



Care and Support in Extra Care Housing

This 2010 Technical Brief has been edited to remove outdated policy information and case studies. It retains the original sections on commissioning care and support in Extra Care Housing, legal relationships, care delivery and how much care. These remain relevant although some source documents have been superseded and terminology changed.

The policy sections have been replaced by the October 2015 Policy Technical Brief, *Care and Support in Housing with Care for Older People* and the case study section has been replaced by the Case Study Report *Approaches to the Procurement and Delivery of Care and Support in Housing with Care*.

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INTRODUCTION

The Housing LIN has published a new Technical Brief which provides a comprehensive overview of care and support policy in Housing with Care for older people. However, we have also edited the existing document so that pertinent aspects, such as practice and operational matters not covered in the new document can still be accessed. Sections of this 2010 Technical Brief which have been superseded by the new separate standalone Housing LIN documents have been removed.

The replacement standalone documents are:

1. *Care and Support in Housing with Care: Policy Technical Brief – 2015 (Policy Technical Brief)*¹
2. *Approaches to Procurement and Delivery of Care and Support in Housing with Care – A case study report – April 2015 (Case Study Report)*²

The Housing LIN *Funding Extra Care Housing* Technical Brief (2013) also contains relevant information.³

Two discussion papers⁴ written in 2013 supplement the information contained in this 2010 Technical Brief:

Improved personalisation in Housing with Care for Older People? and
Improved personalisation in Housing with Care for Older People? Conclusions from Feedback to Discussion Document

The Housing LIN publications above replace the following 2010 Technical Brief topics:

- Section 1: Characteristics of Care and Support in Extra Care including definitions, regulation and distinctive features of care in extra care housing (now in Policy Technical Brief)
- Parts of Section 2: Procuring both care and support from a domiciliary care provider; case studies (replaced by 2015 Policy Technical Brief and Case Study Report. The Case Study Report includes updated versions of some of the 2010 case studies)
- Section 3: Revenue and Charging arrangements (covered in all three documents)
- 2005 case studies

Other sections remain potentially useful (see Index for content) and so have been left in this edited version of the 2010 Technical Brief. The text in these sections has not been changed other than to introduce an editor's note (in italics) at the start of a section or sub-section.

Terminology has not been updated. For example, the concept of personalisation first appeared under the "Putting People First" banner. There have been many publications since, many by Think Local Act Personal (TLAP), the Department of Health and ADASS which have "put flesh on the bones", but the core principles remain much the same. Interestingly, even the term "personalisation" seems to have been superseded. It is not used in the Care Act 2014 although its key tenets run through all aspects of the Act and statutory guidance – indeed individual wellbeing is the key driver of the Act.

¹ www.housinglin.org.uk/_library/Resources/Housing/Support_materials/Technical_briefs/HLIN_PolicyTechBrief_CareAndSupport.pdf

² www.housinglin.org.uk/Topics/browse/HousingExtraCare/ExtraCareProvision/SupportServices/?&msg=0&parent=990&child=9555

³ www.housinglin.org.uk/Topics/browse/HousingExtraCare/FundingExtraCareHousing/

⁴ www.housinglin.org.uk/Topics/type/resource/?cid=8830&msg=0

SECTION 1

CHARACTERISTICS OF CARE AND SUPPORT IN EXTRA CARE

Ed Note 2015: This section which included definitions of key terms, the regulatory framework and distinctive features of care in extra care housing have been superseded by the 2015 Policy Technical Brief.

SECTION 2

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

Ed Note 2015: The introduction to this section and Procuring Both Care and Support from a Domiciliary Care Provider have been removed.

A. PERSONALISATION AND EXTRA CARE

Ed Note 2015: This topic has been retained although the information sources have not been updated as the concepts and models remain central to the procurement and delivery of care and support in housing with care settings.

1.0 PUTTING PEOPLE FIRST

- 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”⁵ “through personalisation, prevention and early intervention”⁶
- 1.2 “In the future, we want people to have maximum choice, control and power over the support services they receive.”
- 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”

⁵ HM Government. (2007) *Putting People First: A Shared Vision and Commitment to the Transformation of Adult Social Care*

⁶ Routledge, M. (2009) *Personalisation: Implications for Providers*. A presentation

- 1.4 The four main themes at the heart of Putting People First are⁷
- 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
 - includes greater emphasis on self-assessment
 - person centred planning and self-directed support becoming mainstream
 - tailoring services to an individual’s needs
 - personalised budgets for everyone eligible for publicly funded adult social care support other than in an emergency
- 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.”⁸ One of these core components reads:
- 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...”⁸
- 1.7 The Local Authority Circular LAC (DH)(2010) on *Transforming Adult Social Care*⁹ gives local authorities information on the use of the final tranche of the Social care Reform Grants and reinforces these messages.
- 1.8 All of the above is commonly referred to as “the personalisation agenda”.

2.0 FUNDING ASPECTS

- 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.

⁷ Department of Health. (2008) *Making a Strategic Shift Towards Prevention and Early Intervention*

⁸ Department of Health. (2009) *LAC(DH)2009 1: Transforming Adult Social Care*

⁹ Department of Health. (2010) *LAC(DH)(2010)1: Transforming Adult Social Care – the Social Care Reform Grants*

- 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.” 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”¹⁰
- 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.¹¹ 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.

2.2 Personal budgets 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.

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

3.0 EXTRA CARE HOUSING AND THE PERSONALISATION AGENDA

3.1 As mentioned earlier, there is no universally accepted definition of Extra Care Housing (ECH). 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.

¹⁰ Department of Health. (2010) *Personal Budgets for Older People – Making it Happen*

¹¹ HM Government. *Community Care (Direct Payments) Act 2006*

- 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 These issues are explored more fully in the discussion paper *The ‘Putting People First’ Agenda and Care and Support Provision in Extra Care Housing*.¹²

4.0 MODELS FOR COMMISSIONING¹³ CARE AND SUPPORT IN ECH

2015 Ed Note: *This section has been retained although some aspects are also covered in the Funding Technical Brief and the Procurement case study report because the discussion of the pros and cons of the different models still apply. Options A to D represent points on a spectrum while Options E and F can be applied to any of the other option.*

4.1 Introduction

- 4.1.1 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.
- 4.1.2 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.

4.2 Option A: Spot-purchasing

- 4.2.1 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. 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.

¹² Garwood, S. (2009) *The “Putting People First” Agenda and Care and Support Provision in Extra Care Housing – A Discussion Paper*

¹³ 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”

- 4.2.2 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.
- 4.2.3 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
- 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*)

4.3 Option B: Core and add-on

- 4.3.1 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.
- 4.3.2 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.
- 4.3.3 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 benefit.

- 4.3.4 While a grant is a safe approach, there is no mechanism for the council to collect charges.
- 4.3.5 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.
- 4.3.6 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.
- 4.3.7 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.
- 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.¹⁴ 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'*¹⁵). 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 not be a good model.
- 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.

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

4.4.1 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 section entitled “How Much Care?”)*

4.4.2 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.

¹⁴ 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.

¹⁵ Vallely, S and Manthorpe, J. (2009) *Building Choices Part 2: ‘Getting Personal’ – The Impact of Personalisation on Older People’s Housing* and associated presentation.

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.

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

4.5.1 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.

4.6 Option E: Co-production or social enterprise models

4.6.1 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.

4.7 Option F: Pump-Priming model

4.7.1 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.

4.7.2 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?
- Are charging arrangements lawful, fair and clear?
- Does the approach risk not being exempt from local reference rents?

5.0 LOOKING AHEAD

2015 Ed Note: *Some of the following developments have come to fruition. Progress on others has yet to come but has been given added impetus by the Care Act and recent TLAP and other publications.*

5.1 Introduction

5.1.1 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 Extra Care Housing 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.

5.1.2 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.”*¹⁶ 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.

¹⁶ Look Ahead and Tower Hamlets. (2010) *Choice, Control and Independence: Personalising Block Contracts in Supported Housing*

5.2 Provision of information and brokerage

- 5.2.1 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 ECH and develop their support plan, including how they wish to manage their personal budget.
- 5.2.2 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.
- 5.2.3 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.

5.3 Personalisation of the assessment and support planning process

- 5.3.1 "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."¹⁷
- 5.3.2 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.
- 5.3.3 *Personal budgets for older people*¹⁷ 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.

¹⁷ Department of Health. (2010) *Personal Budgets for Older People – Making it happen*

5.4 Personal Budgets

- 5.4.1 “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”¹⁷
- 5.4.2 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.
- 5.4.3 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”¹⁸
- 5.4.4 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.
- 5.4.5 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.”¹⁹ These are described in detail in *Contracting for Personalised Outcomes: Learning from emerging practice*²⁰
- 5.4.6 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.
- 5.4.7 Five factors for making personal budgets work for older people are described in *Personal Budgets for Older People* 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.

¹⁸ Adass, LGA and I&DeA. (2009) *Making Progress with Putting People First: Self-directed Support*

¹⁹ Department of Health. (2010) *Personal Budgets for Older People – Making it Happen*

²⁰ Department of Health. (2009) *Contracting for Personalised Outcomes: Learning From Emerging Practice*

- 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.

5.5 Outcome-based commissioning

5.5.1 “Services should be commissioned to more flexible, outcome-focused specifications to ensure that they are fully integrated around the needs of the individual.”²¹ Some commissioners are already using outcome-based specifications for the care and support service in Extra Care Housing.

5.5.2 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.

5.6 Co-production

5.6.1 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.” We are likely to see more of this along with greater peer-to-peer support in Extra Care Housing, although older people at the frailer end of the spectrum may not embrace it as readily as fitter, younger people.

²¹ Department of Health. (2009) Guidance on Direct Payments

- 5.6.2 Social 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*).
- 5.6.3 For some commercial providers, predominantly of Extra Care Housing for sale, there are models where leaseholders own the freehold or have a majority interest in the on-site management company. In such examples, they take shared responsibility for service charges arrangements.
- 5.6.4 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.
- 5.6.5 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.

Up2Us Co-Production Pilot in ECH

Harp House 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.

5.6.6 *A Guide to Co-Production with Older People*²² 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.

5.6.7 It 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?.

²² NDTi and Helen Sanderson Associates. (2010) *Personalisation – Don't just do it – Co-produce it and Live it*

B. CARE PROCUREMENT

1.0 Contract Type

- 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.
- 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.
- 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.”²³ 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.
- 1.4 The advantages and disadvantages of these different procurement approaches have already been covered and will not be repeated here.

2.0 Length of Contract

- 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.
- 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.
- 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.

²³ Department of Health. (2009) *Contracting for Personalised Outcomes: Learning from Emerging Practice*

- 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.
- 2.5 Where integrated housing and care management 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.

3.0 A Partnership Approach

- 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.
- 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.
- 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.

4.0 Involvement of Housing Provider

- 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.
- 4.2 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.
- 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 may also provide housing-related support funded by the local successor to Supporting People. If the housing provider holds the contract for the housing-related support at the scheme, it will be held responsible for the element of support sub-contracted to the care provider.

5.0 Involvement of Extra Care Housing Occupants

- 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.

6.0 Information to Prospective Care Providers

- 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?”*)
 - 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

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.

7.0 Key Qualities

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

8.0 Timing of Procurement

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.

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.

9.0 Specification

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.

- 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?”)

C. HEALTH CARE IN EXTRA CARE HOUSING²⁴

- 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-patient services, community mental health teams etc.
- 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*²⁵)
 - basing GP surgeries and health clinics in ECH (See Case Study 47: *Integrating Extra Care Housing in Staffordshire*)
 - funding the training of care staff in undertaking minor health tasks such as applying ointments and dressings
 - funding training in cognitive stimulation therapy, stroke therapy, rehabilitation, end-of-life care etc to equip staff to provide a better service and reduce the number of people needing hospital or residential care (See Case Study 73: *A healthy partnership: predicting future demand for extra care housing in Calderdale*²⁶)
 - funding an on-site nursing provision if a high number of occupants with nursing needs
 - funding and designing extra care housing to enable the delivery of person centred care and support for people with dementia (See Case Study 96: *Beeches Manor Wokingham: a template for Dementia Housing with Care*²⁷)
 - funding well-being and health promotion programmes (See Case Study 38: *Healthy Outcomes in Blackburn & Darwin Extra Care Housing*)
 - joint-funding of the social care provision on the basis that ECH fulfils a preventative and health promoting function (See Case Study 52: *Health, Housing and Care*)

²⁴ See *Transforming Community Services: Enabling New Patterns of Provision*

²⁵ Housing LIN. (2009) *Shortstay intermediate Care services in a Range of Housing and Care Settings*

²⁶ www.housinglin.org.uk/pagefinder.cfm?cid=8878

²⁷ www.housinglin.org.uk/pagefinder.cfm?cid=9361

working together to achieve a Prevention Model of wellbeing in Extra Care at Marina Court, Tewkesbury²⁸ and Case Study 92: The benefits of extra care housing on the quality of life of residents: The impact of living in Campbell Place, Fleet²⁹)

- combatting loneliness and isolation by accessing quality onsite care and support so that residents in ECH lead more fulfilling lives (See Case Study 91: *Getting the housing offer right for older people: Dreywood Court, Romford³⁰*)

COMMISSIONING OF CARE & SUPPORT IN EXTRA CARE - KEY POINTS

- 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..

²⁸ www.housinglin.org.uk/pagefinder.cfm?cid=8039

²⁹ www.housinglin.org.uk/pagefinder.cfm?cid=9331

³⁰ www.housinglin.org.uk/pagefinder.cfm?cid=9278

D. CASE STUDIES

2015 Ed Note: This section has been removed and replaced by the Case Study report which includes updated information on some of the case studies originally included here.

SECTION 3

REVENUE AND CHARGING ARRANGEMENTS

2015 Ed Note: This section has been replaced by the Funding Technical Brief, the 2015 Policy Technical Brief and the Case Study Report. The 2015 document has the most recent policy content and the Case Study Report has the most recent practice content.

SECTION 4

LEGAL RELATIONSHIPS

2015 Ed Note: The legal relationships described here remain valid and relevant although the Supporting People Administrative Authority has been replaced by Adult Social Services where housing-related support is still commissioned. Also, with the new benefit rules in relation to different categories of supported housing, the Turnbull Judgement doesn't apply. TLAP have recently published a document "Individual Service Funds (ISFs) and Contracting for Flexible Support" which, for the first time, helpfully clarifies the legal position of Individual Service Funds as a form of local authority-managed budget:

www.thinklocalactpersonal.org.uk/Latest/Resource/?cid=10714

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."³¹
- 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."³²
- 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.

³¹ Adass. (2009) *Personalisation and the Law: Implementing Putting People First in the Current Legal Framework*

³² Adass, LGA and I&DeA. (2010) *Personal Budgets: Council Commissioned Services Advice Note*

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.

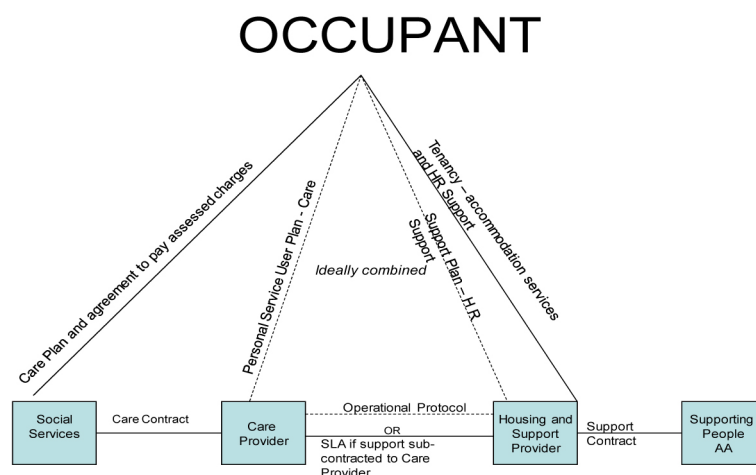
- Adult Social Services and the care provider have at least one contract for the care provision – there may be a volume based contract for the occupants of the facility up to a certain level, and individual needs above that level met under a distinct clause or agreement.
- The care provider is the means 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 Futures³³ 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.

- The Supporting People Administering Authority (previously) and now Adult Social Services 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.
- 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

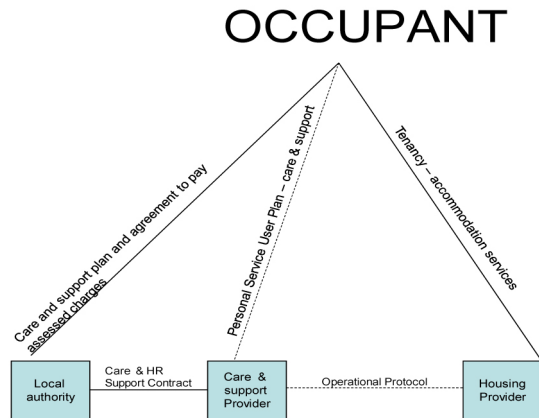


Social Services commission care – separate housing and care provider

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

³³ 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.

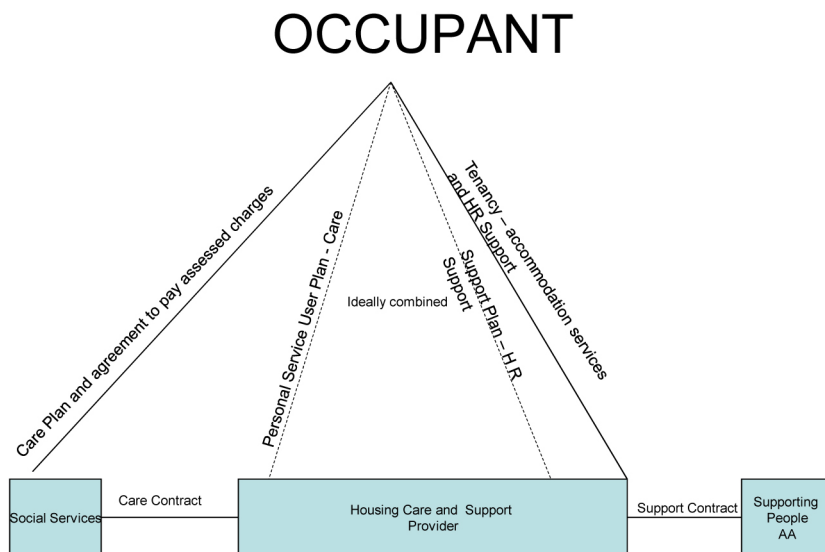
Diagram 2: Local authority commissions care and HR support from care provider



Local authority commissions care and HR support from care provider

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

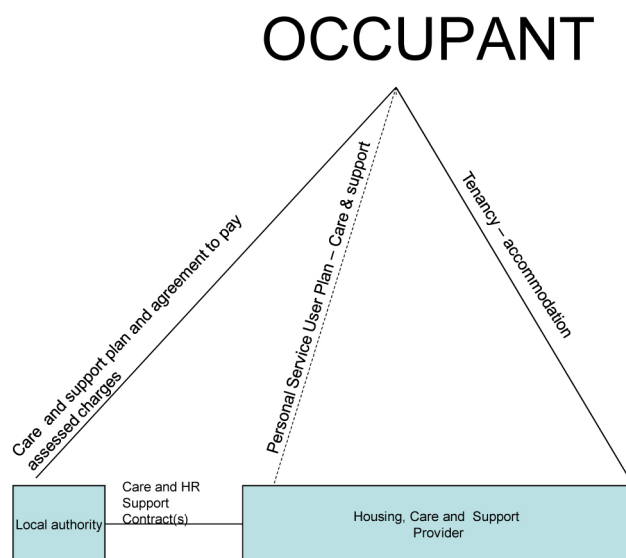
Diagram 3: Social Services commission care – joint housing and care provider



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

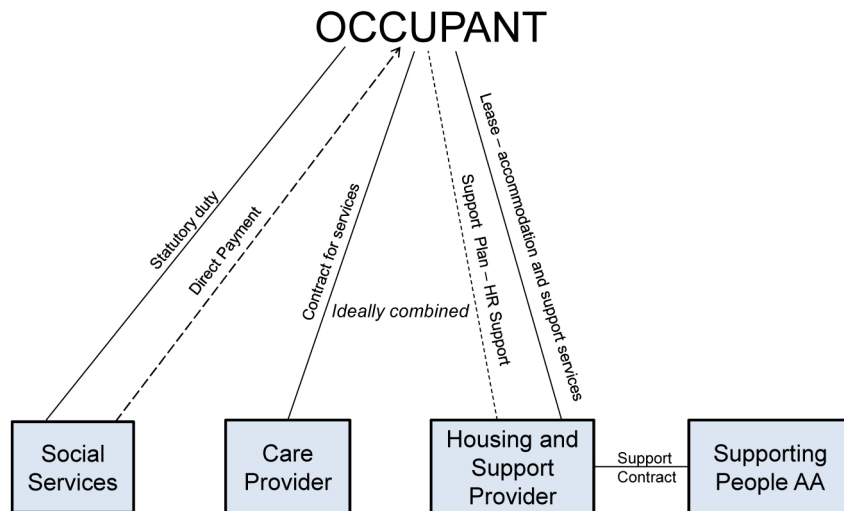
Unbroken line = primary legal relationship or contract Broken line = operational relationships

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

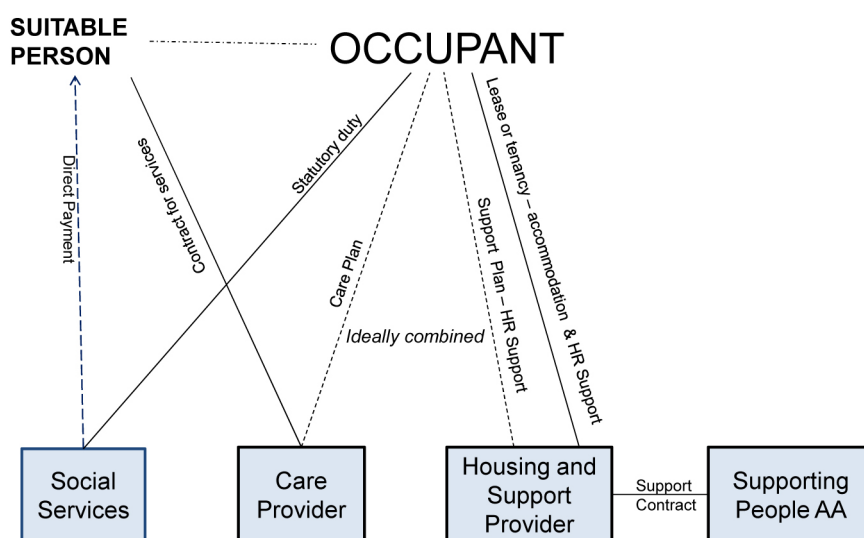
Broken arrow = payment relationship

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

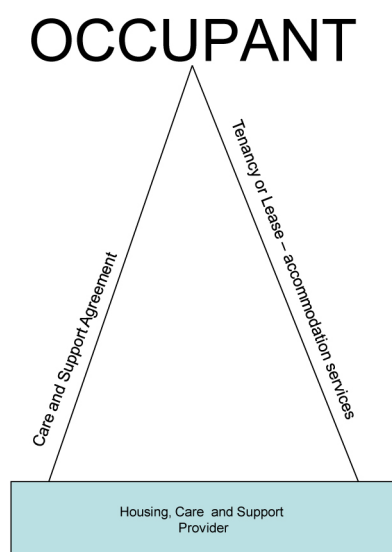
3.1 Self-funders with no local authority involvement

- 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 or directly from a domiciliary care agency.
- 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 guidance³⁴ (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.

³⁴ Care Quality Commission. (2009) *Guidance about compliance: Essential Standards of Quality and Safety*
2015 Ed Note: This Guidance has been superseded but the point still holds good

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



Self-funders – Lease or rent – no Social Services or SP Involvement

Unbroken line = primary legal relationship or contract

3.2 Local Authority Involvement in commissioning care and/or support

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

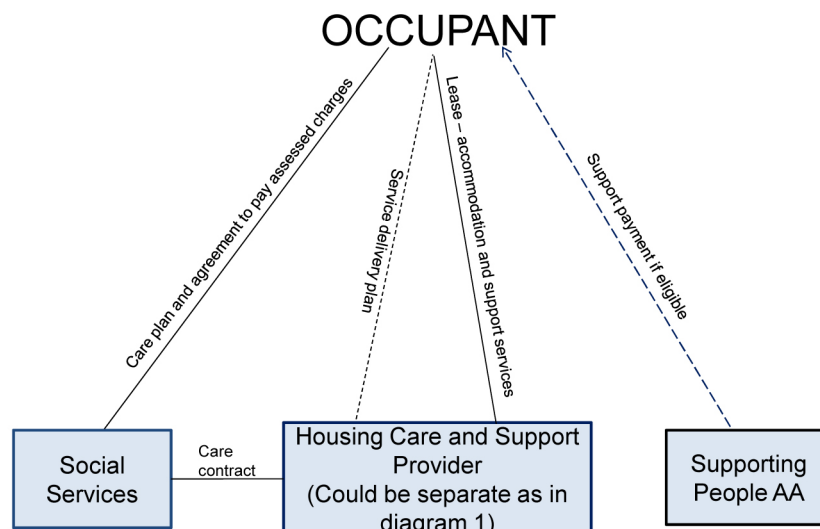
- The individual elects to enter the scheme and purchase on whatever arrangements are offered by the landlord and/or care provider
- The care provider, as part of the sales process (or offering a tenancy in a market rent scheme), assesses the care needs rather than social services. Commonly they will 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, financial assessment etc, as those in any other domiciliary setting. 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.

- **2015 Ed Note:** Supporting People funds were also potentially available to provide support to less well off vulnerable owners. Under previous CLG guidelines, it was a local choice whether or not to make SP funding available to leaseholders. Where it was, those in receipt of pension credit were likely to be funded if they were assessed as needing housing-related support. In this scenario, the owner-occupier related directly to the Supporting People Administering Authority although their relationship was not a contractual one. SP paid the owner-occupier who had the contractual relationship with the landlord and paid the landlord the Support Charge – usually part of the service charge, assuming the support was provided for as part and parcel of the lease. This source of funding is unlikely to apply now but the legal relationships in the following diagram would apply.

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

2015 Ed note: *The range of potential care providers remains much the same as outlined in this section, but the move appears to have been towards housing providers taking on more responsibility for providing the care, either directly or indirectly (via partnerships or sub-contracting). For examples of this trend, see the Case Study Report “Approaches to Procurement and Delivery of Care and Support in Housing with Care”.³⁵*

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.

1.1.3 It is possible that with the emphasis on improved integration, there will be multi-disciplinary teams providing a range of care services.

1.2 Independent Care and Support Agencies or Social Enterprises

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

³⁵ www.housinglin.org.uk/pagefinder.cfm?cid=9555

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.

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

2010 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.*

2015 Ed Note: *The above caution still applies*

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.³⁶ This Brief will briefly look 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

³⁶ Housing LIN. (2005) Factsheet 9: *An Introduction into Workforce Issues in Extra Care Housing*

- 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?

2015 Ed note: *The points made in 1.1 below apply even more now than they did in 2010. Personal Budgets have been placed onto a statutory footing in the Care Act 2015 (See 2015 Policy Technical Brief) and the core and add-on model of care delivery has been a growing feature in Extra Care Housing (See Case Study Report on the Procurement and Delivery of Care and Support in Housing with Care.) We are seeing a shift of risk and responsibility for care procurement and delivery onto housing providers and tight financial margins mean that great caution is likely to be exercised in staffing levels. These factors mean that teams of staff and generous staffing levels will be more difficult to achieve, even when these are seen as desirable. Nevertheless the factors and consideration outlined in this section may be useful in determining the configuration of the care service and staffing levels.*

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 p8), 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.

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 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.

2010 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	s	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.

2010 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*” p21) 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

2015 Ed Note: *With the move from large block contracts to the core and add-on model of care provision, long, inflexible fixed shifts and rotas may not be suited to the demands of occupants' care plans. Similarly full-time contracts for care staff are less suited to the fluctuations in demand where much of the care is in effect "spot-purchased". Zero hour and part-time contracts allow for greater flexibility but may not suit care staff who require greater predictability of work patterns and income. For more consideration of this issue, see the discussion papers at the following link: www.housinglin.org.uk/Topics/type/resource/?cid=8830&msg=0*

- 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

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About the Housing LIN

Previously responsible for managing the Department of Health's Extra Care Housing Fund, the Housing LIN is the leading 'learning lab' for a growing network of housing, health and social care professionals in England and Wales involved in planning, commissioning, designing, funding, building and managing housing, care and support services for older people and vulnerable adults with long term conditions.

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