider, and so that there are no quibbles about responding to emergency or unpredicted care needs.

3.4.2.7 If the Personal Care at Home Bill becomes law, this may have a bearing on how the 24/7 cover is funded and defined.

Advantages

- This approach probably optimises on the financial aspects of PPF by keeping block contracting to a minimum while still ensuring that the essential features of Extra Care (round-the-clock care and support) are provided.
- It incentivises the provider to offer a good quality service at a competitive price.
- In terms of individual packages of care and support, occupants have an open choice: they are not having to opt out of something to exercise that choice.
- The chances are that if the service being offered meets the occupants' aspirations and standards, the on-site provider will be chosen *(see, for example, case study 5 p52)*.
- Going off-site for activities, or people coming in from the wider community to run or take part in communal activities, is something which already happens in Extra Care, so spending PBs on such things could only be of benefit.

Disadvantages

- In smaller schemes, depending on what the core comprises, this approach may be less cost effective. Applying some of the time to planned care for occupants who choose to use their PBs on the on-site service, rather than all the time being "floating" would address this issue.
- Depending on the choices occupants make there may not be the same degree of co-ordination, synergy, cohesion and cost-effectiveness as there would be if most or all the care and support were provided by a single provider. Providers may not choose to invest in a dedicated staff group to deliver the spot-purchased element of the service.
- If many off-site providers were used (although this is by no means a certainty), building security may be more difficult to maintain, potentially undermining one of the current benefits of extra care[v]. In the limited amount of research undertaken, older people in Extra Care have expressed concern about this. (See page 17 of *Building Choices part 2 'Getting Personal'*[30]). Housing 21's research highlighted the following duty of care issues for housing providers:
  - What responsibility do scheme managers have in terms of balancing the rights and risks of people who do not choose "appropriate" services?
  - What if older people's employment choices don't accord with equal opportunities and health & safety legislation?
  - Reputation issues: what is a social landlords' responsibility regarding neglect or abuse?

  The greater vulnerability of many occupants in ECH, coupled with the fact that the model is marketed and valued on the basis of the safety and security afforded by the 24/7 cover, make these judgements and balancing acts more acute.
- For people with dementia where flexible, responsive services rather than planned units of care are particularly important, a minimal on-site core provision may be not be a good model.

[v] Most Extra Care schemes are designed to conform to the progressive privacy principle whereby people from the wider community can use the communal facilities, but not get into the private areas where the dwellings are located. The fear will be that with many different care providers coming on site, they need to access the area of private dwellings. This will be under the control of the individual resident as in the dispersed community.

- It may be more difficult to recruit, train and keep staff where demand is less predictable, and terms and conditions for staff are less attractive.
- Depending on the exact service configuration, contracting and charging arrangements, there may be a slight risk of registration as a care home, but the risk should be minimal if this model is applied with due attention to these issues.
- There is a fear amongst providers that off-site providers will adopt aggressive marketing strategies based on cost to win custom in ECH schemes while not offering the added value of the on-site provision, leaving the on-site provider to "pick up the pieces", and undermining the overall service. It is too soon to know if this concern is realistic.

For examples of this model, see case studies 2 p46, 3 p48 and 4 p50

3.4.3 Option C: Block contract the whole service but allow freedom of choice

3.4.3.1 This is an approach being adopted by some councils, some for new developments and others only until their current contract expires. What the "whole service" comprises will vary; it will range from commissioning an on-site team purely to provide care, to a more general care and support team with a wider brief. *(See also "How Much Care?" p85)*

3.4.3.2 The block contract may be expressed in overall volume terms or in numbers of packages in different bands. Funding sources and mechanisms as well as charging arrangements will also vary, but the critical difference between this and the next option is that occupants can choose to use their PBs to purchase the on-site block-contracted service or use it to purchase services from elsewhere. Occupants are informed of their entitlement to use their personal budgets to buy support from elsewhere.

Advantages

- This approach probably best optimises the benefits of extra care whilst ensuring occupants retain choice and control.
- It ensures that a round-the-clock care and support service, and probably also wider support and activities facilitation, exist on site for occupants to choose.
- It makes advisable a transparent approach in which there is clarity about what the on-site service offers and its benefits, as well as the other choices open to occupants. This is more empowering for occupants. This might include spelling out the component parts and their costs, either in staffing or in terms of function.
- It provides an incentive for the on-site service to be of high quality, with the flexibility, responsiveness and personally tailored services that are the hallmark of good extra care provision anyway.
- It retains the benefit of a care team – cohesion, staff continuity, stability, and flexibility and responsiveness in meeting support needs which a more skeletal approach potentially loses.
- A block contract provides more of an incentive for partners to work together prior to the scheme opening to plan arrangements at the interface between the care and other services.
- It keeps the accommodation and care contractually separate.

Disadvantages

- While transparency is undoubtedly a plus-point, breaking the service up into component parts, particularly if occupants have the freedom to select

some but not others, can undermine the service and result in fragmentation and tension within the community. There would probably need to be a clear policy on what can and cannot be opted out of – e.g. all-or-nothing in terms of the council-commissioned services, or separate elements. There would also need to be clarity as to the implications of withdrawing from the service (e.g. all on-site care and support provision) or particular aspects of the it (e.g. only the planned care, but not the emergency care).
- Potential risk of double-paying – could be mitigated by having an agreement to reduce the block accordingly
- Over-generous block contracts can cultivate a dependency culture which is counter-productive and a waste of resources.
- It may not satisfy the requirement to minimise block contracting

For examples of this model see case studies 5 p52 and 6A p55

3.4.4 Option D: Block contract the whole service – Choice is made at point of entry by selecting ECH

3.4.4.1 This option is described by its exponents as a "package holiday" approach as opposed to the "completely independent traveller". The full care and support provision is block contracted by the council and this is the service occupants in the scheme are expected to use for their care and support.

Advantages
- This approach allows choice upstream so that there is a stable, funded service.
- The advantages of Option C apply, except for the first one.
- It can offer a more cohesive service because the separate service components do not have to be individually itemised and costed, with the frequently commensurate wrangles over definitions and territory.
- It potentially ensures the advantages that apply with a minimum number of providers on site – effective communication and co-ordination, synergy, flexibility, responsiveness and economies of scale.
- Choice and personally tailored service delivery are possible within the constraints of the on-site provision, and people have the freedom to use their disposable income in whatever way they choose.

Disadvantages
- This approach may be tantamount to "personal care and accommodation provided together", even though contracts for accommodation and care are separate, and may therefore be deemed registrable as residential care.
- It does not conform to the vision in Putting People First. Whilst each occupant may have a personal budget, it is not portable – occupants do not have the choice to spend it in another way.
- The flipside of cohesion and synergy can be a lack of clarity and transparency about what the service covers and what occupants can expect. This can be disempowering and not good practice. However, lack of transparency is not an intrinsic element of this approach.
- It is arguably unnecessary. If the on-site service is flexible, responsive and personalised, most occupants are likely to see the benefit of using it anyway, and will only choose to use their personal budget differently if they have a particularly individual requirement.

- Occupants may feel lumbered with an unsatisfactory provider. If the care and support provider is commissioned separately by the council, occupants can in theory join together to bring pressure to bear to oust the provider, but this may not be an intrinsic part of the process, and frail occupants are less likely to be able to organise themselves in this way.
- The last three disadvantages in Option C also apply.

For an example of this model see case study 7 p57

3.4.5 Option E: Co-production or social enterprise models

3.4.5.1 Some kind of co-operative approach could be used. This is an approach which could evolve from any of the other models. It could involve different degrees of co-production from simply influencing the shape of the service, to joining together as a group to directly procure it or employ a particular provider.

Advantages

- It enables the resident group to shape the services they receive, their cost and who provides them.
- Depending on the level of collaboration, it increases participation, choice and possibly control - on a group basis democratically exercised, rather than on an individual basis.
- Some co-production models may lend themselves best to people who have the energy and motivation to get involved.
- This may be a good approach as a supplement to a core service. Thus, for example, it is an approach which works very well in arranging activities.

Disadvantages

- Many occupants of Extra Care schemes may be too frail to play an active part in decision-making of this sort.
- A co-production model which enables members to develop a structure and service together from scratch could not apply to the core extra care service if it is to be in place from the start, unless the resident group is known sufficiently in advance of it opening.

For examples of this approach see case study 9 p62 and Up2Us in the example box p36.

3.4.6 Option F: Pump-Priming model

3.4.6.1 The core or full support service is block contracted for a pre-determined period, thus ensuring that 24/7 care and support is in place from the outset, and that the provider's infrastructure is in place. Once the block contract comes to an end, the arrangement converts to spot-purchasing using PBs or private funds.

Advantages

- It ensures that the core service is available from the time that the scheme opens and can attract and meet the needs of a wide range of people.
- It combines reassurance and certainty at the start to justify the provider's investment, with an incentive for them to make sure the service remains of high quality and competitive.

- It can be a pre-cursor to a number of other approaches, including a co-production approach and spot-purchasing.

Disadvantages

- The council may need to step in if, for whatever reason, the round-the-clock service was floundering; not to rescue the provider, but to rescue occupants whose well-being and health may be jeopardised if the service were lost.

For an example of this approach see case study 9 p62

3.4.7 The case studies starting on page 42 are live examples of some of these models.

3.4.8 Within each model there are numerous possible variations, each potentially introducing or reducing advantages, disadvantages and risks. All models have their pros and cons, and commissioners and providers need to work together to minimise the downsides of their chosen approaches. The questions outlined below should help in shaping and assessing their approach:

- Does this approach still offer the key benefits of extra care housing? Does it offer more than would be available in standard sheltered or general needs housing, and offer an option for people who would otherwise require residential care?
- Does the approach optimise individual choice, control and personalised provision, including access to a personal budget?
- Does it enable opportunities for genuine involvement, co-production and control of on-site services?
- Does this approach retain the potential for seamless, integrated or co-ordinated service delivery?
- To what extent does it enable a cohesive, responsive and flexible service?
- Is the approach relatively simple, transparent and easy to understand?
- Does this approach minimise the risk of being seen as accommodation and care provided together and registrable as a care home? *(See p12)*
- Are charging arrangements lawful, fair and clear? *(See Charging p64)*
- Does the approach risk not being exempt from local reference rents? *(See pp20-21)*

3.5 CURRENT TRENDS

3.5.1 Whilst this refreshed Technical Brief is timely in view of the shifts required in the provision of care and support services, it is also very early in the transformation process. The situation is likely to look very different in two or three years time when many key changes currently being explored and implemented have become embedded and applied to ECH. The following seems to be the picture at present.

- There seems to be general recognition that the core 24/7 cover is an essential ingredient of ECH. However, how that core is commissioned and constituted varies enormously.
- While there are examples of changes to commissioning practice, many local authorities appear to adopting a “wait and see” approach. Many are waiting for existing block contracts to expire, while others are introducing shorter review periods and fewer hours in the block. There are also some encouraging examples of models which, while fully embracing the

personalisation agenda, including PBs, still ensure the availability of care and support around the clock.

- Changes in approach are being introduced to new schemes first.
- Where a core and add-on approach is being used, both commissioners and providers are highlighting to occupants the benefits of choosing the on-site provider, in a bid to prevent fragmentation, and to avoid a range of other issues arising from several different providers in ECH.
- Whilst it is impossible to quantify, quite a lot of commissioners and providers still seem to be taking the line that Extra Care is the choice open to people. Interestingly, the only research thus far in the public domain into the views of ECH occupants suggests that they see it this way too: "Critically, the discussions with extra care occupants as part of this project indicate that for them, moving to extra care **is their choice**, and they express a strong preference for the on-site care provider" [30]
- Many local authorities have not yet introduced resource allocation systems and personal budgets to people in, or considering a move to, ECH. Most are aware that this needs to happen but have not yet developed their systems sufficiently.
- It is still unclear whether PBs based on resource allocation systems will be sufficient to cover the cost of both planned and emergency support, assuming the latter is intended to be covered by PBs in the first place. *(See case studies 1 and 2 for examples where the RAS is applied and sufficient pp44 &46)*.
- Where direct payments are being chosen in Extra Care Housing, it seems to be for those with special needs which cannot readily be met by the on-site provision, or in order to employ family or friends as personal assistants.
- Some local authorities at present describe personal budgets as something they "offer" to those with eligible needs. Others describe them as a way of defining entitlement, and will be automatically applying them across the board, with the service user choosing how they are managed.
- Despite the removal of the ring-fence around SP, there still seems to be some rigidity in relation to the services and activities SP and adult social care money will cover, with gaps in between.
- Involving occupants in shaping and selecting the on-site care and support provision seems relatively under-developed. (See TPAS CHS Good Practice Guide *Effective Resident Involvement and Consultation in Sheltered Housing[34])*

3.6 LOOKING AHEAD

3.6.1 Introduction

3.6.1.1 Over the next few years, it is likely that two things will come together:

- Commissioners and providers will grow more confident that if the on-site service is truly flexible, responsive and personalised, then people moving into ECH will choose to use it even if they have the option not to.
- Coupled with that, providers and local authorities will increasingly embrace the spirit of the personalisation agenda.

3.6.1.2 Even in models that use block contracts, there is much scope for movement in terms of individual and collective involvement, choice and control; truly personalised assessments and support planning; and outcome-based commissioning. Work undertaken by Look Ahead Housing and Tower Hamlets illustrates some of the opportunities for "*personalising block*

contracts in supported housing."[35] The service users in this case were working age adults with complex needs, rather than older people, but it nevertheless offers some relevant lessons, particularly in terms of a fundamental shift in attitude.

3.6.2 Provision of information and brokerage

3.6.2.1 There will need to be very good information and support at the decision-making stage to assist people in deciding whether or not to choose Extra Care Housing and develop their support plan, including how they wish to manage their personal budget.

3.6.2.2 While housing providers could potentially act as brokers in helping occupants access appropriate support once they have moved, it may be argued that they cannot be independent as they have a vested interest in the resident choosing the on-site provision.

3.6.2.3 It is both legitimate and sensible for providers to market their services effectively, highlighting the added value of on-site provision, and making it quite clear what people will be getting for their money.

3.6.3 Personalisation of the assessment and support planning process

3.6.3.1 "Being person centred is about services and professionals working in ways that genuinely put the individual at the centre of decision-making about their life and the services and support they want and need." "It is crucial that everyone starts with older people and what's important in their lives, regardless of their need for support, their 'usual care setting' or condition."[27]

3.6.3.2 We are increasingly likely to see assessments which truly reflect person centred thinking, and more imaginative, dynamic support plans which address aspirations as well as risks and needs, with providers in Extra Care Housing going the extra mile to respond.

3.6.3.3 Personal budgets for older people[27] says that approaches are person centred where:

- the person is at the centre of planning for their lives; planned with rather than for.
- Family members and friends are partners in planning (and reviewing/assessing support arrangements and plans). Everyone is supported to listen and learn about what people want from their lives.
- The plan shows what is important to the person – now and for the future. It shows their strengths and the support they need.
- The plan helps the person to be a part of their community and helps the community to welcome them.
- The plan is ongoing. Everyone keeps listening and learning to make things happen. The plan puts into action the things that the person wants to get out of their support, and fundamentally, their life.

3.6.4 Personal Budgets

3..6.4.1"The transformation of social care requires a whole system change of which personal budgets for older people must be done as part of a wider programme of empowering and enabling all older people to have better lives.

Access to good information, advice advocacy, and enablement services should be central to this" [27]

3.6.4.2 In the coming years, PBs for occupants in ECH with eligible needs are likely to be the norm, and hopefully any glitches in Resource Allocation Systems will have been ironed out. *Personal Budgets for Older People* recognises that mechanisms for managing personal budgets need to be scalable and tailored to the older person.

3.6.4.3 Personal budgets may be deployed and managed in a variety of ways:

- "In the form of a direct (cash) payment, held directly by the person or where they lack capacity, by a 'suitable person'
- "by way of an 'account' held and managed by the council in line with the person's wishes i.e. to pay for community care services which are commissioned by the council, or as an account placed with a third party (provider) and 'called-off' by the user in direct negotiation with the provider.
- " or as a mixture of the above"[36]

3.6.4.4 Under the managed personal budget option, the contract is between the council and the third party/provider while the day-to-day arrangements are between the individual and the third party/provider, as provided for in the contract.

3.6.4.5 One management mechanism which may be particularly suited to Extra Care housing is the "individual service fund". "An Individual service fund is an agreement between the individual and the provider that sits beneath the framework contract. The person asks the council to lodge funds with a provider on their behalf while retaining choice and control over the support and services provided."[27] These are described in detail in *Contracting for Personalised Outcomes: Learning from emerging practice*[37]

3.6.4.6 The PB could be used in a number of ways: to pay for an existing service which has been block contracted; to pay for any other traditional or non-traditional services which meet the need; or a combination. PBs could also be pooled to co-develop or co-commission a service with other users.

3.6.4.7 Five factors for making personal budgets work for older people are described in *Personal Budgets for Older People*[27] as:

- Working with older people to make the change towards self-directed support.
- Having a flexible range of options available for older people to have and manage their money.
- Making it easy for older people to understand these options and decide which will work for them.
- Providing high quality ongoing support services.
- Reviewing, learning and implementing change where needed.

3.6.5 Outcome-based commissioning

3.6.5.1 "Services should be commissioned to more flexible, outcome-focused specifications to ensure that they are fully integrated around the needs of the individual."[13] Some commissioners are already using outcome-based specifications for the care and support service in Extra Care Housing.

3.6.5.2 Whether framework or block contracting is used, providers should be asked to sign up to delivering flexible and personalised services, with the detail determined between the individual and the provider. This will be based on information in their support plan, although the contract will identify broad outcomes.

A council in transition - moving towards self-directed support

One local authority, keen to develop its extra care programme, and maximise choice and control in a measured way, is adopting a methodical, pragmatic approach to getting there.

- Mechanical assessments have been replaced by more outcome-focused assessments while still using the FACS categories.
- While the RAS is being fine-tuned, the cost of traditional services to meet the assessed, eligible needs are used as an indicative budget which can then be spent on non-traditional services.
- As part of the assessment, social workers are required to consider ECH with the client if an accommodation-based solution is needed, and justify why ECH is not suitable. If someone is diverted from a residential care route, the funding saved is diverted into the care in ECH.
- Currently only direct payments or block contracted services are available in ECH, but the authority is moving towards making personal budgets available for spot-purchasing.

3.6.6 Co-production

3.6.6.1 Co-production is described as "active input by the people who use services, as well as – or instead of – those who have traditionally provided them." [19] We are likely to see more of this in Extra Care Housing, although older people at the frailer end of the spectrum may not embrace it as readily as fitter, younger people.

3.6.6.2 Housing providers have a track record of involving and engaging occupants, for example in developing policies and procedures and other written material, selecting cleaning contractors etc. This is likely to increase under the new regulatory regime of the Tenant Services Authority (TSA). (See Standard 1 – Tenant Involvement and Empowerment in the TSA *A New Regulatory Framework for Social Housing in England*[38])

3.6.6.3 Activities in Extra Care Housing are often organised by occupants, although a facilitator helps to avoid the domination of a few individuals. There is scope for parts of personal budgets to be pooled if activities form part of individuals' support plans.

3.6.6.4 However, possibly the greatest scope for change is in the care and support services as a whole, where up until now, occupants have at best been consulted, at worst not even been informed of a pending tender process. For new schemes, where the resident group has not yet been identified, co-producing the support service may not be realistic. However, in established schemes some occupants may be interested in shaping and selecting the

support provision collectively, making a pump-priming approach a reasonable option. *(See case studies 8 p59 and 9 p62)*

Up2Us Co-Production Pilot in ECH

Harp House *(See case study p97)* is the location for Barking and Dagenham Up2Us, which is supported by the Council, Hanover Housing Association and HACT (the Housing Action Charitable Trust). It is one of 6 Up2Us projects in various parts of the country, with funding from CLG and DH. (link http://hact.org.uk/up2us/1010). Up2Us focuses on the impact of personalisation on people living in a range of supported housing settings, and on the implications for housing and support providers themselves. Although located in Harp House initially, the project is intended in time to embrace other extra care housing schemes in the Borough. To steer this work, a Local Reference Group (LRG) represents the local authority, local voluntary and user led bodies, care providers and Hanover. A part-time coordinator has been seconded from the Council's personalisation team, and is based 2 ½ days per week in Harp House. She is working closely with scheme residents to provide them with information about the implications of personalisation; to seek their views on the services they receive now and wish to access in future; and to engage them in work with the LRG to shape the way services evolve.

3.6.6.5 *A Guide to Co-Production with Older People*[39] identifies seven underpinning principles of co-production with older people:

1. Older people are involved throughout the process – from beginning to end.
2. Older people feel safe to speak and are listened to.
3. We work on the issues that are important to older people.
4. It is clear how decisions are made.
5. Older people's skills and experience are used in the process of change.
6. Meetings, materials and venues are accessible for older people.
7. Progress is evaluated through looking at the actual changes in older people's lives.

3.6.6.6 It[39] describes co-production in action in the following steps:

1. Think about who needs to be part of this development.
2. Work out how to support each other in contributing to and making decisions.
3. Work together to understand and agree the issues that need to be addressed.
4. Agree what it is that you want to be different: what success looks like from everyone's perspective.
5. Identify the resources needed to achieve those goals: do you have them? How can you get what you need?
6. Think together about what needs to happen now, in the medium and longer term. Agree who will do what by when.
7. Take action – just do it!
8. Did you achieve the success that you wanted to? What has changed in older people's lives as a result?

4. CARE PROCUREMENT

4.1 Contract Type

4.1.1 Up until now, where Adult Social Services procure the care in an Extra Care Housing scheme, the recommended approach has been to purchase the planned and emergency on-site care in a block, top-sliced from an appropriate budget. A block usually comprises an agreed number of hours but may also be an agreed lump sum, or an agreed contribution to particular posts.

4.1.2 Commonly, there has been a facility to spot-purchase care, should the block contract be insufficient to meet the needs of the resident group. In the context of personalisation, we are seeing a shift in some areas, with the spot- rather than block-purchased hours making up the bulk of the provision.

4.1.3 A framework contract with the care provider may be used to supplement or replace a block contract. "Outcome focused framework contracts aim to assure quality and supply through pre-selection or validation of providers. They do not generally guarantee demand for or volume of service in the way they have been implemented."[37] The local authority may for example require the provider to deliver services in "a more flexible or personalised way regardless of whether their customers are self or state funded." They may seek to fix the price at which personal budget holders can buy their support, but without any guaranteed purchase – spot-purchasing within a framework. Providers may be reluctant to enter into this sort of agreement if commissioners try to tie them in to the price they could offer when they had the security of a predicted volume of work.

4.1.4 The advantages and disadvantages of these different procurement approaches have already been covered and will not be repeated here.

4.2 Length of Contract

4.2.1 Where adult social services commission a single provider to deliver the care in a scheme, it may be tendered for as a separate, discrete service, or it may be tied in to the agreement with the housing and care provider who developed the scheme.

4.2.2 Assuming adult social services has a block contract with the provider to guarantee at least minimum 24/7 cover, the contract needs to be long enough for good providers to be interested and willing to invest in the necessary infrastructure, but not so long that the parties are tied in to terms which no longer fit with the rapidly changing environment. Thus, a contract for the care should probably be no longer than three years, with an annual review built in.

4.2.3 One of the benefits of a separate care contract is being able to select a different care provider without breaching the agreement between the council and provider, if the service being delivered by the existing one does not quite match expectations.

4.2.4 At the same time, continuity is very important to service users, as well as for relationships and team-working. The housing provider's and occupants' views of the care service should be taken into account when considering whether to extend the contract, reconfigure the service, or embark on a new selection process.

4.2.5 Where integrated housing and care management[vi] is the chosen model, the duration of the agreement is likely to be tied in to the time taken to repay any loan on the capital investment in the scheme. Thus, it may be for 20 or 25 years, but the agreement is likely to have review and termination clauses included. *(See p82 for the pros and cons of separate and integrated models)*

4.3 A Partnership Approach

4.3.1 Irrespective of who provides the care and the type of agreement, a partnership approach to commissioning the care rather than a prescriptive purchaser-provider approach is much more conducive to an excellent service.

4.3.2 This should apply to the commissioning of all social care services but merits emphasis in this Brief because very often the providers have specialist knowledge which commissioners may not possess. Each may learn from the other, and tackle problems and issues together if there is an open, trusting relationship. Such an approach is likely to deliver better outcomes for occupants, and outcome-based commissioning dovetails perfectly with this approach.

4.3.3 In addition, if adult social services are seeking to develop a round-the-clock service in Extra Care, and is expecting the provider to bear a significant level of risk, the specification and minimum level of provision should be a joint decision, not one imposed by the council. *(See case study 1 p44)*

4.4 Involvement of Housing Provider

4.4.1 Where the core care service is procured and provided separately from the housing service, the housing provider should be invited to contribute to the process of recruitment and selection of the care provider. The extent of involvement would need to be more limited if a separate arm of the provider organisation is one of the applicants.

4.4.2 There are a number of reasons why the recruitment of a care provider should be undertaken jointly:

- The housing provider owns the building. Usually they have funded the development (or a large part of it) and are bearing the long-term financial risk.
- The housing provider's reputation is closely bound up with the scheme. It is they who:
    - have overall responsibility for the building and everything that goes on in it
    - are tied in to the scheme long-term
    - are identified with the scheme in the public eye
- Housing providers understand better than anyone the unique features of their approach to Extra Care Housing, and can provide important information to prospective care providers to enable them to make an informed decision whether to apply to deliver the care service or not.
- The housing provider will have a slightly different perspective and may be looking for certain attributes, e.g. emphasis on team working and an independence-enhancing ethos, making the selection panel more representative of the needs of the scheme.

[vi] For possible risks of an integrated approach see p12 on avoiding registration as a care home

- Joint selection of the care provider gives the housing provider a sense of responsibility for the choice even though the legal contract is with social services or individual occupants.
- Joint selection also reinforces the message of partnership working to be carried through between all parties, including the care provider once selected.
- Increasingly, the care provider also provides housing-related support funded by Supporting People. If the housing provider holds the contract with the Supporting People Administrative Authority for the housing-related support at the scheme, it will be held responsible for the element of support sub-contracted to the care provider.

4.5 Involvement of Extra Care Housing Occupants

4.5.1 If the basis of care provision or the provider is to be changed, it is essential not only to inform occupants, but also consult with and involve them in the re-shaping of the service. They can assist in defining the core service specification and appoint [a] representative[s] to take part in the selection process. In some models, occupants could ultimately become the commissioners and decision makers.

4.6 Information to Prospective Care Providers

4.6.1 In addition to the standard information included in the domiciliary care tender pack, the following specific information on Extra Care Housing should be included.

- Care:
    - Care specification details that are specific to Extra Care Housing – e.g. staffing levels, management presence, what the hours cover etc *(See section entitled "How Much Care?" p85)*
    - Any specific expectations regarding activities or responsibilities not covered by the council's standard domiciliary care specifications
    - Expectations regarding ethos and approach of care provider
    - If a full block contract, expected facility for varying the volume of care in response to changes in overall needs profile of occupants, on the basis of pre-specified triggers
    - Provision of outreach services or facilitation of in-reach services
- Scheme specifics:
    - Details about the housing provider
    - Extra Care Housing and details of their model of Extra Care – ethos, service delivery, preferred management model
    - Details about the building
    - The facilities available to the care provider
    - What equipment will be provided
    - Any expenses they may be expected to pay
- Expectations of extra-contract involvement and joint working, for example:
    - Pre-completion meetings to agree working practices and develop an operational protocol
    - Joint induction and training of staff
    - Participation in inter-agency meetings once scheme operational
    - Joint provider assessments and service delivery plans for the resident

4.6.2 Irrespective of the process for selecting or appointing the care provider, having this information before applying to deliver the service is likely to

make the care provider better prepared, and more committed to effective joint working.

4.7 Key Qualities

4.7.1 In addition to all the standard criteria for assessing prospective care providers, from an Extra Care Housing perspective, the following are important:

- An understanding of Extra Care housing – desirable but not essential
- A genuine commitment to working flexibly as part of a multi-agency team – essential
- A genuine commitment to promoting the independence of occupants and providing a truly personalised service – essential
- Staff trained to understand and care for those with special needs, especially person-centred care in meeting the needs of people with dementia

4.8 Timing of Procurement

4.8.1 Once the care provider has been selected, it needs time to recruit staff, and comply with registration, Criminal Record Bureau (CRB) and Independent Safeguarding Authority (ISA) requirements, and provide training and induction.

4.8.2 Therefore, the process being used to select/appoint the care provider – if separate from the housing provider – should begin early enough to leave the provider at least three months preparation time. Local authority tendering processes can take three months or more, so should begin a minimum of 6 months before the scheme is due for completion.

4.9 Specification

4.9.1 Specifications should be outcome-focused, require personalised provision which maximises independence, choice and control, and allow for flexibility and responsiveness in service provision and the possibility of Individual Service Funds.

4.9.2 It is even more essential in the context of personalisation and changing contracting approaches, that it is made absolutely clear in the service specification and contract exactly what is required, what is being paid for, and on what basis. Providers need to know, for example, whether only direct contact hours will be paid for, even if the specification stipulates a minimum 24hour presence; or for example, whether the day-time minimum presence specified in a contract is expected to cover emergency care and support only, or whether some or all of it is expected to be used for planned care to individuals. *(See also "How Much Care?" p85)*

5. HEALTH CARE IN EXTRA CARE HOUSING[vii]

5.1 This Technical brief is primarily focused on social care and support in ECH. People living in ECH have access to health services on the same basis as anyone else living in their own homes – to the primary care services of GPs and district nurses, as well as specialist health care through hospital out-

[vii] See *Transforming Community Services: Enabling New Patterns of Provision*[40]

patient services, community mental health teams etc.

5.2 There is, however, significant potential for improving the health and well-being of the Extra Care community and those living in the surrounding area cost-effectively, through targeted investment in services based at Extra Care schemes. Examples include:

- funding intermediate care flats at extra care schemes (See Factsheet 31: *Short stay Intermediate Care Services in a Range of Housing and Care Settings*[41]*)*
- basing GP surgeries and health clinics in ECH (See Case Study 47: *Integrating Extra Care Housing in Staffordshire*[42]*)*
- funding the training of care staff in undertaking minor health tasks such as applying ointments and dressings
- funding training in cognitive stimulation therapy, end-of-life care etc to equip staff to provide a better service and reduce the number of people needing hospital or residential care
- funding an on-site nursing provision if a high number of occupants with nursing needs
- funding well-being and health promotion programmes (See Case Study 38: *Healthy Outcomes in Blackburn & Darwin Extra Care Housing*[43])
- even joint-funding of the social care provision on the basis that ECH fulfils a preventative and health promoting function.

COMMISSIONING OF CARE & SUPPORT IN EXTRA CARE - KEY POINTS

- A local authority procuring both the care and housing-related support directly from a domiciliary care provider may put at risk housing benefit cover of the full rent and service charge.
- The personalisation agenda and introduction of personal budgets is likely to impact significantly on the commissioning of care in ECH.
- There are a variety of possible approaches;
  - each has advantages and disadvantages
  - there are key differences in the type and degree of choice and control available to occupants
  - they also differ in the degree of synergy, co-ordination, continuity, flexibility and responsiveness that can be assured.
- Implementing personalisation is a work in progress. There is much scope for movement in Extra Care settings towards most aspects of self-directed support.
- Contracts for care between local authorities and providers are likely to be any of the following – block, spot, framework or a mixture.
- Outcome-based commissioning will enable the greatest flexibility.
- Where an occupant arranges a service directly with the care provider, there should be a separate contract between them covering the service.
- Where care and housing are managed and delivered separately, the housing provider should be involved in selecting the care provider.
- Prospective care providers need to be given information specific to Extra Care settings as part of the Invitation to Tender process.
- Occupants should be consulted and involved in shaping the service and selecting the provider when contracts come up for renewal.
- Attention should be paid to timing so that providers have sufficient time before start on site to recruit staff and fulfil registration and CRB/ISA requirements.
- The local authority should select the housing and care providers they wish to work with carefully, and adopt a partnership approach characterised by mutual trust and respect.

6. CASE STUDIES

6.1 Whereas the case studies written for the Housing LIN's 2005 Technical Brief *(starting on page 95)* concentrate on the provision and delivery of care in ECH, the case studies in this section have a slightly greater emphasis on the commissioning and contracting aspects.

6.2 They are actual case examples and each approximates one of the models outlined in the personalisation section *(p25)*. Their inclusion in the Technical Brief does not confer official endorsement or recommendation. All approaches have their pros and cons and it is up to commissioners and providers to agree what will work best locally, while trying to keep within the regulatory and legislative framework.

6.3 The anonymised case studies on the following pages contain information under the following headings:

- Number of properties, type and tenure
- Care commissioning approach
- Support commissioning approach (if applicable)
- When the commissioning arrangements began
- Minimum cover requirements, and what that cover includes
- Point and level of choice
- Eligibility for the scheme and target groups
- Approach to personal or individual budgets
- Role and level of RAS
- Charging for care – planned and unplanned
- Charging for housing-related support
- Any tenure differences in accessing care and support
- Management and service model
- Activities facilitation
- Additional features, including catering

6.4 The following table gives a thumbnail sketch of each.

Case Study Number	Key features
1	**Framework contract: Small support core, well-being grant and spot purchasing by band** In this village, a framework contract has been adopted. The contract has three elements: housing-related support; care to be purchased on a spot contract basis by personal budget holders who choose to use the on-site rather than an off-site provider; and a well-being grant to promote the well-being of the village residents and wider community. The provider carries the risk for the difference between the agreed minimum provision and what the contract guarantees.
2	**Core and add-on** 70% of the minimum 24/7core is block contracted, with personal budgets for individual care plans expected to cover the remaining 30%. Personal budgets top-sliced to offset the cost of the core service. The RAS is used for ECH applicants and RAS levels have been aligned with occupancy bands.

3	**Core and add-on** In this model, a minimum core is purchased including sleeping night cover, on-site care manager, and a minimum of 105 day-time hours, all of which could be used for delivering care plans. Additional hours are spot-purchased. At present residents can choose direct payments but are encouraged to use the on-site services. Once RAS and PBs are applied across the board, PBs could be used to purchase services from on-site or off-site provider.
4	**Block core plus spot contract** This is an example of a PFI funded scheme where the care was tendered separately, but the tender was won by the housing provider, enabling an integrated management approach. It combines a minimum block and spot contract approach, with the offer of direct payments to those with special needs.
5	**Block contract with offer of personal budgets** In this scheme, care is block contracted but people have the choice to use personal budgets to select an alternative provider. There is the facility to spot purchase additional care. A fixed charge for the availability of care round the clock is made by the council, subject to a Fairer Charging assessment. It is payable by all tenants.
6	**Block contract in bands** In the village, care and support packages are block contracted in bands. Residents are free to opt for a personal budget if they wish to go off-site for their care. The council has a contract with the housing provider who sub-contracts the care and an element of support to the care provider.
7	**Minimum guaranteed block contract** A relatively generous number of care hours are block contracted with more hours added to the block as required. The service commissioned from the care provider includes a small number of SP hours for more general housing-related support, while intensive housing-related support is provided by the housing provider. In this scheme, people are expected to use the on-site services if they choose Extra Care.
8	**Pump-prime model** This scheme began with a traditional block contract for the care in January 2008. The care contract is now being re-tendered on a spot-purchasing basis with local providers who already have a domiciliary care contract with the council invited to tender.
9	**Co-Production** This scheme is in development for working age adults with physical disabilities. Prospective tenants have been identified and the approach to commissioning the care and support is being developed through intensive consultation with them.

CASE STUDY 1

FRAMEWORK CONTRACT: SMALL SUPPORT CORE, WELL-BEING GRANT AND SPOT PURCHASING BY BAND

In this village, a framework contract has been adopted. The contract has three elements: housing-related support; care to be purchased on a spot contract basis by personal budget holders who choose to use the on-site rather than an off-site provider; and a well-being grant to promote the well-being of the village residents and wider community. The provider carries the risk for the difference between the agreed minimum provision and what the contract guarantees.

Number of properties, type and tenure	242 units 40% rented 28% shared 32% full sale
Care Commissioning Approach	The council has a framework contract with the provider covering both care and housing-related support. The contract has three elements, housing-related support, care to be purchased on a spot contract basis by personal budget holders who choose to use the on-site provider, and a well-being grant to promote the well-being of the village residents and wider community. The provider carries the risk for the difference between the agreed minimum provision and what the contract guarantees. Outcome-based specification.
Support Commissioning approach if applicable	Contract jointly with the care. Block subsidy contract for the housing-related support. Subsidy covers the overnight presence of one staff member.
When did these commissioning arrangements begin?	August 2008
Minimum cover requirements and what minimum includes	24/7 combined care and support cover, but the council does not guarantee to cover the cost of this. The SP block subsidy contract is the only guaranteed element. It is assumed that personal budget holders choosing on site services for their self-directed support plans will enable the cost of this to be covered. The council and provider agreed jointly to a minimum of two staff members on site overnight.
Point and level of choice(s)	Individuals receive personal budgets which they can choose to use to purchase on-site provision or go off-site. If they chose to use their entire budget for off-site provision and needed emergency care (as distinct from support), the provider would deliver this on a one-off basis, but if there were repeated episodes, discussions would be had with the resident to consider altering their purchasing choices.
Eligibility for the scheme and target groups	The original vision includes fulfilling a preventative function. The village aims to cater for a mix of need levels from those with no care needs at all (band 0) at one end of the spectrum, to those with a high level of needs (band 3) at the other. The council will only give personal budgets to those at FACS substantial and critical thresholds. Bands as follows: • Level 1 – low – may equate to 4-5 hrs care per week • Level 2 – medium – likely to average 12 hrs care per week and

	require some night support • Level 3 – high – likely to need more than 17 hours day-time care and 3 hours overnight Ineligible occupants can purchase care privately from the on-site provider or an alternative.
Approach to Personal Budgets	Applied universally
Role and level of RAS	Social work staff assist service users to undertake a self-assessment. If they meet FACS eligibility, they are given an indicative resource allocation. The actual level of the personal budget is determined by how the needs will be met and the cost of these. A personal budget for someone choosing Extra Care will be lower than their indicative resource allocation in recognition of the wider support available in an Extra Care setting. The budget is sufficient to cover the cost of the services in Extra Care which are divided into bands, as described above, with a fixed price for each band.
Charging for care – planned and unplanned	The maximum chargeable in this authority is 75% of the actual expenditure out of the personal budget (as distinct from the level of the personal budget itself). The actual contribution will depend on a Fairer Charging assessment.
Charging for housing-related support	The housing-related support is a condition of tenancy or lease, payable by all occupants. The cost will be divided equally between the properties once the village is fully occupied. Those not subsidised by Supporting People pay the support charge directly to the provider.
Tenure differences	None
Management and service model	Integrated housing, care and support management (See p12 on risks of having a single organisation providing accommodation and care)
Activities Facilitation	Grant provided by the council to cover the costs of promoting well-being - includes activities facilitation for people living in the village and the wider community.
Additional features?	Restaurant on a pay as you go basis. Also have a shop, hairdresser, spa pool and gym. Village has a minibus to take people for regular shopping trips and outings. There is a separate base in the village grounds where a number of health and adult social care services are based, including the council's in-house community care and support service. This is available 24hrs a day and supports people back to independence, particularly after discharge from hospital. They also respond to Telecare requests for personal care issues and would respond to village occupants if the on-site care team needed additional back-up. A Rapid Response Nursing Team is also based there, and would be available to village occupants on the same basis as elsewhere in the locality. They operate a day/evening service, but not overnight. A day centre on the site is run by another provider but those attending the day centre use the village restaurant.

CASE STUDY 2

CORE AND ADD-ON APPROACH

70% of the minimum 24/7 core is block contracted, with personal budgets for individual care plans expected to cover the remaining 30%. Personal budgets top-sliced to offset the cost of the core service. The RAS is used for ECH applicants and RAS levels have been aligned with occupancy bands.

Number of properties, type and tenure	32 2 bed flats and 10 1 bed flats all rented
Care Commissioning Approach	Tenants with assessed social care needs are being offered a personal budget. They can choose a number of pathways to help them manage this and can also choose the core care and support provider (who is registered to provide domiciliary care) or an off-site provider. See details in next box for 24/7 cover
Support Commissioning approach if applicable	The county has recently commissioned care and housing-related support for this new build extra care scheme. The £90K contract is funded by adult social care (71%) and Supporting People (29%). This only covers 70% of the cost of providing 24/7 cover. It was a specification of the contract that the provider should be registered to provide domiciliary care. This would enable residents to choose the on-site provider for their planned care, and allow care to be delivered in an emergency. The core provider is prepared to take the risk of investing the additional 30% of the cost on the basis that enough occupants will choose to spend their personal budgets on planned care and support from them to cover the cost. Thus, some of the 24/7 cover will be devoted to delivering care plans. Personal budgets will be top sliced to offset the core support costs. Joint monitoring will take place of the SP and care contract.
When did these commissioning arrangements begin?	Commissioning process started July 2009, service will commence 1st April 2010
Minimum cover requirements and what minimum includes	The core contract covers support over a 24-hour period including planned housing-related support (e.g. enabling a resident to access on-site activities), emergency care and support, on-call response, activity co-ordination and management of the care and support elements of the scheme. The core also allows for the care and support provider to undertake 5 – 10 minute planned pop-in calls with a small number of high need residents (e.g. some who have moved from residential care).
Point and level of choice(s)	Can choose which provider to use for planned care and support.
Eligibility for the scheme and target groups	Mix of FACS eligible and FACS ineligible, but identified as needing preventative services or at risk of needing services in the near future (identified from the application forms). Have three occupancy bands, low, medium and high and aim to have a third of each. Occupancy bands have been determined by RAS points and bands as follows:

	RAS bands 1-3 = RAS points 4 – 15 = low occupancy band RAS bands 4-7 = RAS points 15 – 48 = medium occupancy band RAS bands 8-10 = RAS points 48 – 70 = high occupancy band
Approach to Personal Budgets	In this authority, personal budgets are seen as the "currency" of provision which they are moving to using a phased approach. However PBs can be deployed using a variety of mechanisms, including a fully care managed pathway which is not significantly different to how care packages have been managed, but will involve the individual as fully as possible in how the care is delivered. The care and support provider is willing to have very short visits commissioned by residents as part of the PBs, making the budgets stretch further.
Role and level of RAS	Following assessment, the Resource Allocation system is used to allocate points and determine the level of the personal budget. So far, the personal budget levels have proved sufficient to cover the cost of services from the on-site provider to meet needs, although there is a panel mechanism, should the budget be insufficient for any reason. Many residents have so far chosen to use their budgets for the on-site provision.
Charging for care – planned and unplanned	Personal budgets will be top sliced to offset the core support costs. The amount will depend on the occupancy band, and ranges between £22 per week and £34 per week. In addition, the ordinary assessed non-residential social care charging policy will be applied. There is no upper limit to the charge so the full amount of the PB would be the contribution of someone assessed to pay the maximum amount. In this authority, rather than actually making the charge, the personal budget will be applied net of any service user contribution.
Charging for housing-related support	For people who are not in receipt of social care the authority has discussed the possibility of making a service charge towards the core costs with the intention of the support provider collecting this. However, this issue has not been resolved in relation to the legality of doing this, as it is not stipulated as part of the tenancy agreement so is unlikely to happen in the near future. There is a charge of £12 per week per property for the SP services for those not entitled to SP subsidy which will be collected by the support provider.
Tenure differences	No difference in access to care and support based on tenure.
Management and service model	Housing management is separate from care and support management, but the two are working together very flexibly and effectively. The housing provider will share office space with the care and support provider.
Activities Facilitation	Included as part of the core support contract and is part of the care and support team leader's duties.
Additional features?	It is hoped that a local luncheon club will move to the extra care scheme to increase revenue from the meal charge and bring together people from community who currently attend the club and residents of the scheme. There will be an independent evaluation of the scheme and commissioning approach in a year.

CASE STUDY 3

CORE AND ADD-ON APPROACH

In this model, a minimum core is purchased including sleeping night cover, on-site care manager, and a minimum of 105 day-time hours, all of which could be used for delivering care plans. Additional hours are spot-purchased. At present residents can choose direct payments but are encouraged to use the on-site services. Once RAS and PBs are applied across the board, PBs could be used to purchase services from on-site or off-site provider.

Number, and tenure of properties	20 flats all affordable social rent.
Care Commissioning Approach	**Currently** Fixed element - Sleeping night care and day-time management presence Variable element – planned care hours. A minimum of 105 day-time care (to cover waking day from 7am to 10pm x 7 days) hours are guaranteed by the LA. These can all be used for planned care, and the emergency response will be covered by the manager or by interrupting planned care delivery. Hours above 105 spot purchased. The care criteria were set at the outset at 'an average of 10 hours planned personal care per week per resident allocated'. So far, hours have always been above 105 and actual hours (currently about around 260 in total) are invoiced to LA with fixed element. If care packages were to leave gaps in cover, LA would pay for intervening time to ensure 24/7 presence. **The future:** At present, all residents receive their care from the on-site provider but could go off site for planned care using PBs. The local authority recognises the necessity of on-site care services management but would be equally happy for this element to be included in the hourly rate rather than an added to the care hours purchased as now.
Support Commissioning approach if applicable	No housing-related support commissioned at this scheme. This has not produced any problems and residents look to the care team, care manager or housing manager for general help and support.
Minimum cover requirements and what minimum includes	One sleeping night person, 24/7 care cover and management time. This covers emergency calls night and day, planned care during the day, and management of the care team. Planned care at night is not a usual part of the service and does not form part of the allocation criteria. However where an existing resident develops a need for planned care at night (as has happened once with a terminally ill resident) this was provided by the care provider supplying an additional care worker with the LA care manager agreeing the extra payment on a temporary basis.
Level of Choice(s)	**Currently:** Could opt for direct payments, but encouraged to use on-site services

	Future: Will probably have to make a contribution for night-time cover and emergency response service during the day; still likely to be encouraged to use on-site services but free to use PBs to purchase services from off-site providers.
Eligibility for the scheme and target groups	Everybody has to have a care need. The scheme aims to have a mix of need levels, averaging out at 10 hours per resident per week.
Approach to Personal Budgets	Seen as a choice to be offered. All new service users from April 2010. Existing service users from October 2010.
Role and level of RAS	None as yet.
Charging for care – planned and unplanned	**Currently:** Charged on basis of non-residential charging policy. Same as in the dispersed community. LA invoices for actual hours delivered. **Future:** Considering the addition of a peace-of-mind charge to cover the extra elements available in ECH which are unavailable in the wider community (i.e. night and emergency response cover). Increasing the ECH charge is one of this council's income targets for April 2010 onwards. No decision yet as to whether to reduce the PB allocation to take into account this block contracted element of the service, or to seek payment for it out of the PB. Amounts to the same.
Charging for housing-related support	N/A
Tenure differences	Not applicable as only tenants, not leaseholders
Management and service model	A partnership comprising an RSL and care provider manage the scheme, but separate staffing for each function.
Additional features?	Activities are provided by a part-time activities co-ordinator and these are shared with the neighbouring care home which is in an adjoining building which can be easily accessed by the ECH residents. In future schemes, LA would consider the addition of a few hours per day to cover activities facilitation but is keen to see these led by tenants as far as possible. Meals are also cooked at the adjoining care home and residents in the ECH can order from the menu in advance. The meals are wheeled over to the ECH on a hot trolley and eaten in the dedicated ECH dining room. This model has saved costs on separate kitchens and cooks, etc. ECH residents can also use the shared communal facilities at the care home which include hairdressing salon, library, small kiosk/shop, IT room plus join in any larger activities/parties/trips out organised at the care home.

CASE STUDY 4

BLOCK CORE PLUS SPOT CONTRACT

This is an example of a PFI funded scheme where the care was tendered separately, but the tender was won by the housing provider, enabling an integrated management approach. It combines a minimum block and spot contract approach, with the offer of direct payments to those with special needs.

Number of properties, type and tenure	Approximately 40 one and two bed apartments (275 apartments across 7 schemes) All for rent
Care Commissioning Approach	Minimum block contract with single care provider of 182 hours per week: • 26 per day to allow for handovers. Day-time hours to be used to deliver planned care. Additional hours for planned care spot purchased by LA. • 8 night-time hours Has been a challenge within some areas of the authority to accept the need for night cover and any time during the day not used up with planned care. In January, the direct care hours delivered across all 7 schemes were as follows: • On site care provider – 1,984 (including the 182 block hours on each) = average 284 per scheme per week though not necessarily equally distributed. • Other providers – 560, so around 80 hours per scheme though not actually equally distributed.
Support Commissioning approach if applicable	No SP funding or housing-related support delivered
When did these commissioning arrangements begin?	April 2009
Minimum cover requirements and what minimum includes	Round the clock presence of at least one person to deliver both planned and emergency care. Waking night support. The contract with the care provider also includes the availability of someone on-site in charge of the care to liaise with the on-site housing manager with a view to ensuring a seamless service.
Point and level of choice(s)	People could choose IBs, but so far, these have only been explicitly offered to people with special needs.
Eligibility for the scheme and target groups	The aim of the schemes is to be a vibrant community, to be achieved with a mix of low, medium and high needs individuals. The minimum age is 55; they need to have a care need and be registered on the housing waiting list. Nominations are 100% from the local authority. Although for planning purposes, partners looked at a mix of one third low, one third medium and one third high, the needs and priorities of

	individuals at the time a void occurs are reviewed and that mix may not always be maintained. Low is seen as less than 4 hours care package a week, medium between 4 and 8 hours, and high 8 plus, but all circumstances need to be taken into account to determine eligibility including risks, support networks and suitability of current accommodation.
Approach to Personal Budgets	The policy within the authority regarding PBs and Extra Care in the future is not clear. At present, those with special needs are offered direct payments or personal budgets. So for example, some older people with learning disabilities have moved in with direct payments to purchase additional support or bring their personal assistants with them. Others who originally continued with their previous arrangements are seeing the advantages of going with the on-site provider and some are switching. Some retain the original arrangements. Direct payments cannot be used to purchase care or support from the on-site provider.
Role and level of RAS	Future approach to RAS and IBs in ECH not clear
Charging for care – planned and unplanned	A Fairer Charging assessment determines what the individual could afford. A well-being charge of £25 is made to cover the availability of round-the-clock cover. In addition, the standard domiciliary care charging policy applies; a charge on the basis of the number of hours in the care plan. If extra is provided, the care provider charges the LA. This may or may not feed in to the charge to the service user.
Charging for housing-related support	N/A
Tenure differences	N/A
Management and service model	Integrated model. The scheme manager's role is split between housing management and care management. There is a care team leader to co-ordinate care provision. (See p12 on risks of having a single organisation providing accommodation and care) The money to cover the care element of the scheme manager's role and care team leader was incorporated into the hourly cost for care.
Activities Facilitation	This was specified in the PFI contract as a housing management function.
Additional features?	There is a restaurant on site and in order for this to be viable, one meal a day is a condition of tenancy and tenants pay £1.75 a day for a three course lunch. In order to ensure that this does not disempower individuals, one of the options is for a packed meal so that people who can cook for themselves can do so, and keep the packed meal for later. There is also a gym on site; individuals have an induction with a qualified professional who will show them what to do and then they can access independently.

CASE STUDY 5

BLOCK CONTRACT WITH OFFER OF PERSONAL BUDGETS

In this scheme, care is block contracted but people have the choice to use personal budgets to select an alternative provider. There is the facility to spot purchase additional care. A fixed charge for the availability of care round the clock is made by the council, subject to a Fairer Charging assessment. It is payable by all tenants.

Number of properties, type and tenure	38 properties all for rent
Care Commissioning Approach	A block contract of 400 hours comprising 37 management hours, 70 waking night hours, 70 sleeping night hours and 223 day-time hours. These were built up of the anticipated number of people in each band multiplied by the mid-point of the lower two bands (see below under eligibility criteria) plus an assumed threshold of 10 hours for the high band. Additional hours for people in the high band will be spot-purchased if the block is fully utilised. There is no dedicated floating time deliberately built in to the contract, but at present, there is some slack. The local authority will review this arrangement on an on-going basis through contract review, and adjust in accordance with service user feedback if needed – if, for example, there appeared to be too much pressure on the block for it to be able to provide a responsive service. The local authority sought to achieve a balance between verifying what was being provided and allowing flexibility within the contract. Care managers have a key role in this as they have a responsibility to review the needs of residents within the scheme and respond to any requests for an increase in care packages. Re-assessments are triggered if someone needs to change charging bands i.e. only if their needs increase or decrease beyond the charging bands in place; not for minor fluctuations in need. The local authority is keen to ensure that a responsive service does not become one that encourages dependency. They are keen to ensure that the residents are supported to maximise their independence as much as possible and therefore OTs from the in-house re-ablement service are involved in all initial assessments and re-assessments. The contract includes a clause allowing for re-negotiation of it in the context of personalisation or any other major changes in demand.
Support Commissioning approach if applicable	In this scheme, the housing-related support is provided by the housing provider .This includes a small proportion of scheme manager's time (no more than 20% of the Managers hours) and the back-up alarm service. All residents within ECH are receiving some level of housing-related support.
When did these commissioning arrangements begin?	Scheme opened August 2009
Minimum cover requirements and what minimum	There are at least 2 care staff on site during the day at all times plus: Dedicated on-site manager of care provision 1 waking and 1 sleeping night carer

<table>
<tr><td>includes</td><td></td></tr>
<tr><td>Point and level of choice(s)</td><td>All applicants are offered the choice of personal budgets. So far all have declined. Even residents who originally thought they would retain their original provider perceived the benefits of using the on-site care provider, and chose that. The benefits they saw were the greater flexibility and responsiveness possible from an on-site provider. They would have had access to care in an emergency anyway, so this was not a factor in their choice.</td></tr>
<tr><td>Eligibility for the scheme and target groups</td><td>Essentially the “thirds” principle but in reality there is a bit of a bias towards the lower end of the spectrum to encourage couples/ carers to move to the scheme.

Low: 0 – 2 hours
Medium: 2 – 10 hours
High: 10 plus hours</td></tr>
<tr><td>Approach to Personal Budgets</td><td>The local authority intends to offer everyone personal budgets eventually but is just piloting their RAS at present.</td></tr>
<tr><td>Role and level of RAS</td><td>Doesn’t yet apply to assessments for Extra Care</td></tr>
<tr><td>Charging for care – planned and unplanned</td><td>£16 per week charge for availability of care in an emergency. This is payable even if individual chooses to use personal budget to buy planned care from an off-site provider.

Charging bands

<table>
<tr><th></th><th>Price payable per week</th><th>No: of care hours p.w. banding represents</th><th>Fit with ECH dependency bandings</th></tr>
<tr><td>ECH Charging Banding 1</td><td>£16 (charge for availability of care around the clock)</td><td>Up to and inclusive of 2</td><td>Low (between 0-2 hours per week)</td></tr>
<tr><td>ECH Charging Banding 2</td><td>Sum equivalent to 2hrs care plus £16</td><td>More than 2 and up to and inclusive of 6</td><td rowspan="2">Medium</td></tr>
<tr><td>ECH Charging Banding 3</td><td>Sum equivalent to 6hrs care plus £16)</td><td>More than 6 and up to and inclusive of 10</td></tr>
<tr><td>ECH Charging Banding 4</td><td>Sum equivalent to 10 hrs care plus £16</td><td>More than 10 and up to and inclusive of 15</td><td rowspan="2">High</td></tr>
<tr><td>ECH Charging Banding 5</td><td>Sum equivalent to 15 hrs plus £16</td><td>More than 15</td></tr>
</table>

Charge subject to Fairer Charging assessment</td></tr>
<tr><td>Charging for housing-related support</td><td>Support charge divided equally between all properties and collected by the landlord as part of the service charge</td></tr>
<tr><td>Tenure differences</td><td>N/A</td></tr>
</table>

Management and service model	Separate housing and care management. Operational protocol in place.
Activities Facilitation	Not specifically specified. Currently some opportunity within the block contract to enable this. The on-site support team have recently embraced the dignity challenge and are encouraging residents to sign up as buddies for others who are less able or willing to take part in scheme activities. If service user feedback indicated that social needs were not being met, the council and providers would work together to resolve the situation.
Additional features?	The on-site caterer operates a service 365 days of the year; a shop is currently being developed with the hope that residents will take an active role in the delivery.

CASE STUDIES 6 – A & B

6A: BLOCK CONTRACT IN BANDS

In this village, care and support packages are block contracted in bands. Residents are free to opt for a personal budget if they wish to go off-site for their care. The council has a contract with the housing provider who sub-contracts the care and an element of support to the care provider.

Number of properties, type and tenure	92 – 60% x 2 bedroom apartments; 40% x 1 bedroom apartments Equal numbers each for rent, shared ownership and outright sale
Care Commissioning Approach	LA commits to purchasing a fixed number of care packages in each of 4 bands. The "commitment contract" is for the 37 units from Level 1 to 4. 7 places at level 1: 5 – 10 hrs per week 10 places at level 2: 11 –15 hrs per week 10 places at level 3: 16 – 20 hours per week 10 places at level 4: over 21 hours per week The contract looks to provide outcomes for people so is not just hands on care. The provider can flex residents up and down levels dependent on need, as part of the contract. This change if permanent, will be ratified by Care Managers at the review stage. Remaining 55 places at Level 0: from no care required up to 5 hours per week. Level 0's can ask for an assessment, with spot purchase, or private purchase an option. The contract is with the Housing provider who sub-contracts the care and an element of support to the care provider.
Support Commissioning approach if applicable	Care and support jointly commissioned from housing provider as overall scheme manager. SP subsidy contract. Separate block contract for one overnight support worker.
When did these commissioning arrangements begin?	August 2009
Minimum cover requirements and what minimum includes	Three waking night staff and three staff at all times. Care Call system for all residents – calls care staff on site. All residents will receive a support plan and review every six months as a minimum. 37 care packages can be in place at any one time.
Choice(s)	Can choose between a number of extra care schemes in St Helen's or other service types. Could also opt for a personal budget rather than using the directly commissioned service, but so far little interest in doing so.
Eligibility for the scheme and target groups	A mix of need levels ranging from people who do not require care at all to those who are FACS eligible. See bands above. LA's threshold for social care eligibility set at moderate level.

Approach to Personal Budgets	Seen as a choice for occupants.
Role and level of RAS	RAS not finalised yet. Not clear whether RAS allocations will match costs in extra care at relevant band/level.
Charging for care – planned and unplanned	Based on LA's charging policy for Extra Care. Fairer Charging assessment. Self-funders will pay the local authority the full cost of the relevant band.
Charging for housing-related support	Divided equally between properties and collected by the housing provider as part of service charge. Support is a condition of tenancy/lease.
Tenure differences	None
Management and service model	Integrated model in that the local authority contracts with the housing provider for the care and support, but the housing provider sub-contracts the care to a separate care provider, so the delivery of housing management is separate from the care provision.
Additional features?	An activity coordinator is employed to facilitate activities. The village has a pay as you go 'bistro' service offering hot meals, snacks, drinks, soups and salads. It is currently open daily from 11-2 and are planning to open on a Friday evening soon. Once the village is fully occupied, it is intended to make this service available from 10-8.

6B: SPOT PURCHASE IN BANDS

A similar village development comprising approximately 300 properties has been developed in another local authority area by a different provider. There, the council has agreed a contract with the provider to spot purchase up to 60 packages spread between five different bands. The council is seeking to divert potential residential care clients to the village. Supporting People contribute to the cost of the 24/7 cover, as do the payments made to the provider for people placed in the top two bands. FACS eligible service users moving to the village can either use the on-site provider for their care or opt for direct payments to employ a personal assistant or purchase care from an alternative provider. Some have started with direct payments and switched to the on-site provider for the convenience offered.

CASE STUDY 7

MINIMUM GUARANTEED BLOCK

A relatively generous number of care hours are block contracted with more hours added to the block as required. The service commissioned from the care provider includes a small number of SP hours for more general housing-related support, while intensive housing-related support is provided by the housing provider. In this scheme, people are expected to use the on-site services if they choose Extra Care.

Number of properties, type and tenure	41 properties of which 30 for rent. Remainder shared ownership
Care Commissioning Approach	Block contract guaranteeing 260 care hours per week, of which 63 waking night cover, and an additional 20 hours support (See next box). The contract allows for up to 400 hours per week, but the LA would purchase more if the needs of occupants required them. Daytime hours all expected to be used for care and support plans which are intended to be broad in their focus, incorporating not only hands-on care but also prompting, helping people to get to, and take part in, activities etc. Expectation that apart from planned and emergency care at night, night-time hours to be used for admin and other suitable tasks. The hourly unit cost covered everything, including for example, the on-site care manager – i.e. not separately itemised.
Support Commissioning approach if applicable	Intensive housing-related support is commissioned by SP from the landlord and is provided through the scheme manager, 70% of whose salary is funded by Supporting People. SP also covers the cost of the back-up alarm service. In addition, 20 hours of housing-related support are jointly commissioned with the care from the care provider. This is intended to be slightly broader in focus than that provided by the landlord. Despite joint commissioning, the HR support remains strictly delineated and separately monitored.
When did these commissioning arrangements begin?	Handover was the beginning of Sept 2009
Minimum cover requirements and what minimum includes	Has to be at least one member of the care team on site around the clock to provide emergency response. Waking night cover. On-site care manager - office hours
Point and level of choice(s)	The choice is between Extra Care schemes and other services. Occupants are not at present offered PBs or direct payments.
Eligibility for the scheme and target groups	All applicants are expected to have a care need although some of the shared owners may not to have. The aim is to have the following mix: High: 40% 12.5 plus hours care per week Medium: 40% 7 – 12.5 hrs Low: 20% 2 – 7 hours This authority sees Extra Care as fulfilling a preventative function, and while FACS thresholds apply to service provision in the wider community,

	they are not used as a gateway to Extra Care, or to care in Extra Care. Identifying suitable applicants with high need levels has been rather slow.
Approach to Personal Budgets	Not being offered to those moving to/living in Extra Care schemes at present.
Role and level of RAS	Not applicable
Charging for care – planned and unplanned	No separate charge for the round-the-clock cover. Apply the standard domiciliary care charging policy. Charge collected by the local authority on the basis of a Fairer Charging assessment.
Charging for housing-related support	The support hours provided by the care provider are charged by the local authority on the basis of a Fairer Charging Assessment. This element is based on care and support required and the individual's financial means to pay for it. The support provided by the landlord is a condition of tenancy or lease, forms part of the service charge, and is collected by the housing provider from those who do not have an SP subsidy. It is divided equally between properties.
Tenure differences	None. All are entitled to care in an emergency and all can be assessed by the local authority if they choose to. Self-funders can purchase care directly from the on-site provider at the same cost as the LA pays. Some tenants are self-funders
Activities Facilitation	This falls within the remit of the scheme manager . The service specification includes enabling tenants to access on-site and off-site activities as part of the care plan, but not to develop those activities. The scheme manager and Community Participation worker do the latter. This scheme has a wider community focus, and the local authority has allocated funds for an initial 18 months to pay for a Community Participation Officer to facilitate integration into, and participation by, members of the local community. As well as maximising the use of the building as a community hub, this approach also contributes to assisting the financial viability of the restaurant (see below)
Additional features?	This scheme specifically targets people with dementia, using an integrated/pepper-potted approach. The care provider's support hours are able to contribute towards prompting and enabling people with dementia to do things for themselves although care hours are used for this as well. The Older People's Mental Health team were active in the development of the scheme and provide specialist input to the care team. All activities are available to people living with dementia and the scheme is being monitored to ensure that they are being included and their voices are heard within the community. The restaurant facility is run by a social enterprise and use of the facility by the wider community is encouraged to make the restaurant financially viable.

CASE STUDY 8

PUMP-PRIME MODEL

This scheme began with a traditional block contract for the care in January 2008. The care contract is now being re-tendered on a spot-purchasing basis with local providers who already have a domiciliary care contract with the council invited to tender.

Number of properties, type and tenure	62 Mixed tenure
Care Commissioning Approach	This scheme opened in January 2008, when two separate contracts, one for care and one for housing-related support were awarded. The block contract for care was for 450 – 500 hours and, after an agreed phasing in (over 8 weeks), guaranteed a minimum of 450 day-time hours, as well as night cover. The care provision at the scheme is now being re-tendered. The local authority area is sub-divided into zones, and within each zone is one main and two subsidiary domiciliary care providers. They already have an infrastructure in the authority's area, and it is they who have been invited to tender. The specification requires a minimum of two staff members on site between 7a.m. and 11p.m. with sufficient additional staff to deliver packages of care. Importantly, the local authority is not guaranteeing any of the day time cover. This appears to be seen as an acceptable risk by those tendering to provide the care because: • Demand for the scheme continues to be high • The hours in the previous block contract were always fully utilised, and this provides comfort • Even when some residents, dissatisfied with the current block provider, were offered direct payments instead, very few took these up • It is a ready-made group of service users with existing care packages – doesn't have to be built up from scratch • The balance will be maintained by offering a new vacancy to the person on the waiting list whose need level maintains the agreed balance of care in the scheme Daytime hours - Spot purchasing arrangement with no guaranteed income for provider Night-time – a block contract - guaranteed income for provider The local authority would not have sought this type of contract for a new scheme. The contract is being set up as a variation to the existing contract with the zone providers (the latter being reducing hours contracts moving providers from a previous block arrangement to a zero hours spot contract arrangement over the 5 year contract length). The local authority will continue to commission the overnight cover.
Support Commissioning approach if applicable	Commissioned separately from the care contract in 2008 and awarded to the housing provider. Support a condition of tenancy. Will continue to be provided by the landlord.
When did these commissioning	Currently at the tender evaluation stage

arrangements begin?	
Minimum cover requirements and what minimum includes	2 on site from 7 a.m. to 11 p.m. 1 waking and 1 sleeping night carer.
Point and level of choice(s)	Have always offered Extra Care occupants the choice between using the on-site provider or having a direct payment.
Eligibility for the scheme and target groups	• All applicants will be FACS eligible ('moderate high' or above) • The agreed balance of care at the scheme is o 20% under 5 hours care primarily for people who have a condition that could make it harder to make the transition at a later stage – e.g. those with dementia or deteriorating visual impairment o 30% 5-10 hours o 50% 10+ • The applicant will have been accepted onto the housing list • Target group – older people. 5 flats reserved for older people with a learning disability
Approach to Personal Budgets	Being offered them. LA is committed to not restricting choice. This LA is still developing its different personal budget deployment mechanisms. Direct payments tend to be lower than the cost of directly-commissioned services because they were primarily set up for people employing personal assistants.
Role and level of RAS	Not yet involved in extra care allocations.
Charging for care – planned and unplanned	Currently do not charge for availability of emergency cover. Charge on the basis of the non-residential charging policy that applies to people receiving domiciliary care in the dispersed community: on the basis of actual hours delivered. The LA is looking to develop a less bureaucratic approach. LA does not currently include the higher rate of Attendance Allowance as income in the Fairer Charging assessment for Extra Care occupants.
Charging for housing-related support	Divided equally amongst rented properties and paid to the landlord.
Tenure differences	Housing-related support available on a menu basis for leaseholders, not a condition of lease, as LA does not pay SP subsidy for homeowners.
Management and service model	Was integrated but with separate contracts. Moving to a model where care provision separate.
Activities Facilitation	Not specifically funded.
Additional features?	There is a very popular café which is open every day including weekends, for lunches and snacks on a pay-as-you go basis. It closes at about 4pm but will also provide cold tea trays. The caterer is a private business and also runs a small shop on site.

	The caterer is 'commissioned' by the housing provider and there is no council subsidy. There is also a day care service at the scheme (for occupants and other local people) and 20-25 have a hot lunch each day. (The price for day care clients is set by the Council and fed into commissioning arrangement between the housing provider and caterer) The caterer is well linked to voluntary sector and also provides work experience for adults with a learning disability.

CASE STUDY 9

CO-PRODUCTION

This scheme is in development for working age adults with physical disabilities. Potential applicants have been identified and the approach to commissioning the care and support is being developed through intensive consultation with a group of prospective tenants.

Number of properties, type and tenure	10 flats for rent to working age adults with physical disabilities. The re-development will also include a community area which will be leased to a user led organisation
Care Commissioning Approach	The scheme is due to open in September of this year. Nine people, aged between 20 and 40, have been identified as potential tenants. All currently have care funded by the LA. A pilot project is being funded to work with this group to identify and agree a preferred model for the provision of personalised care on site. Consultation with the group has led to the following model of care • The local authority is going to commission: o A rise and retire service based on site to cover going to bed and getting up o An emergency on-call night cover – someone based on site overnight who will respond to emergencies and support rise and retire staff • Services commissioned by the service user: o They will be able to bring with them any existing service they choose, e.g. PA or HR support service o They can purchase additional care and support from the LA-commissioned provider o They are free to purchase additional care and support from any other provider they choose. The service users have specified some important requirements from services including: • Joined up and integrated services • Flexibility and responsiveness to changing aspirations • Individualised pace and quality service • Availability of a menu of services • Recognition that the model is evolutionary for both service users and provider • Some services users will participate in the selection process One of the challenges of developing a service user led model has been that tenants needed to inform the model development but also needed enough clarity about the model before they could sign their tenancy agreement. All the tenants who worked with the consultants have been offered tenancies, although two have declined to follow this through.
Support Commissioning approach if applicable	No housing related support funding is being invested in this project.
When did these commissioning arrangements begin?	The new care model has been developed by prospective tenants, who have since been involved in the short-listing of potential care providers, and will be involved in the final selection of the commissioned care provider.

Minimum cover requirements and what minimum includes	24/7 on site care was part of the tender for the capital funding. However, since the successful bid, personalisation of services has become a much stronger feature of the care provision and the final model will be based on the tenant's expectations and needs rather than a fixed care model.
Point and level of choice(s)	The tenants have strongly influenced a personalised model of care, have participated actively in the selection of the care provider, will be involved in the selection of the care provider. It is likely that up to 70% of their personal budgets will be available to spend on services from any source. Any new applicants will have the choice whether or not to move in to the scheme with the model and services on offer.
Eligibility for the scheme and target groups	Adults of working age with physical disabilities. May be congenital or acquired. All the prospective tenants will have met FACS critical or substantial, will have mobility issues which require adapted accommodation, and would otherwise be living in residential accommodation.
Approach to Personal or Individual Budgets	Everyone with on-going support and care needs is being offered a personal budget in Brighton & Hove.
Role and level of RAS	At present RAS is being piloted. An indicative budget based on the cost of the current care packages is being used as the starting point for RAS, alongside a support plan. Ultimately, RAS will apply to everyone. The model within this extra care scheme will need to demonstrate value for money when compared to people living in residential care or individually in the community.
Charging for care – planned and unplanned	Care within extra care will be subject to charging. The model we have within extra care is that planned and un-planned care is subject to a charge.
Charging for housing-related support	There is no housing related support built into this model.
Tenure differences	N/A
Management and service model	The landlord will provide the housing management service. They have been fully engaged in the consultation process. Service users have specified they wish to have a say in what goes on and some favour a resident's association.
Activities Facilitation	The consultation group is very keen to get involved in shaping the community area of the scheme and participate in activities there. Some service users will continue to organise meaningful occupation themselves while others need support to access training and employment. Most also want to access better social activities and healthy activities. It is anticipated that the tenants will be represented on the community space management steering group. Support to travel is key to this. As part of the planning agreement, the developer will provide an adapted vehicle within the existing City Car Club.
Additional features?	The PCT are also actively engaged and there are proposals to develop health and wellbeing initiatives within the community space.

SECTION 3

REVENUE AND CHARGING ARRANGEMENTS

1. REVENUE FUNDING

1.1 It is usual for the care in social sector Extra Care Housing for Rent to come from adult social services' core budget, or from Care Trusts or PCTs where budgets are pooled. This general statement however masks a whole range of service and funding configurations. Variations include:

- Clear demarcation – Social Services pay for care delivered by separate staff group and other revenue sources cover other staff members such as a scheme manager.
- Combined care and support – Adult Social Services and Supporting People pay agreed contributions towards a combined care and support staff group. Care packages funded exclusively by Adult Social Services.
- Combined housing, care and support staff group – different revenue sources contribute different proportions to different posts, e.g. scheme manager, senior care assistants/support workers, care/support staff
- There may be some occupants who pay for their own package of care from their own resources. Some Extra Care Housing schemes are entirely occupied by self-payers and others have adopted a policy of letting or selling a percentage of properties to people who will pay their own way as a deliberate risk management strategy.

1.2 The detail will not be explored in this Brief. Technical Brief no.2: *Funding in Extra Care Housing*[44] looks in depth at funding arrangements.

2. CHARGING FOR CARE AND SUPPORT IN ECH

2.1 Introduction

2.1.1 It is not the intention of this Technical Brief to go into detail about different charging options. These have been covered in other Housing LIN publications. It is however necessary to update the information in the context of personalisation, and also to re-state some important principles.

2.1.2 This section focuses primarily on Extra Care Housing schemes where some public money is invested in the provision of care and support. Since the publication of the original technical brief, this is an aspect of Extra Care which has seen increasing complexity. It is strongly advised that legal advice should be obtained for any arrangements made for charging (regardless of by whom) outside the usual Fairer Charging framework for those eligible and in receipt of care from social services, or, in the case of support services, for any arrangements outside support as a condition of tenancy or lease, payable to the landlord.

2.2 Legislative and Regulatory Framework

2.2.1 Fairer Charging

2.2.1.1 Extra Care is a form of housing, **not** residential care. Therefore, the care and support provided to those living within it will be covered by non-residential charging provisions and principles. Section 17 of the Health and Social

Services and Social Security Adjudications Act 1983 (HASSASSA) gives councils a discretionary power to charge adult recipients of non-residential services provided by the council (whether they have been assessed as eligible for them or not). The non-residential services most likely to be provided in Extra Care Housing are those covered by the following Acts:

- National Assistance Act 1948, s29: non-residential services for disabled people
- By extension of s29, above, Chronically Sick and Disabled Persons Act 1970, s2: non-residential services for disabled people
- Health Services and Public Health Act 1868, s45: non-residential services for older people
- NHS Act 2006, s254 and schedule 20: non-residential services for illness and mental disorder

2.2.1.2 For, the local authority to be able to charge the service user under Fairer Charging guidance, it needs to have contracted with the provider to deliver services under one of these Acts, and the recipient of the services needs to fit into one of the categories covered by the legislation.

2.2.1.3 Guidance issued under s7 of the Local Authority Social Services Act 1970, *Fairer Charging Policies for Home Care and other non-residential Social Services*, *Guidance for Councils with Social Services Responsibilities*[45] applies to community care services arranged for individuals by the local authority. The following list covers key points but is not comprehensive. Authorities must refer to the full Guidance.

- Charges are discretionary – so each local authority can make a different decision.
- Charges need to be 'reasonable' in terms of the HASSASSA Act 1983.
- The charge to an individual must be no more than it is practicable for him or her to pay, in relation to his or her means.
- Charges need to be fair as between different service users – or else risk a potential discrimination charge. Not all differences, however, may be automatically discriminatory; they may be justifiable and explicable.
- The overall objective of promoting independence and social inclusion should not be undermined by poorly designed charging policies.
- Where several different services are provided, ability to pay should not be assessed, and charges should not be levied, for any one service in isolation. For example, if a person is not automatically passported via HB to receive an SP subsidy, the charge for SP services would also need to be taken into account under Fairer Charging calculations.
- Flat rate charges or charges which do not vary with the level of service may be acceptable in limited circumstances (but are more generally acceptable for meals at home or day care where these charges substitute for ordinary expenditure).
- Charges which reflect the costs of services provided to users and which are based on hours of service provided are generally preferable to charges based on broad "usage" bands, which can create perverse incentives and spread subsidy unfairly.
- The cost of services should be set out for the client before finalising the care and support plan, which implies that assessment of financial means should take place towards the end of the support and care planning process, although it should not impinge on the question of eligibility itself.

- Users' incomes should not fall below basic Income Support Levels or the Guarantee Credit of pension Credit plus a buffer of 25%.
- Assessments should take full account of any disability-related expenditure, where disability-related benefits are taken into account as income.
- The maximum charge cannot reasonably be higher than the full cost of the service received by the user.
- Councils should consult as necessary on any proposed changes to their existing charging policy in accordance with Fairer Charging Guidance.

2.2.2 Charging in the context of Personalisation

2.2.2.1 *Fairer Contributions Guidance: Calculating an Individual's Contribution to their Personal Budget*[46] was published in July 2009 to guide councils in developing charging policies where the unit of support is expressed in financial rather than service terms. "The chargeable amount is the maximum possible contribution a person can be asked to make to their personal budget, subject to their available income and savings." This cannot be higher than the actual cost of the services. "The calculation of the actual amount to be paid begins with a means test which determines the income and savings available to make a contribution." The council needs to decide what the maximum possible contribution will be, based on a percentage of service users' personal budgets. This could be up to 100%. A person's actual contribution will be whichever is lower: the maximum possible contribution, or the individual's available income established by a Fairer Charging assessment.

2.2.2.2 "It is important that consideration of charging policies is not purely budget-based, but takes account of service needs. The design of charging policies needs to be sensitive to the variety of users' circumstances and needs. The ways in which charging policies are developed also need to be sensitive and to involve users and carers"[46]

2.2.2.3 "Any new policy should not produce a disincentive to service users accessing personal budgets as direct payments or traditional packages by having a more favourable regime for one or another"[46]

2.2.2.4 "The legislation on direct payments provides that with certain exceptions direct payments must be made gross unless the Council decides they will be paid net. Councils may find that paying personal budgets net of contribution provides for greater efficiency."... "Where a council decides to pay a personal budget net of the person's contribution, it should ensure that the person is clearly informed of the amount of the contribution, and how both the personal budget and the contribution have been calculated."[46] There are circumstances when it would be better to make the personal budget available gross. This would apply for example where the service user lacks capacity and no-one has the legal authority to access their bank account to pay their assessed contribution.

2.2.3 Entitlement to assessment

2.2.3.1 Under the 1990 NHS and Community Care Act, people have a right to a community care assessment whether or not they appear to have significant financial assets. It is government policy that if, following a community care assessment, they have eligible needs (i.e. meet local FACS eligibility thresholds), the local authority should help the individual as far as necessary

to develop a support plan, which may involve a move to an Extra Care Housing scheme, or support within an ECH scheme if already there. "Councils are reminded that people who can fund their own care are still entitled to an assessment of their needs. These people who are eligible for social services and who as a result of the financial assessment will meet the full costs of their care, are still entitled to help in making appropriate care arrangements"[46]

2.2.4 Ordinary Residence Rules

2.2.4.1 The Department of Health has just issued new guidance on the meaning of ordinary residence: *Ordinary Residence: Guidance on the identification of Ordinary Residence of people in need of community care services, England*[47]. Broadly speaking, the situation regarding a housing setting remains the same. Where someone chooses to move to independent living accommodation where they sign their own tenancy agreement or lease, that new home becomes their place of ordinary residence for the purposes of determining which local authority is responsible for undertaking the community care assessment, and funding any care to meet eligible needs. "Ordinary residence is the place a person has voluntarily adopted for settlement purposes for short of long duration"[47] "There is no minimum period in which a person has to be living in a particular place for them to be considered ordinarily resident there, because it depends on the nature and quality of the connection with the new place."[47]

2.3 Some considerations in drawing up charging policies

2.3.1 Introduction

2.3.1.1 An important consideration in determining the charging policy for care in Extra Care Housing, is that it should not be structured in such a way that it militates against flexible, responsive service delivery. It can be difficult to reconcile a transparently fair charge with an approach which allows some flexibility and responsiveness. With the advent of self-directed support, and choice over how personal budgets are spent, an additional challenge may be maintaining a preventative element in the service which, while delivering better long-term outcomes for people, personal budget holders may not wish to pay for.

2.3.1.2 There are currently many different charging policies and arrangements in operation in ECH schemes. The maximum possible contribution may be based on:

- a single flat rate contribution made by Adult Social Services to the provider irrespective of the amount of care the individual receives at one end of the spectrum (described as an insurance approach)
- bands which reflect levels of service to a greater degree but still have a cliff-edge effect
- the amount of care actually delivered or included in the care plan, an approach arguably fairer, but making flexible and responsive service delivery more difficult.

2.3.1.3 Some authorities make a charge for the planned care only, others make an additional charge for the availability of round-the-clock care and support.

2.3.1.4 Some authorities collect the charge themselves, others arrange with the care provider to collect charges on their behalf. Fairer Charging principles still apply.

2.3.1.5 Where the local authority contracts with the provider to deliver community care services to some or all occupants, the Authority sets the charges and the Fairer Charging framework applies. Where the agreement for services is made directly between the occupant and the care provider, charges are paid direct to the care provider under contract.

2.3.1.6 Factsheet 19 on *"Charging for Care and Support in Extra Care Housing"* [48] and the Housing LIN report *Charging in Extra Care Housing*[49] outline the various charging models in ECH and consider the pros and cons of each. Thus, no further detail will be covered here. The Housing LIN case study 43 *Reeve Court Retirement Village: Block contracting in bands & individual budgets*[50] considers the pros and cons of commissioning and charging in bands.

2.3.2 Future charging policies in Extra Care

2.3.2.1 In considering charging policies for the future, two additional elements warrant highlighting in addition to Fairer Charging principles:

- whether the adult social care provision is expressed in service terms or financial terms
- the size and nature of the contract between the local authority and the care provider

2.3.2.2 Where self-directed support, resource allocation systems and personal budgets are the approach adopted with Extra Care occupants, then the most logical charging policy is the approach outlined above in the context of personalisation, though a banded approach based on RAS points may be employed *(see case study 2 p46).*

2.3.2.3 Where the service is arranged by the local authority and expressed in service terms, how the service is commissioned from the provider makes some charging approaches more suitable than others. So, for example, if the service is commissioned in bands *(see case study 6 p55)* it may make sense to charge in bands. If bands are the "currency" it is essential for the cost per band to reflect fairly and transparently what is provided in each. If on the other hand a minimal core service is block contracted, with any additional care spot purchased on top, whether by the council or service user, then a contribution for the core and a charge based on the cost of the additional spot-purchased service may make more sense.

2.4 Charging for the 24/7 cover

2.4.1 Introduction

2.4.1.1 Whereas in 2005 when the Housing LIN Technical Brief was first written, it was not unusual for only the planned care to attract a charge, many local authorities now take the view that an additional charge should be levied in recognition of the round-the-clock cover, including night care, to which people dispersed in the wider community do not have access.

2.4.1.2 In Extra Care schemes a range of situations apply:

- In some, all occupants meet local FACS thresholds and are eligible for social care services, while in others this applies to a proportion of occupants only.
- In some, there are private arrangements for care and support between occupants and providers, as well as other arrangements for those occupants supported by the local authority.
- The local authority may wish to contribute to the round-the-clock cover for all occupants, or only those to whom they are providing planned community care services.

2.4.1.3 Where the local authority wishes to contribute to the 24/7 cover for everyone living at the scheme, and not everyone meets local FACS eligibility thresholds, can they recover a charge for the availability of round-the-clock care and support?

2.4.1.4 They can use two approaches for contributing to the 24/7 cover, and these in turn affect charging options: via a contract or via a grant.

2.4.2 Contracting for the 24/7 cover

2.4.2.1 Eligibility for services under s29 of the National Assistance Act and s2 of the Chronically Sick and Disabled Persons Act is restricted to those who have a disability("blind, deaf or dumb), have a "permanent and substantial handicap through illness, injury or congenital deformity, or who have a mental disorder of any description"[49]. Not all Extra Care occupants necessarily fall into these categories. A more suitable option therefore, for the purchase of round-the-clock care and support which is available to all occupants in Extra Care housing for older people, is a contract for the provision of services under s45 the Health Services and Public Health Act 1968. This provision allows local authorities to make arrangements for promoting the welfare of older people, and includes practical assistance, information, visiting and advice. As all occupants potentially benefit from this service, they could be charged for this under Fairer Charging, whether or not they had been assessed for care. However, anyone moving into such accommodation needs to be given due notice of this charge being an incident of choosing to live in that particular place.

2.4.2.2 In the context of Personal Budgets (PBs), where occupants also have eligible unmet needs which the local authority has a duty to meet, care needs to be taken in determining the maximum contribution, and undertaking the financial assessment. The PB that is signed off at the end of the support planning process is the amount provided by social services for eligible assessed needs, by reference to Fair Access criteria and policy; but the person's environment and what was available there, may well have been the justification for lessening the resource allocation in the first place. A person who lives with a carer, for instance, has needs, but some of those needs, at least, will be met needs, and ineligible for financial support. In Extra Care, where the housing arrangement itself may well provide for core support and emergency help, that background level of support may meet needs that would otherwise have had to have been reflected in the resource allocation process and ultimately in the Personal Budget. The charge for the 24/7 cover could not be simply netted off of the client's direct payment or managed personal budget, as, technically, the cost of the core provision should not have been included *within* the personal budget for assessed eligible needs in the first place, and the charge is based on a percentage of the personal budget.

2.4.2.3 The advantage of the Authority contracting for the 24/7 cover is that there is no danger of the core support triggering any registration concerns, because the accommodation arrangement will be separate from the support arrangement, even if the nature of the support tips over into personal care, for instance in an emergency.

2.4.2.4 If local authorities wish to pay for the availability of round-the-clock cover for their own assessed services users only, the cost needs to be incorporated in the amount charged to the local authority by the provider (e.g. in the band or hourly cost) and the charging policy based on that.

2.4.3 Providing a Grant for the 24/7 cover

2.4.3.1 "Authorities can also – regardless of the level of assessed need in an area – also choose to grant-fund voluntary organisations under the Health Services and Public Health Act 1968 for the provision of services similar to the ones the authorities would otherwise make arrangements for" [50] A grant can be used to make the round-the-clock care and support available to all occupants. Grant-funded organisations can set and collect their own charges. The local authority can include charging parameters in the grant conditions but cannot itself recover a contribution from service users. If, however, the charge levied by the provider is compulsory and includes any possible element of personal care, the registration-as-care-home risk might apply.

2.4.4 The core service including 24/7 cover as a condition of occupancy

2.4.4.1 In the private sector, it is quite usual for the provision of and payment for round-the-clock cover (described as support, not care) to be a condition of occupancy, while a separate contract is in place if people require planned care. This approach is now also being adopted in the social housing sector, particularly where there is a mix of private and state-subsidised arrangements: so, rather than the local authority making the charge for the core service, the provider makes what is commonly called a "well-being charge" which covers a range of services: health and well-being promotion, housing-related support, activities facilitation as well as an emergency response service. Some RSLs make this charge for part of the tenancy agreement or lease.

2.4.4.2 Where the emergency support is not merely housekeeping, general support or an undertaking to ***call*** the emergency services, but could also include personal care as defined in the new Act, there is the risk that it will be seen as care and accommodation provided together and registrable as such. Providers are confident that this will not be the case, arguing that the total configuration of arrangements at the scheme enable them to demonstrate that they are not providing "accommodation and personal care together".

2.4.4.3 Drawing up a separate contract between the care and support provider and the occupant is unlikely to eliminate this risk if the service is compulsory, as it is likely to be seen as a collateral contract and tantamount to being a condition of occupancy.

2. 5 Private arrangements

2.5.1 Good practice suggests that providers' own charges should be fair, reasonable and transparent. While Fairer Charging Guidance applies only to

local authority charging policies for community care services, the principles are sound for those providing and charging privately for services in Extra Care Housing where some public investment has been or is being made.

2.5.2 Anything in ECH which is to be charged for privately needs to be supported by a contract. Since occupants will be operating as consumers, the Unfair Contract Terms Act will apply, and the OFT will scrutinise contracts for unfair terms. Applicants need to be able to assess whether the charges being levied are reasonable for what is being offered, and agree to them in advance. This should be in writing.

2.6 From private arrangement to state funding

2.6.1 Concern has been expressed about people who move to Extra Care Housing as a private arrangement and then seek local authority funding for the care.

2.6.2 Scheme eligibility criteria may play a part in who moves to ECH in the first place, but once there, a person who moved there as part of a life-style choice is just as entitled to an assessment, a support plan and a Fairer Charging assessment as someone who moved there as part of the local authority referral process. Ordinary Residence rules apply.

2.6.3 If following assessment, the individual meets the local community care eligibility thresholds, the local authority has a duty to meet eligible needs and undertake a Fairer Charging assessment. If the cost for community care services at the scheme is higher than the amount the authority considers it reasonable to pay to meet the individual's needs, it can offer to contract for services up to PB level (net of any assessed financial contribution) - assuming that the service user or another source is willing and able to pay the difference (i.e. to meet a portion of their own needs, leaving the authority only with the unmet need to make arrangements to cover). Alternatively, they can work with the individual to identify less expensive services from a different provider which fully meet eligible needs. In this scenario, a number of other questions may need to be considered. Are the providers' costs reasonable? Is the level of personal budget reasonable to meet the assessed eligible needs? If selecting an alternative provider would place the occupant in breach of tenancy or lease, is the arrangement in reality "accommodation and personal care provided together"?

3. CHARGING FOR SUPPORTING PEOPLE SERVICES

3.1 *See also "Procuring both care and housing-related support from domiciliary care providers" p20.*

3.2 Where housing-related support is a condition of tenancy or lease, and funded under the banner of Supporting People, the support charge is commonly collected by the landlord together with the rent and accommodation-related service charge, whether the landlord provides the support directly, or sub-contracts it out. Most ECH schemes charge a fixed amount per occupant irrespective of the level of support provided, although a banded approach is also sometimes applied. At present, someone receiving housing benefit is exempt from paying the support charge, and the Supporting People Administrative Authority commonly has a block subsidy contract with the landlord.

3.3 Where housing-related support is commissioned by the local authority together with the care, and delivered by a combined care and support provider, the support charge can be invoiced with the care charge by the local authority following a Fairer Charging assessment. This becomes more complex however where a support charge is payable, it is not written into the tenancy or lease, and the resident is not eligible for social care services under the local threshold for community care. In this scenario, it needs to be clear when the applicant is considering Extra Care Housing that s/he will be expected to pay this charge, and a separate agreement covering it should be made between the support provider and the occupant. Assuming a Supporting People payment is being made for support at the scheme, someone not in receipt of housing benefit could request a Fairer Charging assessment.

3.4 In some schemes, the support charge is a condition of tenancy but not lease, on the basis that the local authority's SP policy is not to subsidise leaseholders. Leaseholders can purchase housing-related support privately if they wish.

3.5 We are likely to see many changes in the future regarding funding and charging for housing-related support services following the removal of the SP ring fence and the role of Local Area Agreements in determining priorities for funding.

REVENUE AND CHARGING ARRANGEMENTS – KEY POINTS

- In social sector and hybrid extra care schemes, it is usual for authorities with adult social care responsibilities to pay for some of the care provision, but the way in which this is channelled, and who and what it covers, varies considerably.
- Extra Care is housing, not residential care, and is covered by non-residential charging provisions and principles, including s7 of HASSASSA which gives councils the discretionary power to charge adult recipients of non-residential services funded by the council.
- The Fairer Charging framework applies to any charges made by, or on behalf of, the local authority for care and support services they have commissioned.
- Where the local authority has a duty to provide services under community care legislation to an individual with assessed, eligible, unmet needs, the local authority cannot absolve itself of its responsibility for applying the Fairer Charging Framework by leaving the provider to set its own charges.
- As long as the services and occupants are covered by the relevant statutes, the council can charge for the round-the-clock care and support, even if the occupant does not have an assessed, eligible need.
- The local authority cannot recover a charge if it makes a grant for services under the Health Services and Public Health Act 1968.
- Making the core service, including round-the-clock cover, a condition of tenancy or lease may run the risk of being seen by regulators as providing "accommodation and care together", even if the availability of care in an emergency is only one small aspect of the service. The position is not clear and may depend on other arrangements at the scheme.

SECTION 4

LEGAL RELATIONSHIPS

1.0 PERSONAL BUDGETS

1.1 In the context of personal budgets, "service contracts will either be between the local authority and the provider or alternatively between the provider and the *client*, or his or her third party representative. A contract between a local authority and a provider can allow, through its terms and conditions, for whatever level of involvement of the client or third party that the two parties are willing to include, short of delegation of the ultimate responsibility of determining how to meet the needs of the client via the contract, which must remain that of the local authority."[52]

1.2 "Whereas with direct payments, the contract is between the service user and their chosen provider, who may be an individual or agency," "in a managed budget arrangement, the contract remains between the council and the provider, either as a spot purchase from within a framework contract or as part of a pre-paid block contract." [53]

1.3 The legal arrangements in Extra Care Housing schemes can be complex and there are a number of variations. The following scenarios include the two contractual possibilities which apply in the context of personal budgets.

2.0 SOCIAL HOUSING SECTOR

2.1 Local Authority as Service Commissioners

2.1.1 The following legal relationships apply where Adult Social Services are involved in commissioning the care; the occupant has had a community care assessment or supported self-directed assessment; the care/support plan has been agreed and signed off by the local authority; and the care provider(s) deliver(s) the care/support in accordance with the support plan. This applies in the context of personalisation where an individual has a PB, but has opted to have a managed budget arrangement rather than taking a direct payment.

- Adult Social Services and the care provider have at least one contract for the care provision – there may be a volume based contract for the occupants of the facility up to a certain level, and individual needs above that level met under a distinct clause or agreement.

- The care provider is the means by which the Adult Social Services' duties to the client are discharged. In the context of personalisation, the contract is likely to specify that the provider should deliver the care plan according to each individual's wishes within certain parameters related to needs and outcomes or the client's priorities. The contract between Social Services and the provider(s), is likely to specify broadly defined outcomes and may require the availability of Individual Service Funds whereby the provider is given access to the client's budget and operates a running account.

- The occupying service user has a clear basis for deciding how to spend the managed budget, via the signed care or support plan with Adult Social Services. [It is not right to call this an agreement because that implies contract and this is a statutory duty to provide, not a contract as such.] It is Adult

Social Services, not the care provider, who has the statutory duty to provide services to meet assessed eligible care and support needs, and the power to alter the support plan or the funding for it, via a review, and after discussion with the client. So, that is the primary legal relationship with the service user.

- The service user's main day-to-day contact is with the care provider. From a practical rather than a legal perspective, this is the key relationship for the client. Ideally, the care/support plan will be outcome based, giving the client and care provider flexibility in how to meet specified needs. Even in a managed PB, the service should be personalised and the client should feel in control.

- The client has a separate and personal contract with the housing provider for the accommodation, in the form of a tenancy or lease.

- In this model, **housing**-**related** support services delivered by the housing provider are likely to form part of the occupancy agreement with a support plan drawn up. Despite the Alternative Futures'[viii] case, it is not necessary in legal terms for the avoidance of care home registration rules, to separate the housing-related support services from the tenancy, so long as there is no danger of them being seen – in reality – as services which could amount to assistance with bodily functions, under the current law. Indeed, if the housing related support services ARE separate from the tenancy, then it can have a negative impact on Housing Benefit in relation to the definition of excepted accommodation and higher levels of benefit for un-capped rents. *(See p21)*

- The Supporting People Administering Authority usually has the support contract with the housing provider/landlord who may sub-contract some of the housing-related support to the care provider. Where this is the case it establishes the necessary relationship between the Provider and the support provider to bring the accommodation within the Turnbull rules for excepted accommodation (i.e. that the support is provided on behalf of the Landlord). (*See diagram 1*)

- There are arrangements where the local authority jointly commissions the care and housing-related services together without the housing provider as intermediary, and the support is not made a condition of tenancy or lease. *(See diagram 2)*

- It is good practice for a service delivery plan to combine care and housing-related support to ensure a cohesive service, but it is important that the nature of the services is kept conceptually distinct, from a legal and registration perspective.

- The Housing/Support and Care Providers, if separate, will have contracts or protocols between themselves defining each party's role.

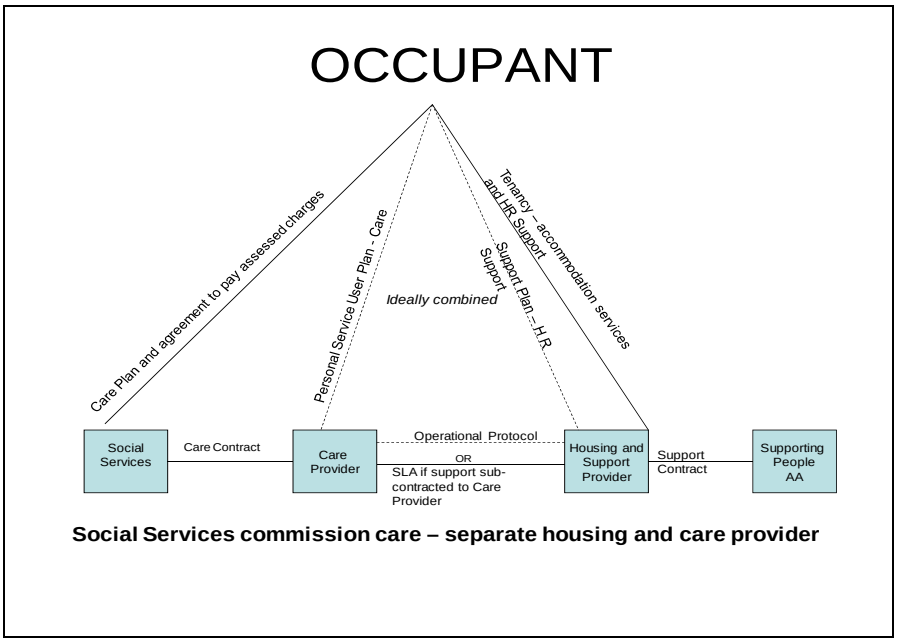
[viii] This is a case in which the company, Alternative Futures sought to de-register a home for people with learning disabilities and issued tenancies to the ex-occupants. The Care Standards Tribunal concluded that the company were still running a home. The 'tenants' took the case to Judicial Review. The judge held that the CST's decision had been correct because the tenancies covered both accommodation and services [established on the evidence in that particular case, by comparison of a before and after analysis of what was provided to each client, the service constituted personal or nursing care.]

- Even where Adult Social Services commission the care and non-housing related support, a client can usually make a private arrangement with the care provider for additional services if they wish to.

2.1.2 In some care village models, the principles remain the same as those described above, though there may be some variations in the mechanics, for example, who collects the assessed care charge.

2.1.3 Where Adult Social Services commission the care, the following 4 diagrams illustrate the typical relationships:

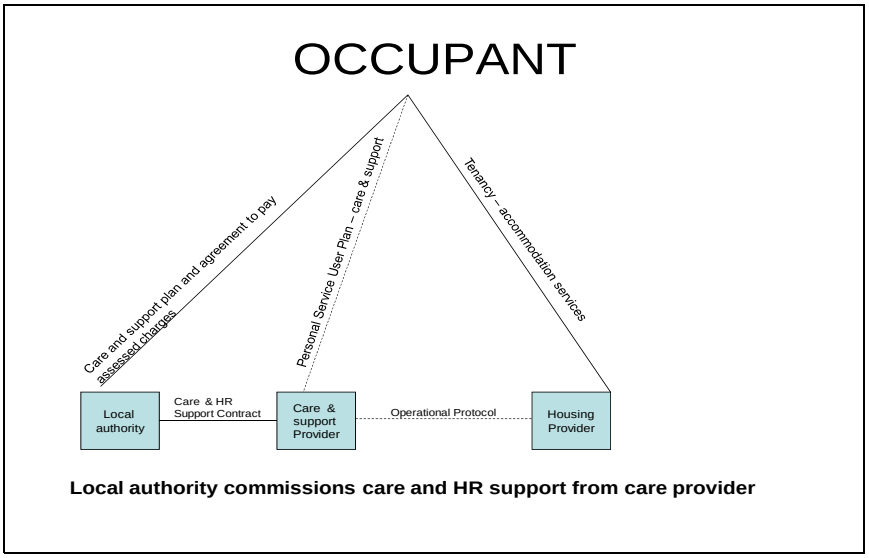
Diagram 1 Social Services commission care – separate housing and care provider



Social Services commission care – separate housing and care provider

Unbroken line = primary legal relationship or contract Broken line = operational relationships

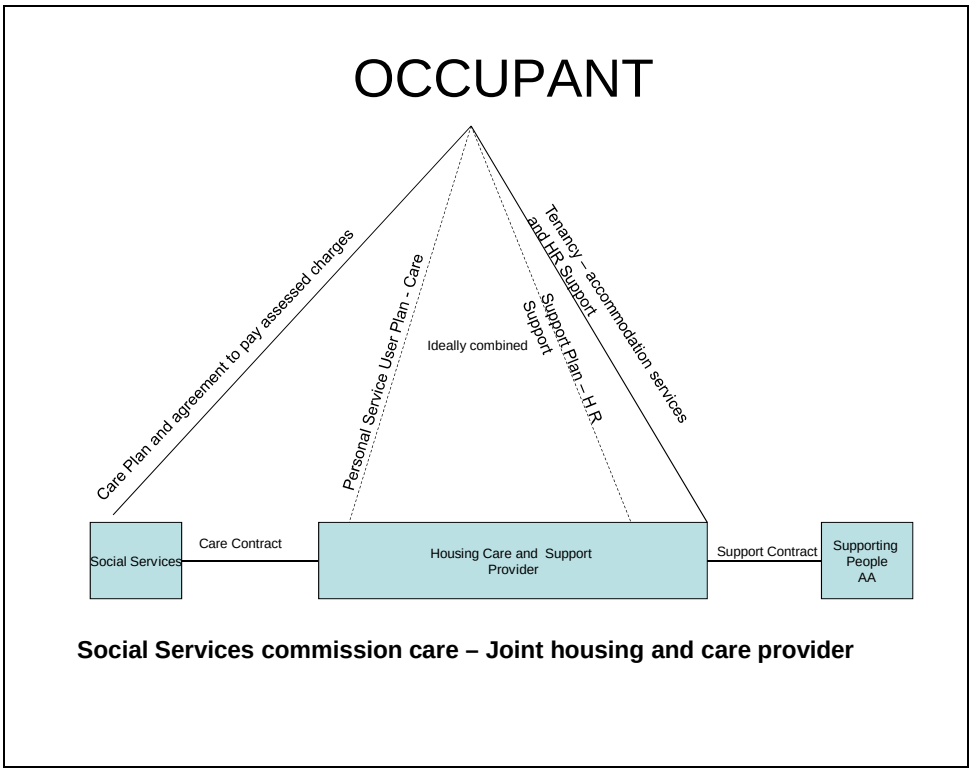
Diagram 2 Local authority commissions care and HR support from care provider



Local authority commissions care and HR support from care provider

Unbroken line = primary legal relationship or contract Broken line = operational relationships

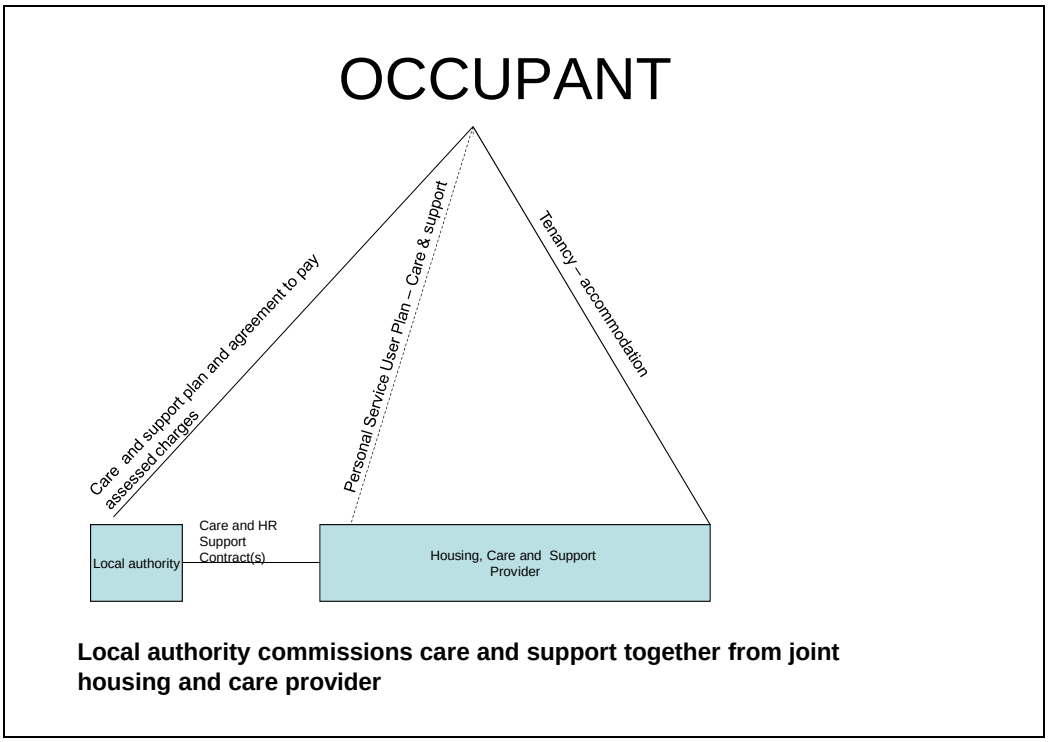
Diagram 3 Social Services commission care – joint housing and care provider



Social Services commission care – Joint housing and care provider

Unbroken line = primary legal relationship or contract Broken line = operational relationships

Diagram 4 Local authority commissions care and support together from joint housing and care provider



Local authority commissions care and support together from joint housing and care provider

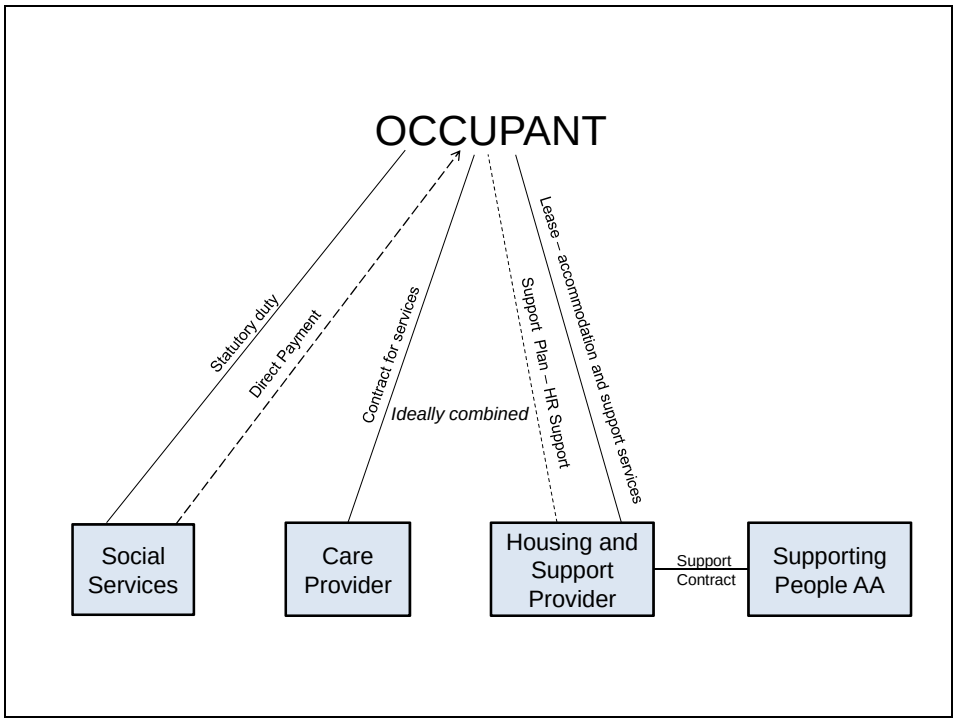
Unbroken line = primary legal relationship or contract Broken line = operational relationships

2.2 Direct Payments

2.2.1 With a Direct Payment the client will need to be contracting with an individual by offering an employment contract, or engaging a self-employed person, or buying services from an agency. They may also contract with the scheme's on-site care providers for some or even all their care and support services if they wish, assuming (in England, but not Scotland) that the care provider is not a Adult Social Services in-house service. Even though the direct payment comes from the local authority, it is transferred to the ownership and control of the client for specified purposes, and the ensuing contract for services is between the service user and service provider, as if it were a private purchase.

2.2.2 The relationships are as follows:

Diagram 5 Direct Payments



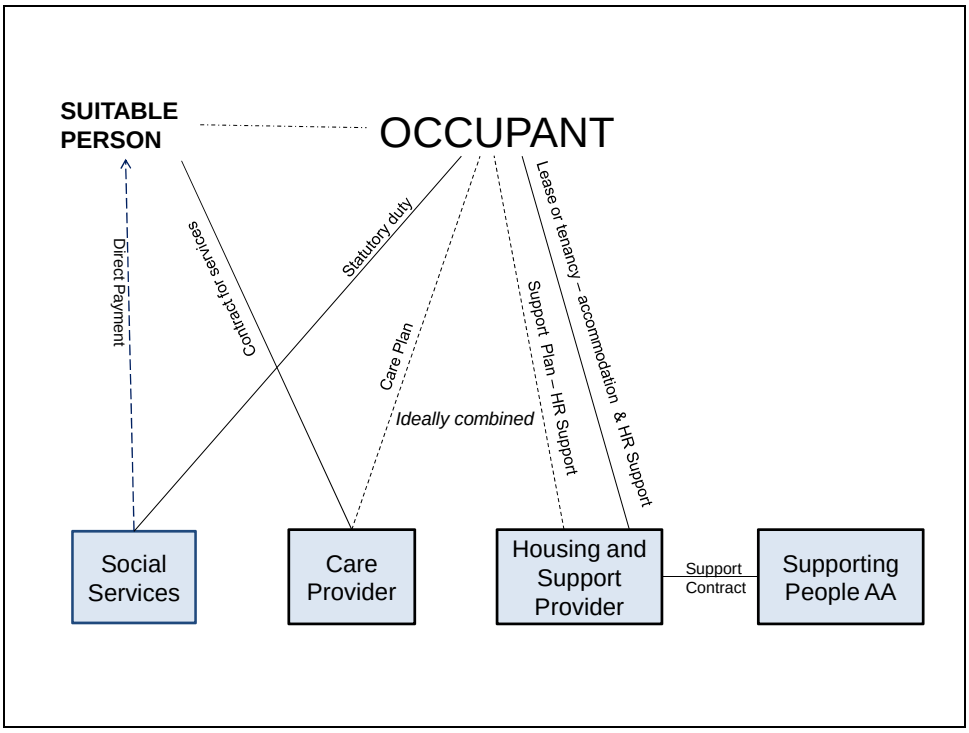
Unbroken lines = formal legal relationships
Broken line = operational relationships
Broken arrow = payment relationship

Over time, we are likely to see more of the relationships in Diagrams 5, 6 and 7 and fewer in Diagrams 1- 4 and 8.

2.2.3 If the Direct Payment is being held by an incapacitated person's Suitable Person, under an appointment by the local authority, the Suitable Person will be the contractor, in their own name, and not legally on behalf of the service user, although the service user will get the benefit of that relationship. To the extent that the Contracts (Rights of Third Parties) legislation is NOT excluded by that contract, the service user will obtain enforceable contractual rights thereunder, as if they were a direct party. Ultimately, therefore, they could be represented by a litigation friend, who could bring or defend legal proceedings related to the contract, if necessary.

2.2.4 The relationships are as follows:

Diagram 6 Direct payments via suitable person for incapacitated occupant



Unbroken lines – formal legal relationships
Broken arrow - Payment relationships
Broken lines – operational/informal relationships

3. THE PRIVATE HOUSING SECTOR

3.1 Self-funders with no local authority involvement

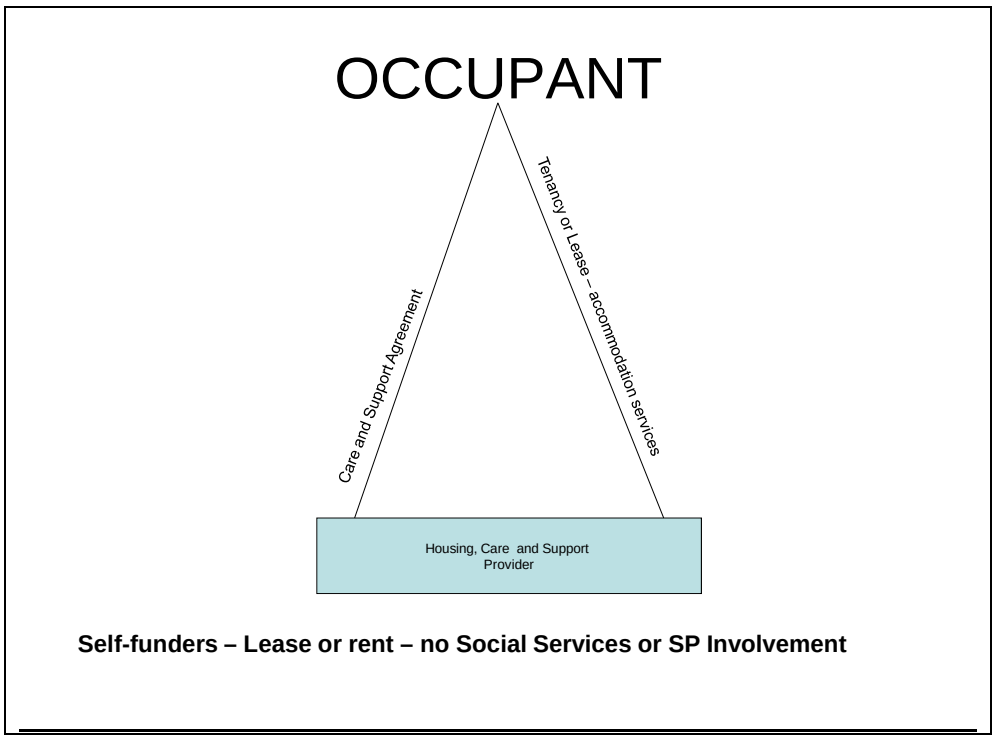
3.1.1 In most private sector Extra Care Housing, there is no third party commissioning care at a "macro" level. The provider determines levels of care provision as well as assessing care needs with the resident and delivering the service. Self-funding occupants purchase the care directly from the care provider.

3.1.2 Where Adult Social Services have had no involvement in commissioning the care, the primary legal relationship is between the occupant and the care provider. This could be the housing provider if they are also registered to provide domiciliary care.

3.1.3 This should be reflected in a separate care or care and support agreement between client and provider. Outcome 3 of the CQ guidance[7] (Regulation 19 of the *Care Quality Commission (Registration) Regulations 2009*) provides that where a person is responsible for paying the costs of their care (either in full or partially), the registered person must provide a statement in writing to the service user, or person acting on their behalf, specifying the terms and conditions in respect of the services to be provided, including the amount and method of payment of fees, and the form of contract for the provision of services. Where possible this should be done before the service begins.

3.1.4 Where the local authority has no involvement, relationships are more simple and are as follows:

Diagram 7 Self-funders – lease or rent. No local authority involvement



Unbroken line = primary legal relationship or contract

3. 2 Local Authority Involvement in commissioning care and/or support

3.2 Adult Social Services may commission care from the provider for individual occupants who are less well-off. The essence of the arrangements is usually these:

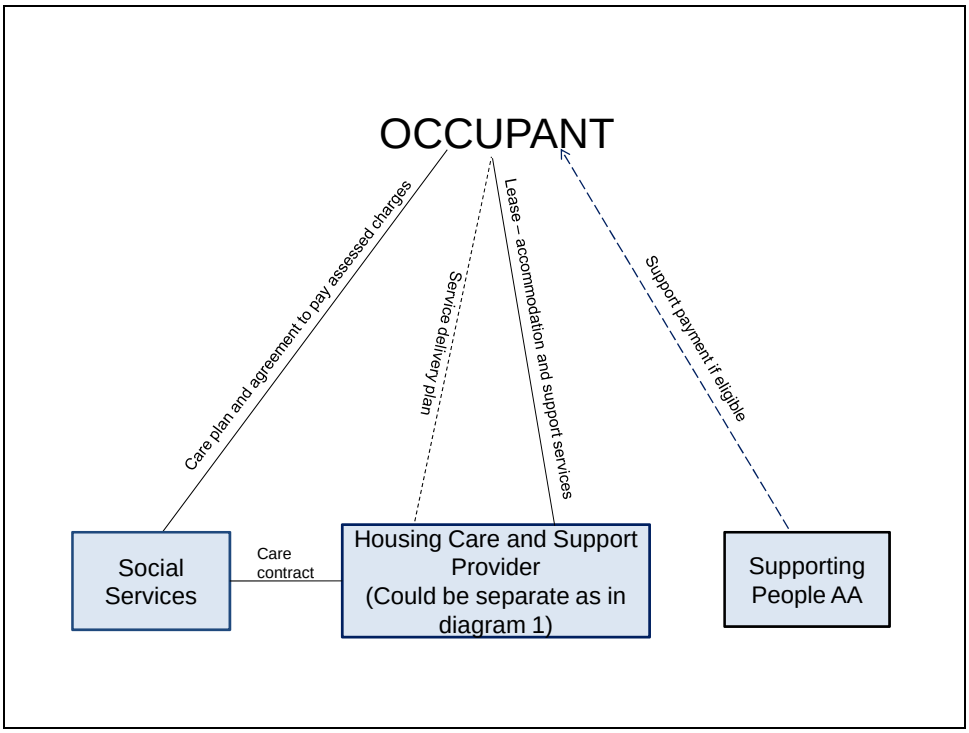
- The individual elects to enter the scheme and purchase on whatever arrangements are offered by the landlord and/or care provider
- The care provider as part of the sales process (or offering a tenancy in a market rent scheme) assesses the care needs rather than social services. Commonly they will seek reports from the individual's doctor. A conscious decision is made to sell (or let) to the individual in the light of their assessed needs. The provider may, for example, decline to accept someone who already has some specified illness such as a form of dementia.
- Services are provided on a similar basis to all occupants in accordance with whatever care and financial arrangements are in place at the scheme. These range from "packages" tied to a particular assessed level of need on, say, a six point scale, through to arrangements where occupants pay, for example, a basic service charge for a defined set of services and then, according to care and support they actually use, on a pre-determined charging unit.
- Individuals are entitled to a community care assessment if they so choose. They would then be subject to the same principles of service commissioning, a Fairer Charging financial assessment etc as those in any other domiciliary setting. *(See also Charging for Care and Support p64)* It should not be assumed all owners have substantial additional resources. In schemes which have been deliberately designed to cater for poorer owner-occupiers by

offering shared ownership, they may well not. Indeed, some housing providers operate a form of means test which ensures that shared owners purchase the maximum equity share they can afford thus leaving them with minimal free capital after purchase.

- Supporting People funds are also potentially available to provide support to less well off vulnerable owners. Under CLG guidelines, it is a local choice whether or not to make SP funding available to leaseholders. Where it is, those in receipt of pension credit are likely to be funded if they are assessed as needing housing-related support. In this scenario, the owner-occupier relates directly to the Supporting People Administering Authority although their relationship is not a contractual one. SP pay the owner-occupier who has the contractual relationship with the landlord and pays the landlord the Support Charge – usually part of the service charge, assuming the support is provided for as part and parcel of the lease.

3. 2.2 In these scenarios, the relationships are thus:

Diagram 8 Extra Care for sale – possible Social Services and SP involvement on an individual basis



Unbroken line = primary legal relationship or contract
Broken line = operational relationships
Broken arrow = payment relationship

LEGAL RELATIONSHIPS – KEY POINTS

- The way in which the services are commissioned affects the legal relationships.
- With personal budgets, under managed arrangements, the contract for care is between the local authority and provider.
- With direct payments and private arrangements, the contract for care is between the occupant and provider.

SECTION 5

CARE DELIVERY

1 WHO PROVIDES?

Social care in Extra Care Housing can be delivered by any of the following:

- In-house adult social services home care service
- Independent care and support agencies and social enterprises
- Personal assistants
- Individual carers

Because of the lack of clarity in relation to the risk of registration as a care home if housing providers deliver both care and housing management, even under separate contracts with the occupant, the housing provider has not been included in this section as a possible provider of care, despite what exists on the ground.

1.1 Adult Social Services In-House Provider

1.1.1 Using an in-house provider is becoming less and less common as these services are much reduced in size and increasingly tend to have a specific focus, for example providing re-ablement and other short-term services.

1.1.2 There was a time when use of the in-house service meant greater flexibility in service levels. This probably does not apply any more. There does not seem to be any clear justification for using a service whose unit costs are generally higher than those of independent counterparts. Also, because often the commissioning arrangements with an in-house service are not as robust as with an external service, there may be a risk of greater collusion between adult social services commissioners and providers if problems arise with the care service.

1.2 Independent Care and Support Agencies or Social Enterprises[ix]

1.2.1 A block contract for delivering care in an Extra Care Housing scheme may be quite attractive to care and support agencies, depending on the terms. The physical environment is usually appealing and there is no travelling between visits, a cost often carried by staff themselves. The ECH model and ethos is good to be part of, so staff can derive significant job satisfaction. Where employment contracts are made more flexible and less secure in order to accommodate service users' greater freedom of choice, and any block contracted element is very minimal, some of the attractions of providing care in Extra Care Housing may be reduced.

1.2.2 With the advent of PBs, there may be a number of different agencies delivering individual care and support plans as well as a single on-site agency providing the round-the-clock emergency cover.

[ix] A social enterprise is defined as "a business or service with primarily social objectives whose surpluses are principally reinvested for that purpose in the community, rather than being driven by the need to maximise profit for shareholders and owners". http://www.communityfirst.org.uk/social-enterprise.htm

1.2.3 Over time we are likely to see an increase in social enterprises offering care and support services.

1.3 Personal Assistants

1.3.1 Direct payment holders can employ personal assistants directly to deliver their care. They would be unlikely to be able to deliver a responsive and flexible service around the clock. People may choose a combination of access to round the clock emergency cover from part of their personal budget while taking a direct payment for the rest to employ a personal assistant.

1.4 Individual Carers

1.4.1 Occupants may choose to use their personal budget to purchase a care and support service from a self-employed individual carer who may provide a tailored service to a number of people, or from family or friends.

2. INTEGRATED OR SEPARATE HOUSING AND CARE MANAGEMENT

2.1 Overview

Note: *This topic is covered because these approaches are currently in existence. However, a single provider and an integrated management approach run a greater risk of being seen as "accommodation and personal care provided together" and registrable as such. The legal meaning of this phrase is not clear. Current guidance and its application in practice give an ambiguous picture. The advice from CQC is against an integrated approach. Therefore, this Technical Brief cannot recommend it even though in practice it may have benefits. See p12 for further discussion.*

2.1.1 In Extra Care Housing there are two distinct approaches to providing and managing the care service; much of the service configuration in an ECH scheme depends which of these approaches is adopted.

2.1.2 Housing providers who are registered to provide domiciliary care may appoint a single scheme manager to manage the care and housing services at the scheme. This option is not possible for housing providers who are not registered to provide personal care, and in their schemes, the care service has to be provided and managed by a separate organisation. Some ECH schemes have a separate management model even though a branch of the housing provider organisation provides the care.

2.1.3 Section 2 of the Housing LIN Fact Sheet No.9 on *Workforce Issues in Extra Care Housing* describes these models in greater detail[18]. This Brief will briefly looks at the pros and cons of each approach.

2.2 Advantages of an Integrated Approach

2.2.1 Some advantages of an integrated housing and care management model (and by implication the disadvantages of a separate approach) are said to be:

- Greater cohesion between services - less risk of services falling between two stools
- More effective co-ordination of services
- More effective building cover when housing manager in separate model is off site

- Relationships are clearer and less complex –
  - Relationship between tenant and provider – “one-stop shop” for occupants
  - Only one agency to work with and better understanding between purchaser(s) and provider
- The level and clarity of the scheme manager’s role provides:
  - A better negotiating platform with external service providers
  - Greater authority to provide scheme leadership

2.3 Advantages of Separate Approach

2.3.1 Some of the benefits of a separate management structure (and by implication, the downside of an integrated approach) are described as:

- There is less resemblance to a residential care management structure and less risk of registration as accommodation and care together
- Collusive and bad practice is more easily identifiable if two separate providers monitor each other, with greater scope for scheme manager to act as advocate for occupants
- Given that the housing provider generally owns the property and is tied in to it as landlord for at least 25 years, it is easier to re-tender the care service if that is delivered by a separate provider
- Each service provider is a specialist in his or her area. Therefore:
  - They can more easily provide the expert management needed to deliver a good quality service
  - There is less risk of housing management tasks being subsumed by care issues or vice versa
- Clearer link between each funding source and the services it pays for

2.3.2 Both models can work very well – and not so well. Effective preparation between partners during the scheme commissioning phase is fundamental, as is inter-agency liaison and quality monitoring once operational.

2.3.3 In a separate model, the relationship between the scheme manager and care team leader is pivotal, and where it works well the effect is synergistic. It is essential for the housing and care providers to discuss and agree liaison, and a whole range of other arrangements at the interface between housing and care.

3. CARE IN THE PRIVATE SECTOR

3.1 The models of care delivery in the private sector vary hugely. They range from those which are very similar to the social housing sector approach, through adjacent care homes providing an outreach service to lessees in surrounding properties, to lessees forming a co-operative company which employs all staff. What all these approaches have in common is that care is delivered on an individualised basis according to an agreed care plan.

CARE DELIVERY – KEY POINTS

- Care can be provided by Social Services in-house providers, independent agencies, the housing provider if they are registered to provide domiciliary care, personal assistants or individual carers.
- There is a wide range of models for service management and delivery

- There are pros and cons to both integrated and separate housing and care management models
- Irrespective of the management model, effective co-ordination and close working relationships are fundamental to a good service

SECTION 6

HOW MUCH CARE?

1. FACTORS INFLUENCING LEVEL OF PROVISION

1.1 Introduction to Factors Influencing Level of Provision

1.1.1 In the 2005 Technical Brief, we outlined a range of factors which played a part in determining the level of staffing in an Extra Care Housing scheme. There is now a major addition to add to the list: Putting People First. The personalisation agenda, personal budgets, stakeholders shared vision and the commissioning model being applied will be the starting point. Block contracting the entire on-site care provision will no longer be the norm *(see models from p25 and case studies from p42)*, and we may see local authorities making fewer procurement decisions, with individuals and groups of individuals having increasing levels control.

1.1.2 Nevertheless, insofar as an element of collective provision is retained, irrespective of the commissioning approach, the following factors may be helpful to decision makers in determining staffing levels. These factors need to be looked at in combination rather than separately.

1.2 Number of Properties

1.2.1 The scale of the development will have an influence on staffing levels, but this needs to be considered alongside the following variables.

1.3 Purpose of the Scheme

1.3.1 If the vision for the scheme is to replace residential care, or cater specifically for people with dementia, you would expect the care provision to be higher to reflect that.

1.3.2 Two other lettings decisions will similarly impact on levels of care provided, staffing levels and roles:

- Allocating a number of properties for intermediate care use
- Letting or selling properties to people with learning disabilities

1.4 Eligibility Criteria and Anticipated Community Mix

1.4.1 Related to the above point, what is the target group for the scheme in terms of individual care needs or dependency levels? For example:

- are you aiming to achieve a mix of need levels, say on the “thirds” principle (low, medium and high care needs) or
- are you targeting one particular group, e.g. those who would otherwise require residential care?

If you are adopting an apportioning approach:

- how are you defining each service level (e.g. Below 5 care hours per week, between 5 and 10, and above 10)?
- Do you have a minimum care need as an eligibility criterion; for example, 4 hours care a week or more?
- Do you have an upper limit to the size of the care package on entry?

1.4.2 The ideal is to target a group of people through the eligibility criteria whose combined care needs justify expenditure on round-the-clock cover.

1.4.3 Absolute statements about where this level is - and the cost-effectiveness of Extra Care Housing generally - are very difficult to make because of the wide range of factors which are relevant to the equation. These include:

- dependency levels;
- costs of care at the scheme compared to other settings;
- the charging policy for care at the scheme compared to alternatives; the number of self-funders vs. those on state benefit;
- the level of care provision relative to composite needs of the resident group; the savings achieved by economies of scale and absence of travel time; and
- the level of care available for those who need it compared to that available in alternative settings.

1.4.4 However, it does not necessarily follow, for example, that the higher the need levels, the more cost-effective the service will be for social services. Because domiciliary care tends to be purchased by the hour whereas residential care is purchased for a fixed (or range of fixed) fee(s), Extra Care Housing may become more expensive to social services above a certain point. If the Personal Care at Home Bill becomes law, those in ECH with the highest needs will be entitled to receive the care free, which, from an adult social services perspective, changes the cost-effectiveness equation.

1.4.5 Equally, targeting everyone in low dependency groups is unlikely to be cost-effective because of the basic minimum cover, including night care required at a scheme. Thus, aiming for a mix of need levels or targeting those with medium levels of need are the two approaches most likely to make the average cost per resident cost effective whilst enabling a good level of care provision.[x]

1.4.6 Cost-effectiveness aside, from a good practice perspective, many Extra Care Housing providers believe that aiming for a community with a mix of need levels and domains enables a more vibrant, balanced community, and that to target only those who would otherwise need residential care risks the scheme feeling like residential care even though it is technically housing.

1.5 Staff Roles

1.5.1 Is the care provider only going to undertake care tasks, or are staff going to undertake other roles with appropriate funding, such as housing-related support and housing management services? While this will not affect the number of care hours commissioned it will affect staff structures and levels.

1.5.2 Furthermore, there is a significant degree of variation in the tasks and activities different social services authorities will cover under the broad umbrella of care – or at least what they are willing to pay for. With the advent of self-directed support, the range of eligible support activities is likely to broaden. For example, some authorities will pay for an additional hour per resident per week to cover the cost of facilitating activities, whereas in other areas this function may be funded from Supporting People with a scheme

[x] For further information on use of resources see *Use of Resources in Adult Social Care: A Guide for Local Authorities*[54]

manager undertaking the task. Individual flat cleaning may be included as part of the care package or purchased by the occupant.

1.6 Commissioner Priorities and Budgetary Considerations

1.6.1 Competing demands for limited budgets and the motivation of commissioners in developing Extra Care Housing is likely to influence the level of care commissioned. Some adult social services see Extra Care Housing primarily as a way of saving money, while others participate primarily for quality of life reasons and seek to enable a home for life if at all possible. Their position on this spectrum will play a part in determining levels of care, as will their approach to personal budgets and the amount they consider it appropriate to tie up in block contracts.

1.7 Level of Confidence

1.7.1 If it is the provider taking the risk on staffing levels at a scheme, the level of confidence that individuals will choose the on-site provider for their care and support packages will be important.

1.8 Staffing Variables Checklist

1.8.1 It is possible to construct quite a long list of factors that may impact on care staffing levels. A checklist of principle considerations is as follows:

- Lettings policy
    - Proportion of occupants with high, medium, low needs
    - Proportion of occupants with learning disabilities, dementia and other mental health problems
- Division of responsibility between housing management and care/support functions
- Practice of supporting people to make meals/require meals to be taken in restaurant, and which meals
- Use of assistive technology to substitute capital for labour/aid efficiency of support and care delivery
- How leisure, social and health based activities are arranged and managed
- Decisions on which different/distinct roles to have within an ECH scheme
- Direct Payments use by occupants and occupants' decisions on how to arrange direct support
- How much of a personal budget is left to individual choice

2. OPTIMAL COVER

2.1 Introduction to Optimal Cover

2.1.1 Even if you accept that anything less than 24 hour dedicated care on site is not Extra Care Housing, there are enormous variations in the level of cover provided across schemes in the country which do count as ECH. These differences are not purely a reflection of different needs levels within a scheme though this should be the key determining factor.

2.1.2 At the lower end of the spectrum, minimum cover could be one person on site available to deliver care at all times plus any extra needed to meet care package requirements. However, if most of that person's time is taken up delivering planned care during the day, then there is little scope for responding to emergencies or fluctuations in need. On the other hand, many

schemes, whether with an integrated or separate structure, have three levels of care staff; namely:

- care team leader or scheme manager,
- a number of senior care assistants and a team of care or
- care and support workers who are dedicated to the scheme.

2.2 What might optimal cover include?

2.2.1 Uncommitted time

An allowance of "floating time" which is not tied in to individual care packages enables service co-ordination, staff supervision, participation in reviews, liaison with other agencies and responding to emergencies and fluctuations in need. How much time to allow will be influenced by the size of the scheme and need profile - and consequent service level requirement - of the resident group. Very often, this non-committed time is provided through a full time care team leader, or in an integrated model, the scheme manager and possibly some of the senior care assistant time, often with some administrative support.

2.2.2 Minimum day time presence

Two members of staff may be preferable to only one as the minimum level at the scheme at any one time. This can include Care Team Leader or Scheme Manager so long as they can deliver hands-on care in an emergency. It allows for greater flexibility and responsiveness.

2.2.3 Flexibility

Assuming that at least some care plans are delivered by the on-site provider, it is best if providers have the freedom to respond to fluctuating need and alter the care plan with the minimum red-tape and bureaucracy. Outcome-based commissioning will facilitate this.

2.2.4 Waking night staff

Many Extra Care schemes only have one member of care or care/support staff on duty at night and of these, a significant number only provide sleeping night cover. Some argue that to provide waking night cover reduces the cost effectiveness of Extra Care compared to other provision. On the other hand, many ECH schemes provide waking cover at night and some authorities and providers would not consider anything less, arguing that it cannot be a real alternative to residential care without it.

If waking night cover is not provided, any service users requiring planned care input at night are effectively prohibited from moving to the scheme since sleeping staff can only respond to emergencies. This reduces the pool of potential occupants and many people who need assistance at night would be perfectly suited to living in Extra Care Housing. The other implication of having only sleeping assistance is that unless the cover is upgraded to waking cover as occupants' needs change, occupants would have to move out of the scheme if they started to require planned care at night. Whilst it may be possible to bring in peripatetic night cover to provide this service, this is not ideal, not least because it introduces a security risk overnight.

Another benefit to the occupants of having waking night staff is that they then have greater choice over bed-time if they need assistance. It is unusual to be able to arrange or extend daytime shifts beyond 10p.m. at night and some occupants prefer going to bed later. Waking night staff can use any non-contact time constructively by, for example, doing the laundry for those occupants who have this as part of their care plan, thereby freeing up the facility during the day for occupants' use.

Some schemes have achieved night cover – usually sleeping - by splitting the cost between Adult Social Services and SPAA on the basis that whilst staff are not actively delivering care, their presence is just as much about housing-related support as care. Where waking night staff undertake tasks such as laundry, they are clearly undertaking tasks within Adult Social Service's remit, not SP and therefore Social Services or the individual should pay. Some SPAA have withdrawn from funding this aspect of the service arguing that it is care. On the other hand, some CSCI inspectors have viewed the SP contribution to the night cover as evidence that the scheme is housing not residential care.

2.2.5 Handover Time

Allowing handover time between shifts enables better communication and continuity, even if communication books are used. If personal budgets result in additional providers on-site more time needs to be allowed for handover and liaison.

2.2.6 A Dedicated Team

If it is possible to achieve within the context of personal budgets, a consistent staff group is desirable for a host of reasons: service users prefer the continuity; it is better for co-operative working; and it facilitates better understanding of the setting and on site processes. Some consider a key worker approach to offer advantages.

2.2.7 Management Presence

It is desirable for someone with management responsibility to be on site at least during day time hours. This could be either the care team leader or one of the senior care assistants. An alternative approach suggested by one major provider of Extra Care Housing is to appoint a shift leader when the scheme manager (in integrated model) or care team leader is not on site. He/she would have an enhanced rate of pay for that particular shift. Night staff should have access to off site management back up.

2.2.8 Independence Promotion

Ideally, sufficient time needs to be available to allow staff to assist service users to undertake tasks themselves, rather than doing it for them which is often quicker.

Note: *Whilst the author considers the above features to represent optimal care provision, they are matters of judgement. The list is not intended to be exhaustive or prescriptive and it is up to project partners, and the commissioners (both macro and micro) in the final analysis, to decide.*

3 LEVEL OF SERVICE PROVISION

3.1 Number of Hours

3.1.1 Introduction to Number of Hours

This section was written in 2005 when macro-commissioning was the norm, and commissioners sought to quantify how many care hours were likely to be needed over and above an agreed minimum core. While we are likely to see much smaller block contracts in the future, this section has been left in the 2010 Technical Brief to assist decision-makers in their thinking. In the future hours may not be the unit of purchase, but they still tend to be at present.

If a care service is to be collectively available certain principles should apply whatever method is used to calculate the number of hours:

- Once the scheme is up and running, the service should not drop below the agreed minimum levels which might include, for example:
  - Specified number of staff on site at any one time during the day
  - Specified number of waking/sleeping staff on site at any one time at night
  - Number of hours not tied in to individual care packages
  - Expectations regarding management presence on site
- There should be agreed arrangements for varying the overall service level in response to changes in the overall need profile of the occupants.

3.1.2 Standard Figure Approach – Some years ago, some providers worked on the basis that a scheme of average size and eligibility will require a standard figure, say 400 contact hours for a 40 unit scheme, the distribution of which could then be determined by the care provider on the basis of minimum requirements and care package patterns. This approach has been replaced for the most part by one which is based more on anticipated need levels of the target resident group.

3.1.3 Staffing Ratio approach – In some care villages where staffing is characterised by multi-skilled staff undertaking a range of activities, staffing is based less on a calculation of anticipated hours of care, and more on staffing ratios needed, determined by the size of the village and projected resident profile within pre-determined bands.

3.1.4 Minimum cover plus estimation of additional hours needed - the estimation could be based on

- An estimate of the composite of care plans derived from eligibility criteria, or
- A likely schedule of cover.

Example calculation – traditional block purchasing

The following gives an example of a calculation of care hours needed in a 40 unit scheme based on the "thirds principle" – i.e. a projected dependency level of a third low (less than 5 hours care), a third medium (5 – 10 hours), and a third high (more than ten hours) – and no special features. The approach assumes:

- a minimum block contract topped up by additional blocks of 50 and/ or spot purchased hours
- 2 staff on site during day time hours

- 1 staff member on at night
- Care team leader/unallocated time additional

Minimum block contract:

Day time cover – 2 members of staff x14 hours x 7 days per week = 196 hours
Night cover – 10 hours x 7 days per week = 70 hours
Handover time – 1hour x 7 days per week = 7 hours
Care Team leader/floating time = 37 hours

Total – **310** hours inclusive of care team leader hours

If the scheme is likely to take a couple of months to fill, commissioners may wish to consider phasing in the block. If so the care team leader's hours could form part of the minimum 2 person cover = **273** hours initially (for first month or two).

Total amount of care needed:

Based on a 40 unit scheme, two approaches could be taken to estimating the amount of care needed –
a) An estimate of day time hours per week needed, based on the "thirds principle", **or**
b) The likely schedule of cover based on experience

a) An estimate of day time hours per week needed, based on the "thirds principle":

No: Occupants	Hours of Care per week each	Total hours per week
13	3	39
13	7.5	97.5
7	13	91
5	15	75
2	20	40
Total for all 40 occupants		**342.5 hours per week**

Total basic day time hours = 342.5 + 70 night hours = **412.50** hours per week (or 449.50 if you add on the care team leader's hours. See the sub-section on "Costing the Service" below)

b) Likely schedule of cover:

Times of the Day	Length of session in terms of hours	Number of staff on duty	Number of staff hours per session per day
7.30 – 10 a.m.	2.5	5	12.5
10a.m.– 12 noon	2	2	4
12 noon – 2 p.m.	2	4	8
2 p.m. – 6 p.m.	4	2	8
6 p.m. – 10 p.m.	4	4	16
Handover time			1
Total Staff Hours per Day			**49.5 hours per day**

Total 49.5 hrs per day = 346.5 per week + 70 night hours = **416.5** hours per week (or 453.5 if you add the care team leader's hours)

On that basis, 400 contact hours per week seems a reasonable working target, though:

a) it is unclear how quickly that level of input would be needed.

b) the need might be higher once the scheme is full and over a period of years is likely to increase from its starting point

c) it would be preferable not to have a ceiling

Top up of minimum block contract:

This means looking at approximately 100 hours on top of the minimum block contract of 310 hours

3.1.5 One large provider's preferred approach is for the block contract to comprise the total of the minimum eligibility requirement (e.g. 4 hours per resident per week) plus the night time cover, plus the Care Team Leader post, and for the remainder of the care to be spot-purchased on top of that. Important in this approach is allowing the care provider flexibility to determine – with the occupants – how each care package is to be delivered to maximise efficient use of time.

3.1.6 Local authority commissioners may pare down any block-contracted provision to a single carer on site at any one time. For example:

Example calculation - Core and add-on

Minimum cover block contracted – 175 care hours per week (56 night, 112 day and 7 allowed for handover)

Of the 112 day time hours, 40 hrs management and floating time for emergencies. The remainder available for delivery of planned care.

Additional care spot-purchased by local authority or individual from the on-site provider or off-site provider.

3.2 Costing the Service

3.2.1 The most usual way to purchase domiciliary care is still by the number of contact hours. This means that the costs of the Care Team Leader post and other non-contact activities and costs are loaded into the hourly rate for the commissioned contact hours. These would include management and administrative tasks including supervision, liaison and rotas as well as meeting and handover time, training etc. They would also include a percentage to cover annual leave and sick pay entitlements. Equally, night time costs will be calculated at the relevant unit cost and then included in the total costs to come up with a single hourly rate which is charged for all the contact hours commissioned.

3.2.2 The care does not have to be commissioned in this way. The Care Team Leader hours can be added to the total and a different hourly rate attributed for them. Or, as happens in at least one authority, Adult Social Services contributes an agreed proportion of the cost of a given post, e.g. scheme manager. Similarly, whilst night-time cover is usually part of the total contact hours with the same hourly rate as described above, if only sleeping cover is provided, it can be itemised and costed separately.

Note: *If going out to tender for the care, it is essential for the commissioner to specify how the care provision proposal should be costed so that like can be compared with like when comparing submissions. Commissioners must be clear, for example, whether the 400 hours do or do not include the night cover and care team leader, and whether each of these different components should be costed separately or built*

into a single hourly rate. This in turn will help to avoid misunderstandings about what exactly will be paid for and how. If the traditional approach of a unit cost per contact hour is adopted, it is advisable to ask for a breakdown of the component parts.

3.2.3 Some providers offer an open book accounting approach in which the cost of every component of the service is itemised and transparent. This enables commissioners and providers to negotiate components which might be boosted or omitted. At the end of the financial year, any surplus is re-distributed on a pre-determined basis. A relationship of trust and a partnership style of working is fundamental to this approach.

3.2.4 It is very helpful for providers to be granted some start up costs in recognition of the preparation needed to set up a care team in an Extra Care Housing scheme *(see "Information to Prospective Care Providers" p39)* and to fulfil registration requirements.

3.3 Timing of Provision

3.3.1 If the whole service is to be block contracted and it is anticipated that for a period of time the block will stabilise at around 400 hours a week, should that be the level of the block contract from the outset?

3.3.2 It is probably safest to commit to the minimum block initially aiming to have an additional 50 hours in a month or so later and the full 400 a month after that.

3.3.3 The project group should make a judgement on this, depending on how quickly allocations are being made to the scheme. In some areas, all units have been allocated prior to opening whereas in others, for various reasons, it may take a several months. In some areas, a Voids Indemnity Agreement is reached with social services to cover the cost of rent and service charge if units remain unfilled after an agreed period of time, or if properties are being held empty until applicants with the appropriate level of need can be identified.

3.3.4 It is good practice to have the basic team in place and able to meet as a group from the date of scheme completion, even though occupants may not move in for a week or two. Although a scheme may not fill immediately, having the core team there from the outset enables effective team building and an opportunity to get accustomed to the environment before having to deliver the service.

3.3.5 It also means that staff can provide additional support to new occupants moving in. They quite often need fairly intensive support and care whilst settling in, before their care needs stabilise, often at a lower level.

3.3.6 A range of pre-requisites to registration as a domiciliary care provider also necessitates the core provision being in place before starting to deliver the service.

3.4 Distribution of Hours

3.4.1 This is best left to care providers to determine. It depends what precisely has been commissioned and what the provider decides to have in place in addition. Assuming the on-site care provider will be delivering a significant number of care and support plans, there is usually a need for a concentration

of staff in the mornings to help occupants to get up and dressed. Additional input may be needed at lunch time, depending on what the meal arrangements are at a given scheme. Afternoons are usually the time least in demand for delivering care plans. Thus, so long as the care team leader or scheme manager (in an integrated model) is available, one care assistant might suffice depending on the scope of the care assistant's role. Tea time and preparation for going to bed in the evenings usually form additional peaks.

3.4.2 Unfortunately, the times when a concentration of staff is needed do not always coincide neatly with availability of staff or straight-forward shift patterns and therefore compromises may be required. Increasingly in the domiciliary care sector, staff are employed on zero-contracts. While this allows for greater deployment flexibility (to the extent that workers are available when needed) and protects the provider from paying wages when staff are not working, it is less satisfactory from the perspective of staff retention and service continuity. In ECH a guaranteed minimum contract, with the likelihood of additional hours may be viable.

3.5 Shift Patterns

- These do not differ significantly from those in the wider community.
- Part-time staff often assist in boosting provision at peak times.
- In six to ten hour shifts an unpaid break of half an hour must be taken for lunch
- Two short breaks of 15 minutes each are allowed mid-morning and afternoon
- Night shifts commonly run from 10 to 7 but are sometimes extended and/or started half an hour later to boost morning provision

HOW MUCH CARE – KEY POINTS

- The personalisation agenda is likely to have a significant impact on the level of care collectively available
- Factors relevant in determining the level of care collectively available include
    - Commissioning model
    - Number of properties
    - Scheme purpose and target group(s)
    - Level of confidence in likely uptake of on-site service for care and support packages
    - Staff roles
- Optimal cover will vary from scheme to scheme, but may include
    - some non-contact hours, however costed, enabling flexibility, responsiveness and co-ordination
    - round-the-clock presence including waking night staff
    - enough time to facilitate an enabling approach
- Improved outcomes are more likely where decisions are driven by the interests of the occupants and not purely on the basis of budgets
- A dedicated team promotes service cohesion and teamwork but may not always be achieved if only the minimal core 24/7 cover is block contracted
- Transparency in care costing is valuable to both commissioners and providers

ORIGINAL 2005 CASE STUDIES UPDATED IN 2010

SOMERVILLE – ST MONICA'S TRUST

RETIREMENT VILLAGE – INTEGRATED[xi] HOUSING AND CARE MANAGEMENT

Name and brief introduction to the Scheme	Somerville Very Sheltered Housing scheme in Westbury Fields Retirement Village, Bristol. The scheme was developed in partnership with Bristol City Council Health and Social care Department (HSC) who will eventually provide 600 extra care dwellings. St Monica Trust is a charity founded more than 80 years ago by the Wills tobacco family. The Trust has started an ambitious programme of new development for older people in Bristol and the surrounding areas. One of their first was Westbury Fields retirement village. The community has three distinct elements, laid out around a central cricket field with a pavilion and public house: • An 80 place care home which incorporates 15 intermediate/ short term care places where people stay for up to 6 weeks and a 15 bed specialist residential dementia care wing • 105 sheltered flats for sale • 51 flats in a Very Sheltered Housing scheme • 10 of the flats in the Village can be purchased on shared ownership terms. Some services such as porterage, security, grounds and building maintenance are organised to serve the village as a whole but for simplicity, our example concentrates on the very sheltered housing facility. This is called Sommerville.
Number of Units and tenure	51 units – social housing tenanted
Housing Provider	St Monica Trust
Care Provider	St Monica Trust
Care Commissioner	Social Services
Thumbnail sketch of model it's illustrating	St Monica is both the care provider and landlord and provides an example of an integrated care and housing service. The Operations Manager, based in the extra care building, has responsibility for all aspects of day to day management and maintenance of the buildings as well as care and support services. Located off site are central services common to St Monica Trust wider activities such as finance and marketing. Care and housing-related support are delivered by the same staff group
Fundamentals of eligibility criteria and any target	Customers are wholly nominated by Bristol City Health and Social care Department on a 40/ 40/ 20 basis of high, medium and low care needs.

[xi] See p12 on risks of having a single organisation providing accommodation and care

groups	Health and Social Care (HSC) undertake a needs-led assessment based on F.A.C.S eligibility. The Trust also assess them on the "Easycare" assessment model. All residents have on-call help and waking night cover.
Care charges paid to?	St Monica's
Care staff structure - posts and number in team	15.77 day care staff plus 3.73 night care staff. 1x full time Care and Support Manager 1x 30 hour Care and Support Service senior. The manager is additional to the contracted hours while the senior is part of it. In addition, the team also provides care to the rest of the retirement village and a Domiciliary care service in the surrounding community and further afield.
Minimum cover requirements	Minimum of 1 care staff on at night but with one "special resident" who receives 24/7 care that means that there are always 2 carers on site. Manager is on call 24/7 as is the Operations Manager. Porters are also available to assist they are on duty 24/7. At night just one is on duty. They are trained in lifting and handling and assist the carers if needed.
Care hours and distribution of hours during the day	Health and Social Care contract a block of 483 hours of care a week and SP fund 104 hours of housing-related support per week for the 51 residents.
Night time cover	56 hours
Shift patterns	6am-2pm ; 2-10 pm and 10-6am
Any responsibilities apart from those relating to care?	Providing housing related support. Single comprehensive team.
Additional Features	Spread over 3 floors the building is configured in a Y shape. Going through the entrance two enclosed wide streets make a big impact. Along the streets are bowling, boules and other games, tables and chairs on the "streets" creating a Mediterranean atmosphere. The scheme has a wide array of additional amenities now characteristic of villages including: • restaurant • several lounges and activities and meeting rooms • IT suite • Gym and pool • Conference/meeting facilities • Hairdressing salon.

HARP HOUSE – HANOVER HOUSING ASSOCIATION

SEPARATE HOUSING AND CARE MANAGEMENT WITH INDEPENDENT CARE PROVIDER

Name of Scheme	Harp House, Barking
Number of Units and tenure	36 units for rent
Housing Provider	Hanover Housing Association
Care Provider	TLC Care Services – An independent home care provider in London which specialises in services for people with dementia
Care Commissioner	LBBD Social Services Department
Thumbnail sketch of model it's illustrating	Separate housing and care management and service delivery. Full time Estate Manager employed by HHA. Care staff employed by TLC.
Fundamentals of eligibility criteria and any target groups	One-third low (0-5 hours), one-third medium (5-10) and one-third high (10 hours plus a week)
Care charges paid to?	LBBD
Care staff structure - posts and number in team	Care Team leader – 35 hours per week. No planned care input 2 Care co-ordinators – senior care assistants. Both part-time, working 27 hours per week each, of which 7 office hours each and 20 hands on care. One manager present during day time hours Approx 12 members of team, some part-time in addition to seniors and Care Team Leader. All staff have 20 hours guaranteed but are invited to do more. Staff benefit from custom and practice protection but enables greater flexibility for rotas
Minimum cover requirements	2 on at all times
Care hours and distribution of hours during the day	385 hours per week block contracted. Block has recently been increased to reflect increases in care plans. Also 35 hours for the CTL post plus 14 hours office for care co-ordinators. Only contact hours specifically commissioned and counted in block hours. The cost of non-contact hours is incorporated into unit cost for contact hours. 7 – 7.30 a.m. = 2 people (the two night workers) 7.30 – 9.30 a.m. = 4 people

	9.30 – 1a.m. = 3 people 1 – 10 p.m. = 2 people
Night time cover	140 hours – 1 waking 1 sleeping 10 p.m. – 7.00a.m. The sleeping person works a half-hour shift from 10 – 10.30 p.m. as a waking worker, and also from 7 – 7.30 a.m.
Handover time	15 minutes overlap at 4.30 p.m. and at 7.30am. One person.
Flexible care	Up to 4 hours per week per care service user agreed on temporary basis to reflect changing care needs.
Any responsibilities apart from those relating to care?	Have recently got agreement to provide 16 hours support to 2 people from SP on Saturdays and Sundays
Carers special grant	Small grant to support families / carers Has been used for carer relief for husband; lives in HH with his disabled wife. Plans to run quarterly family support sessions
Additional scheme features	Harp House in Barking was developed in partnership with the London Borough of Barking and Dagenham. It is an example of core and cluster housing with the core being Extra Care housing and the cluster being sheltered bungalows in the grounds of the scheme. Sheltered tenants make use of the facilities in the core. It is fortunate to have a range of additional facilities, thanks to capital made available by the local authority. There is a cybercafé but the funding to run it and provide training for people with learning disabilities ceased 2 years ago. The local PCT runs Pulmonary rehabilitation sessions a couple of days a week. The bowling green provides additional recreational opportunities in the summer months. In the past this has never been used, but as of last week residents have stated they will be using it and inviting others to play and considering how it might be developed in the future. LBBD have recently announced that they will no longer be commissioning Age Concern to run day centre facilities at Harp House. The LA is therefore considering other options to meet the needs and may well be funding other such activities at the scheme in the future. Harp House is one of the sites for the Up2Us co-production pilot project. *For further detail on this, see the example box on p36*

PINEAPPLE PLACE – HANOVER HOUSING ASSOCIATION

SEPARATE HOUSING AND CARE MANAGEMENT WITH BOTH INDEPENDENT CARE PROVIDER AND HOUSING PROVIDER DELIVERING HOUSING-RELATED SUPPORT

Name of Scheme	Pineapple Place, Birmingham
Number of Units and tenure	34 flats of which 31 one-bedroom two-person flats and 3 two bedroom two person flats. All for rent
Housing Provider	Hanover Housing Association
Care Provider	Care UK, a large independent care provider
Care Commissioner	Birmingham City Council Social Care and Health Directorate (SC&H)
Thumbnail sketch of model it's illustrating	Housing management and some (25% of EM time) providing Housing Related Support provided by Hanover's Estate Manager. Additional housing-related support and care provided by Care UK's on-site dedicated team, with joint funding coming from Birmingham City Council and Birmingham Supporting People Authority.
Fundamentals of eligibility criteria and any target groups	Aim for a mixed community High – 25% Medium – 45% Low* – 30% * This category to include low care needs or housing-related support needs only.
Care charges paid to?	Birmingham City Council
Care staff structure - posts and number in team	Care Manager works 9 – 5 weekdays co-ordinating the service, responding to emergencies and covering when people are absent. Manager's post is added to hours and paid for in addition rather than being added to the unit cost of the contact time. 9 care and support workers
Minimum cover requirements	At least one care and support worker on site at all times – made up of sleeping night worker, care manager's post and care support worker time.
Care hours and distribution of hours during the day	300 care hours per week, 80 support hours, plus 37.5 hours combined care and support manager time - Block purchased.
Night time cover	Combined care and support sleeping night cover of 1 person 10 p.m. – 7.15a.m = 64.75 hours per week including handover time
Shift patterns	3 on between 7 a.m. and 2.30

	3 on between 2.30 and 10.p.m. Care Manager 9-5 weekdays Additional staff as needed
Any responsibilities apart from those relating to care?	Yes – housing-related support (in addition to that provided by EM)
Additional scheme features	Lunchtime meal (Condition of Tenancy) cooked on the premises provided 7 days a week and served in dining room.

DENHAM GARDEN VILLAGE, ANCHOR TRUST

MIXED TENURE VILLAGE

Name of Scheme	Denham Garden Village
Number of Units and tenure	184 leasehold houses and apartments for outright sale 143 properties for rent, nominations come via Licensed Trade Charity who have first refusal on all void rental properties
Housing Provider	Anchor Trust
Care Provider	Anchor Trust registered as domiciliary care providers
Care Commissioner	Individual residents except where care spot purchased for individual residents by Social Services.
Thumbnail sketch of model it's illustrating	Local authority has not been involved in the development of this scheme, but has agreed to spot purchase care from the on-site provider for those assessed by SSD as needing care. Access to 24 hour emergency support is included in service charge but care packages assessed and charged on an individual basis. Denham offers a menu of services from which residents can select.
Fundamentals of eligibility criteria and any target groups	People of retirement age (over 55) who have the resource to purchase the properties, since the village has had no subsidy. A proportion of the lettings come through the Licensed Trade Charity for retired publicans and those with links to the drinks trade,
Care charges paid to?	Anchor Trust unless commissioned by SSD, in which case charge to SSD. Domestic help and support as well as care are charged per hour
Care staff structure - posts and number in team	We have a Registered Manager and approximately 10 staff who offer the care and support packages, as well as staff who cover a 24/7 period for emergency and general support (not care).
Any responsibilities apart from those relating to care?	Housing-related support
Additional Interesting features	Handy-person service available at an hourly rate. The village has a café bar on site open to the wider public, a GP practice which also serves the wider community and a range of leisure facilities including a gym and swimming pool.

OAK HOUSE – HOUSING 21

INTEGRATED[xii] HOUSING AND CARE MANAGEMENT

Name of Scheme	Oak House, Stutton, Suffolk
Number of Units and tenure	38 flats of which 8 two bedroom flats. One flat is a respite flat and one is for intermediate care. Assured Tenancies
Housing Provider	Housing 21
Care Provider	Housing 21. Up until July 2009 when the care was retendered, the care team were seconded to Housing 21 from Suffolk Social Services. Since then they have been TUPE transferred to Housing 21
Care Commissioner	Suffolk County Council. The contract is reviewed annually having previously been five yearly.
Thumbnail sketch of model it's illustrating	Integrated management model where Housing 21 is responsible for the housing and care delivery. Oak House opened in 2004 and is an extra care scheme in a rural area intended for older people with a range of conditions including dementia, physical disability and sensory impairments. Stutton is a small village on the Shotleigh Peninsula roughly 8 miles away from Ipswich. Oak House was built as a replacement for an old residential care scheme in Stutton. Staff and residents transferred from here to Oak House. Housing 21 employs scheme manager ("Court Manager") who manages all services on site. All staff including care staff are employed by H21 including P/T admin assistant, cleaners, P/T activities co-ordinator and P/T handyman. Care and housing-related support delivered by same staff group. An on-site day centre is held 3 days a week and there are 40 places in all – 15 on a Tuesday and Thursday, 10 on a Wednesday. The Day Centre Co-ordinator and support staff are employed by Housing 21. When it opened, Oak House had a specialist 'pod' of six flats intended for people with dementia. The effectiveness of this model has been evaluated, and in 2009 it was decided to decommission it for a number of reasons, including the fact that people in other parts of the scheme developed dementia, so concentrating staff time in the pod no longer made sense. Whilst there are still people with dementia in the former specialist units, the 'pod' itself has now been opened up and staff have worked to integrate it into the wider scheme.
Fundamentals of eligibility criteria and any target groups	All applicants should need a minimum of four hours personal care. They should also have a housing need, a local connection to the area and be aged 55 or over.

[xii] See p12 on risks of having a single organisation providing accommodation and care

Care charges paid to?	Paid to Social Services in accordance with Suffolk County Council's domiciliary care charging policy. Following "Fairer Charging" financial assessment, Social Services bill residents on the basis of the actual amount of care delivered. A small number of residents purchase a few additional hours privately from Housing 21 direct.
Care staff structure - posts and number in team	Full-time Scheme Manager Seniors – 3 Support Assistants – 4 night-time and 12 daytime (mostly on part-time contracts) There are currently 25 staff who have varying contracts.
Minimum cover requirements	Always a senior member of staff on duty during the day and most nights. We are contracted to provide two waking night staff with the staffing in the day being based on the care needs of the service users. Never less than three care/support staff on duty at any one time during the day. This is operationally determined rather than being a requirement of the Commissioner. For example, if less residents required care then the numbers of staff on duty at any time would reduce accordingly.
Care hours and distribution of hours during the day	The contract is for 523 hours (day and night-time) Block = 390 day hours daytime Additional hours are 'spot purchased'.
Night time cover	2 waking members of staff 133 hours per week
Shift patterns	In order to ensure flexible and responsive service delivery, Housing 21 has moved away from a regimented shift pattern although there are still some shifts in place – some staff start at 7am, others at lunchtime.
Any responsibilities apart from those relating to care?	Yes, housing-related support. Seniors also deal with urgent building and housing management tasks when Scheme Manager off site.
Additional Interesting features	The restaurant opened roughly a year after the scheme opened. It is run by a local business who also runs restaurants and meals delivery services at Housing 21's other extra care sites in Suffolk. Nearly all of the residents have chosen to have a mid-day meal at the restaurant. A minority have meals delivered to their flats having been prepared in the restaurant kitchen. The restaurant is successful largely because most of the residents have fairly high dependency levels and are unable to cook their own meals. Additionally the restaurant provides a venue for social interaction.

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ABOUT THE HOUSING LEARNING AND IMPROVEMENT NETWORK (LIN)

The Housing LIN is the national network for promoting new ideas and supporting change in the delivery of housing, care and support for older and vulnerable adults, including people with disabilities and long term conditions.

The Housing LIN has the lead for supporting the implementation and sharing the learning from the Department of Health's £227 million Extra Care Housing Grant arrangements and related housing, care and support capital and revenue programmes.

For further information about the Housing LIN and to access its comprehensive list of on-line resources, visit www.dh.gov.uk/extracare

The Housing LIN welcomes contributions on a range of issues pertinent to Extra Care housing. If there is a subject that you feel should be addressed, please contact us.

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