# Housing Learning & Improvement Network

The Health and Social Care Change Agent Team (CAT) was created by the DoH to improve discharge from hospital and associated arrangements. The Housing LIN, a section of the CAT, is devoted to housing-based models of care.

# Intermediate Care Services within Extra Care Sheltered Housing in Maidenhead

An example of an integrated intermediate care service providing short term, intensive support and assistance combined with the facilities and services offered by extra care sheltered housing

**STRATEGIC PLANNING IN PARTNERSHIP FOR EXTRA CARE HOUSING**

**Local Authority:** Royal Borough of Winsor and Maidenhead

**PCT (Health):** Winsor, Ascot and Maidenhead Primary Care Trust

**Lead contact:** Ed Thompson, Joint Commissioning Manager, Social Services, Royal Borough of Winsor and Maidenhead

**Housing Association:** Maindenhead and District Housing Association

## Aim

To prevent hospital admissions and to facilitate quicker and more flexible hospital discharge for older people who need rehabilitation or who cannot return directly to their own homes.

## Key Strategic Issues

- Policy objective to maintain and extend older people's capacity to live independently; also to promote a focus on rehabilitation to help people regain their skills and confidence;
- Strategic goal of re-orienting the wider home care service away from a task-based approach ('doing for people') and towards a rehabilitative model;
- Distinction between short term and long term home care services, with the former geared up to meet immediate and crisis needs;
- Aim of integrating intermediate care into the mainstream of local health and social care services;
- Development of sheltered housing as a multi-purpose resource, which supports wider health and social care goals and responds to the needs of increasing numbers of frail older people;
- Government policy of facilitating timely hospital discharge, combined with local concern about unnecessary admissions to hospital for non-medical reasons;
- Government target for local authorities to provide intensive support at home to a growing proportion of older people receiving services.

## Local service context:

The intermediate care service in Windsor and Maidenhead is a partnership between the local authority Social Services Department, the Primary Care Trust and Maidenhead and District Housing Association. The Head of Joint Intermediate Care is employed jointly by Social Services and the Primary Care Trust, while the service manager and frontline care staff are employed by Social Services. The sheltered housing manager lives on-site and works for the housing association.

The intermediate care service is part of the wider Rapid Response and Rehabilitation Team and the service manager also has responsibility for the short term rehabilitation team, which helps people living at home. The Rapid Response and Rehabilitation Team has been in operation since 2000, when some members of home care staff were taken out of the main team and freed up to work more flexibly in response to crisis. The team was originally set up for six months but this was extended because it was seen to be making a valuable contribution. It developed into an intermediate care service after the National Service Framework for Older People came out, with its aims for Standard Three on intermediate care.

The sheltered housing development opened twenty five years ago and some of the original tenants are still living there. It has since evolved to cater for tenants with higher care needs.

There is a mix of two bedroom, one bedroom and bedsit apartments and the building has recently been re-furbished. It is located in an attractive residential area and blends in well with the surrounding houses. Fifteen of the thirty-two apartments are occupied by people requiring extra care services and a further six are designated for use as intermediate care accommodation. The intermediate care service was launched in July 2004. There is one other extra care housing scheme within the borough and a third, featuring a gym and jacuzzi among its facilities, is due to open shortly.

## How it works:

Referrals to the intermediate care service come from hospital and community based teams and from GPs. There are no self-referrals but people can seek to be referred through any health or social care service. While GPs are now making many appropriate preventative referrals of people who should not need to go into hospital, medical consultants wanting to discharge patients are still inclined to think of the residential care option first. This is changing gradually as the service becomes better known and understood.

Potential clients go through the usual process of care assessment and should be assessed as requiring at least ten hours care and support per week. In some cases, a stay in one of the designated sheltered apartments can also be used as a way of assessing longer term care needs within a normal domestic environment. This also gives individuals and their families the chance to build self-confidence and see what they can do and how they can expect to manage in their own homes.

The allocation of the apartments is decided by the service manager, who needs to make judgements about whether people can be made safe at home instead of coming through intermediate care. During the short time that the service has been operating, there have been periods of high demand and competition for places. Stays are expected to last around six weeks, after which most people go home but some may move to another sheltered housing or extra care housing scheme.

While the service is explicitly designed to be short term, it is fully integrated with the generic and long term home care service. A proportion of clients have predominantly social needs which have affected their skills and ability to cope (e.g. isolation, illness or death of family carer, loss of structure in daily life). The service primarily works with older people who live alone. Housing issues feature quite prominently among the reasons why people come into the service, although the local experience is that property adaptations are now being processed and carried out more efficiently than before.

The model of support is enabling and facilitative. The aim is to work towards a highly flexible and person-centred service, where eventually clients will know how many hours of assistance they have and can choose how that support time is spent. While personal care will always be important, the main emphasis is on rehabilitation and regaining skills. The team are on waking duty within the sheltered scheme 24 hours a day and cover both the short term/intermediate care and the long term accommodation for tenants with extra care needs.

The staff team comprises people with a range of levels and types of skills, including care managers, occupational therapists and physiotherapists. There are also highly trained administrative staff, who take referrals and make initial decisions about whether the person should be assessed or referred on to a more suitable service. While in intermediate care, clients also have access to the services of the Welfare Benefits team, who will check to ensure that they are receiving all the benefits that they are entitled to.

**Examples:**

- A woman with terminal illness, who was neglecting herself and losing the skills to manage in her own home. She came into the intermediate care service so that she could be helped to re-establish routines and assert her capabilities. After five weeks, she was still living in the sheltered housing and making good progress.

- Two clients who had had falls and were in full-leg casts. Coming into the service for a short period allowed them greater mobility, gave them necessary assistance with personal care and meant that the staff could demonstrate the use of different items of equipment that might be helpful when they returned home.

- A man with symptoms of dementia exhibiting difficult behaviour and causing distress to his neighbours. He was disoriented when he entered the service, but this was turned around within a few days once he started to receive intensive support.

- A woman who had started using an extra wide wheelchair and needed to wait for adaptations to be carried out to her home.

**Resources:**

The service is jointly funded by the local authority (Royal Borough of Windsor and Maidenhead) and the Windsor, Ascot and Maidenhead Primary Care Trust. Government support has been provided in the form of an 'Access and Systems Capacity Grant', which can be used to fund a number of types of services, including intermediate care. Other boroughs within Berkshire and elsewhere have chosen to use funds to promote different service models, so local patterns of services are developing quite variously. In Windsor and Maidenhead, the developmental focus for older people has been on short term, rehabilitative services, including accommodation for those who cannot be supported at home.

Clients using the intermediate care services are not financially assessed and receive free services, although they enter means-testing and charging if they move on from short term/intermediate care support to longer term home care services. This follows the *Community Care (Delayed Discharge etc) Act 2003*, which removed social services' ability to charge for community equipment and intermediate care services, so that the services could be provided jointly with the NHS.

## Benefits of service:

The multi-disciplinary nature of the team means that it can offer routes into all other services within the local health and social care system. For example, clients can readily be referred on to a day hospital, to extra care housing or to long term home care. The strong partnership between social care, health and housing professionals is evident at all levels, from senior management to frontline staff. The cross-fertilisation of ideas and skills can help to create a culture which is empowering for staff, as they know they can draw on other resources to enhance their own input and learning.

The service is relatively highly staffed, which is essential if it is to be able to respond to crisis and complex situations at any time of day or night. For example, the three staff based at the sheltered scheme overnight may be called on to take people to Accident and Emergency or to assist with hospital admission, as well as providing routine night care and cover.

In the relatively short time that the service has been running, there has been very positive feedback from clients and their families. People appreciate the fact that the intermediate care accommodation offers a breathing space, usually after a difficult and disruptive period, where they can take stock of their situation and test out their skills and abilities. It may also help them to test out different kinds of aids and equipment, or allow time for home adaptations to be designed and carried out. This can ensure that the right decisions are made and that people will be comfortable with using the equipment once they get home. For some clients, a further advantage of this model of intermediate care is that they find out what it is like living in sheltered housing and can make an informed decision about whether they would like to stay in such accommodation on a long term basis.

A national evaluation of intermediate care services has been commissioned by the Department of Health and the results are expected in 2005/06.

## Challenges and learning points:

- The Windsor and Maidenhead intermediate care service has a pivotal role in the local economy of health, social care and housing. As an integrated and jointly managed service, it has strong links to the other relevant services for older people and operates effectively as a bridge and an access route.

- It is important to educate staff in mainstream health services about the objectives, specific features and potential benefits of intermediate care accommodation. This can apply particularly to senior hospital doctors, for whom the model of extra care housing may be unfamiliar or perhaps indistinguishable from a residential care home.

- It is difficult to estimate the level of need for short term accommodation, but the Windsor and Maidenhead experience shows that extra care housing offers a setting for flexible services which can respond to a wide range of needs (rehabilitation; learning to use equipment; testing out skills; waiting for adaptations etc). The Windsor and Maidenhead example of starting small and seeing how demand evolves seems to be a sound approach.

- The work involved in the 'hotel' aspects of the service should not be underestimated. Time is needed to prepare the apartments for use and to assist the temporary residents with the practical matters which inevitably arise when they are moving in or out. Arrangements with the housing provider may prevent this work becoming too much of a time commitment for frontline care and support staff.

Case study prepared by **Lynn Watson**, Pathways Research, 2005

Other Housing LIN publications available in this format:

Case Study no.1: **Extra Care Strategic Developments in North Yorkshire** (01.09.03)
Case Study no.2: **Extra Care Strategic Developments in East Sussex** (01.09.03)
Case Study no.3: **'Least-use' Assistive Technology in Dementia Extra Care** (02.02.04)
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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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