Housing Learning & Improvement Network

An introduction to Extra Care Housing and Intermediate Care

This fact sheet provides an introduction to Extra Care Housing (ECH) and the links with the development, implementation and delivery of intermediate care.

Prepared for the Housing Learning & Improvement Network by
Martin Shreeve & Nigel Appleton, Contact Consulting

The Health and Social Care Change Agent Team (CAT) was created by the Department of Health to improve hospital and social care associated arrangements. The Housing Learning & Improvement Network, a section of the CAT, is devoted to housing based models of care and support for adults.

DH Department of Health

Other Housing LIN publications available in this format:

Factsheet no.1: **Extra Care Housing - What is it?** *This factsheet gives essential basic information, explains the various forms extra care housing takes, and describes key ingredients and central principles (28.07.2003 updated August 2004)*

Factsheet no.2: **Commissioning and Funding Extra Care Housing** *Summary of essential facts about commissioning extra care and other housing based solutions for care. Most important facts about funding, what is involved, who is involved, who has to be involved and how long projects can take.(28.07.2003 updated August 2004)*

Factsheet no.3: **New Provisions for Older People with Learning Disabilities** *An introduction to the characteristics and needs of an emerging group to be provided for in developing new housing and services for older people. This includes extra care (23.12.2003 updated August 2004)*

Factsheet no.4: **Models of Extra Care Housing and Retirement Communities** *An explanation of the different types or retirement community and examples of how key decisions about the choice of model are made (04.01.2004 updated August 2004)*

Factsheet no.5: **Assistive Technology in Extra Care Housing** *AT can play a part in supporting people in extra care housing. Summary of the most common applications, with examples and where to get more details (20.02.2004 updated August 2004)*

Factsheet no.6: **Design Principles for Extra Care** *Basic information about key design principles and issues to consider when designing and developing a brief for a new Extra Care Scheme. Variety of models and ways of developing a range of different sites (26.07.2004)*

Factsheet no.7: **Private Sector Provision of Extra Care Housing** *The private sector has had an involvement in the provision of extra care housing for at leas 20 years. This factsheet is intended to help statutory authorities commissioning extra care housing and private developers work together with a better understanding (21.07.2004)*

Factsheet no.8: **User Involvement in Extra Care Housing** *The role of the users in the development and management of extra care schemes, linked to concepts of independence, self determination, control and choice, key themes in national policy (24.08.2004)*

Factsheet no.9: **Workforce Issues in Extra Care Housing** *One of the most important issues in Extra Care Housing is the quality of the local management team and the quality of the provision of care and support services to the tenants (04.01.2005)*

Factsheet no.10: **Refurbishing or remodelling sheltered housing: a checklist for developiong Extra care** *This factsheet provides a framework in decision making for developing Extra Care Housing from ordinary sheltered housing. It is based on work with Trafford MBC and the North West Housing Learning & Improvement Network (04.01.2005)*

Case Study Report: **Achieving Success in the Development of Extra Care Schemes for Older People** *A practical guide to assist developers of Extra Care Housing (July 2004)*

Published by: Housing Learning & Improvement Network
Health and Social Care Change Agent Team
Department of Health, Room LG33
Wellington House
135-155 Waterloo Road
London SE1 8UG

Administration: Housing LIN, c/o EAC
3rd Floor
89 Albert Embankment
London SE1 7TP
Tel 020 7820 1682
email housinglin@e-a-c.demon.co.uk

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1. Introduction and Definition

Intermediate Care: Intermediate care is a range of integrated services designed to:

- Prevent unnecessary admission to an acute hospital bed
- Promote faster recovery from illness
- Support timely discharge
- Reduce avoidable use of long term care
- To maximise independent living

It is envisaged as part of a re-ablement process for an individual requiring a comprehensive assessment prior to the development of a care plan which identifies the active therapy, treatment or opportunity for recovery required. The active intermediate care intervention is seen as essentially short term, usually no more than six weeks, but in some situations considerably shorter. The services are intermediate to care at home or treatment in hospital. They can include:

- home from hospital services
- intensive home support
- day rehabilitation at a day hospital or day centre
- rapid response services
- supported discharge e.g., in extra care housing

Extra Care Housing: Extra Care Housing (ECH) is understood for the purpose of this paper to be integrated housing and care provision with mobility standard, person centered design including facilities for rehabilitation or re-ablement.

The best examples promote a culture of continuous achievement, supportive leisure opportunities and access to wider community activities. Care and support is available 24 hours a day with the capacity through an integrated management of housing and care to flexibly adjust the environmental and care inputs over time to maximise independence and minimise the development of institutional dependence. ECH is seen as a “home for life” where through the provision of appropriate care inputs the need for more institutional care can be obviated.

At present, there is no single or normative definition of extra care, or as it is sometimes called very sheltered, housing. Many schemes that carry the label of ECH are in fact enhanced sheltered housing without integrated management or 24 hour care availability on site (for further discussion see *Extra Care Housing for Older People - An Introduction for Commissioners,* Department of Health).

It is likely that some enhanced sheltered housing schemes could offer the full range of intermediate care interventions envisaged in this fact sheet. Indeed, some local housing authorities, stock transfer housing associations and Registered Social Landlords (RSLs) have developed Intermediate Care facilities in partnership with their local primary care and NHS trusts. This has often been in previous “hard-to-let” or remodelled sheltered housing schemes.

2. Policy and Regulatory Context

From the originating Department of Health Circular (HSC 2001/001) through to the *National Service Framework For Older People (*March 2001) and subsequent guidance such as *Discharge from Hospital: pathway, process and practice* (Department of Health 2003), ECH has been identified as a potential site for an appropriate enabling environment for intermediate care.

Circular HSC 2001/01 describes intermediate care as follows:

a) targeted at people who otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute in-patient care, long term residential care, or continuing NHS in-patient care
b) provided on a basis of a comprehensive assessment, resulting in a structured individual care plan that involves therapy, treatment or opportunities for recovery
c) having planned outcome of maximising independence and typically enabling patients/users to resume independent living
d) being time-limited, normally no longer than 6 weeks and frequently as little as I-2 weeks or less, and
e) involving cross-professional working, with a single assessment framework, single professional records and shared protocols

The Circular suggests “supported discharge arrangements may work well in accommodation that has been appropriately designed and equipped for providing extra support, such as sheltered or very sheltered housing schemes”.

For Registered Social Landlords, the Housing Corporation have taken a “light touch” on the use of Housing Corporation grant for non-housing purposes. This has enabled some RSLs to develop dedicated Intermediate Care facilities within the footprint of an ECH scheme. Further clarification from the Housing Corporation is expected shortly. This should help set out how health and other community related services delivered from ECH can become integral to ECH (and other schemes where care and support services are delivered on-site and/or off-site).

It should also be noted that the regulation and inspection for Intermediate Care services are distinct from the monitoring and inspection arrangements for ECH under Supporting People (support services and costs), the Housing Inspectorate (housing management), the Housing Corporation (capital and development costs) and the Commission for Social Care Inspection (CSCI) for personal care arrangements.

Figure A Regulatory regimes

	Extra Care	**Intermediate Care**
Accommodation	Regulated by the Housing Inspectorate and, for RSLs, by the Housing Corporation	Regulated by the Housing Inspectorate and, for RSLs, by the Housing Corporation
Support	Monitored by Supporting People Administering Authority for the area.	Monitored by Supporting People Administering Authority for the area, but likely to be through specific arrangements distinct from those for Extra Care.
Care	Regulated by the Commission for Social Care Inspection	Monitored by NHS or PCT commissioning service and by Strategic Health Authority

3. Intermediate Care in Extra Care Housing Settings

i) Step Up and Step Down

Extra Care Housing can be resourced not just for supported discharge (Step Down) but also for preventing the need for hospital admission (Step Up). The combination of an environment, which is designed to promote re-ablement and staff to provide temporary therapeutic inputs which facilitate self care and independence can be an effective intermediate resource between home and hospital. An individual who has completed a clinical treatment in hospital but is not yet functionally capable of coping at home can be re-abled in a supportive setting which offers opportunities and experiences more akin to their home environment. However, it will require the individual to be:

- medically stable, able to have their medical and nursing needs met through GPs and District nurses
- have no functional mental health problems
- willing to participate in a therapeutic programme
- having a reasonable expectation of being stabilised within 14 days
- competent to consent to use of the service

ii) Design and Access

Suitably designed and equipped ECH also offers the opportunities of further assessment and trialling of adapted environments and equipment. It also offers the opportunity for confidence building and reflection on what service and support might be needed on return home. It provides the breathing, thinking and planning space not only for the individual older person but for the professionals and non professional carers in the whole system of care to prepare for the transition home. Whilst major adaptation of the home property environment is not feasible in the duration of intermediate care, minor adaptation, stairlifts and the provision of other equipment is possible, much of which can be demonstrated and trialled in the comparatively safe and supervised setting of ECH. (Further information on design principles for ECH are set out in fact sheet 6 in this series at www.changeagentteam.org.uk/housing)

iii) Financial and legal issues

While someone is receiving an active therapeutic programme within an intermediate care setting they remain the responsibility of the NHS and therefore the service remains free at the point of delivery. If an individual then requires on-going domicilliary care and support once they return home or move on to sheltered or ECH, then this would attract a charge under home care and/or Supporting People charging arrangements.

Also, because of the relatively short spells of intermediate care, those receiving therapeutic support in ECH would not become tenants of that scheme. They would be expected to return to their own home, to move on to alternative housing such as sheltered or ECH (whether in the same scheme or a different on) or a long-term care setting.

iv) Benefits of Intermediate Care in Extra Care Housing

Equally some older people who are at imminent risk of acute hospital admission can be appropriately cared for in ECH provided the necessary medical care is available to the individual in the scheme setting. Apart from the initial cost saving to the overall health economy there are other benefits both to the individual and to the whole system from *Step Up* intermediate care in an extra care housing setting. For example, for an individual the avoidance of risk of infection and the loss of confidence for self-care that is so often the consequence of hospital admission are key.

There are also the opportunities for more appropriate assessment in an adapted environment and to trial new equipment (such as telecare) or service models in a relatively stress free setting. Neither should the opportunities for confidence and capacity building be underestimated.

In addition, provided the extra care scheme is within proximity of the normal home environment of the older person the whole system benefits from being able to maintain or only marginally adjust the primary care team inputs to the individual.

v) Avoiding cultural dissonance

The provision of Intermediate Care facilities within an ECH development calls for sensitivity to the impact on the long-term residents of the scheme. Many will have come into the scheme on the basis of its lifestyle claims and may find the emphasis on concentrated professional interventions to achieve rehabilitation that is essential to Intermediate Care to be at odds with that. Others will find the constant change of individuals involved in a time limited stay for those benefiting from Intermediate Care to be disruptive of the settled community within the scheme. This issue may present itself even more sharply in mixed tenure developments. Others of course will welcome the introduction of new people and the re-assurance of knowing that such assistance is available.

vi) other issues

- ECH is primarily a "home for life" concept and care should be taken in developing its intermediate care potential to retain the strengths of the model. The provision of intermediate care should not be allowed to compromise the primary function of providing long term housing for the majority of the resident community.

- Over recent years extra care villages have been developed. They are larger scale than the original extra care schemes and many of those currently in development. They offer a mixture of tenure options and provide a wider range of community services on site. Such village schemes offer greater opportunities to develop the intermediate care facility as a discrete service without disturbing the primary function of a home for life for the majority of tenants or lessees. They also offer the opportunity of extra care to become a greater resource in the local whole system of care, potentially the focus for primary care in the locality or a base for the development for the single assessment process.

4. System and Organisational Requirements

Increased national emphasis on partnership working, and the new incentives in the health and care economies such as reimbursements, payments by result, more intensive home support and the new extra care funding programmes provides the opportunity for further exploiting the potential of ECH. To maximise the "dividend" of intermediate care in an ECH setting demands a partnership approach between health, housing and social care. This is a time-limited, therapeutic process which requires the same discipline as that required for managing effective hospital discharge. Unless staff share the same values and are motivated to see the intermediate care episode as a transition in a wider care plan for the individual then it is unlikely to be successful. This has implications for the organisation of and communications

within the wider whole system as well as the training and development of staff.

The minimum requirements are:

- Flexibility and integration in the local whole system to assess and provide rehabilitation or other appropriate therapeutic interventions to the site.
- A dedicated care team appropriately trained and supported.
- A clear focus on a time-limited return home.
- Systems in place to adapt the home property, supply equipment or otherwise appropriately adjust the care package on a return home.

In other words intermediate care in an extra care setting requires a seamless integrated partnership approach between health, housing and social care to be successful. The table below sets out how this might be achieved.

Figure B The contribution of partners to a seamless service

Social Care	**Housing provider**	**NHS/Primary Care Trust**
- Home support - Social workers, social work assistants, rehab support workers and care assistants -Transportation (home, appointments etc) - Screening of referrals and liaison with NHS/PCT staff - advance payment of rent to housing provider	- Flats that can be occupied by older people in receipt of IC - Arrangements to have flats decorated and carpeted - Warden/scheme manager support and community alarm/ lifeline package tailored to individual needs - Cleaning, shopping as needed - Regular meetings with social services, NHS and PCT partners	- Tenancy agreement (incl. Tel. and utility bills) - Refurbishing flats and provision of equipment as needed - Occupational therapy and nursing expertise - Other allied health professional/ medical staff - Undertake assessments (SAP), rehab plans, weekly reviews, information collection, monitoring and evaluation

In taking this forward in an ECH setting, you should consider the following checklist for action:

Tenancy rights

- What occupancy arrangement does the resident have whilst receiving intermediate care?
- What rights does this give them?
- Who is responsible for payment of rent and service charges?

The care package

- Who nominates into the scheme? Is there a pooled social care and health budget?
- Will a 24hr service be provided? If not, who manages the out-of-hours service?
- What services are included in the active therapeutic programme (chiropody, rehabilitation, advocacy, support)?
- Are meals, laundry etc provided?

Roles and responsibilities

- What is the role of the warden/scheme manager?
- What access is there to the care team
- Will they assist in advising on move on options?
- What happens if the person is not fit to return home after 6 weeks or cannot move home eg, awaiting adaptations?

Scheme use/condition

- How will the short-term intermediate care affect the remainder of the scheme (where there are designated units)?
- Will the property require upgrading/decorating?
- Will the units be furnished/equipment provided?
- How will this be funded?

Access to information

- What information is available to the older person about the intermediate care programme and the ECH accommodation?
- What are the implications for benefit entitlement? Is this examined in the care or support plan?
- What information is there to advise on move on accommodation, benefits, direct payments, and access to further formal and informal care and support?

5. Good Practice Examples

There are, as yet, few well developed models of integrated intermediate care within ECH. There are more examples of sheltered or enhanced sheltered housing being utilised as locations for intermediate care interventions. The relative infancy of intermediate care also means that there are few schemes that have been evaluated over time. Two evaluated examples, however, are worthy of note:

Tomlinson Court, Housing 21

Tomlinson Court, a partnership scheme between Derby PCT, Derby City Council, and Housing 21, has provided a short term rehabilitation service

since May of 2000 utilising 10 upgraded flats. It has clearly stated objectives:

- To prevent or delay admission to residential care or nursing homes
- To provide a interim service following discharge from hospital before returning home
- To provide short term intensive rehabilitation over a period of 6-8 weeks followed by a co-ordinated service on returning home
- To enhance the independence and choice of older people by enabling them to develop the skills they need to live independently

The objectives clearly meet the criteria for intermediate care and the intake: 60% on discharge from hospital, 20% from residential care homes and 20% from their own homes, encompasses both the Step Up and Step Down interventions. Almost 80% of the first twenty-five tenants returned to their own homes or alternative housing, whilst two entered residential care and four died.

Shield Court, Newcastle City Council

Shield Court, in Newcastle on Tyne, is another partnership project, bringing together the Newcastle PCT, Newcastle City Council, the National HAZ innovation project and the Tunstall group. The intermediate care focus is very specific: patients suffering from chronic heart disease.

The project is nurse led. The Primary Care Trust leases units of sheltered housing from the City Council Community Housing and Housing Directorate in order to provide assessment, care and therapy to patients who less than 72 hours earlier had been admitted to the Royal Victoria Infirmary as acute patients. Whilst all patients are still in need of 24 hours nursing care on admission, they are medically stable. The facility provides an intensive bio physico/social assessment and rehabilitation programme assisted by a tele-monitoring link to the Chest Clinic of the hospital utilising the Community Care Alarm Service. The objective is to create an individually tailored programme of care and support that will enable the older person to maintain a high quality of independent living in the community once they return home. Only a small proportion of the first seventy patients admitted to the scheme subsequently required readmission to hospital following further acute episodes.

Both Tomlinson Court and Shield Court demonstrate that where the objectives of the intermediate care service are specific and clearly understood by partners ECH can be both an appropriate location and environment for successful assessment, intervention and rehabilitation.

Further good practice examples can be viewed on the Housing LIN website at www.changeagentteam.org.uk/housing.

6. Key Learning Points

- ECH can be a particularly appropriate location in which to provide therapeutic intermediate care interventions. Its strengths are as an environment with design features which aid mobility and provide access to care staff offering the opportunity for continuous and consistent assessment with the ability to pick up changes in condition and to respond very quickly. Its distinctive quality is that it offers communal support facilities whilst maintaining many of the characteristics of domestic accommodation.

- ECH has many variants and intermediate care many different formats. There is tremendous scope and potential to marry the two concepts or processes but there needs to be clarity in the precise objectives being pursued and the nature of the partnerships required to deliver the service.

- ECH also has the capacity to provide appropriate transitional or interim care, but this should not be confused with the more active rehabilitative ambitions of intermediate care. There is a need to be clear when intermediate care episodes begin and end, and what the wider contribution of extra care to the whole system of support for older people in the community may be.

- The primary objective of the best ECH is to provide a “home for life” which enhances independence and a quality living experience with the opportunity to exercise informed choice on the community support required. The introduction of an intermediate care facility into to such an environment can disturb the balance of the scheme unless it is in harmony with the overall objectives and culture of the residential community.

- Lastly, it is as a preventative resource that ECH housing is at its most effective. It could be argued what many older people already resident in the model receive “intermediate care” at times of crisis without it being designated as such, with a consequence of substantial saving to the whole system.

7. Some useful references

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