Housing Learning & Improvement Network

Extra Care Housing Training & Workforce Competencies

This report outlines a researched set of competencies which local authorities, registered social landlords (RSLs), voluntary and independent sector providers of Extra Care Housing (ECH) may wish to use in defining the tasks and duties of scheme managers. The executive summary is also available on the Housing LIN website under the section entitled Other Reports and Guidance.

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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

1 BACKGROUND TO THE STUDY

In Autumn 2004, the Institute of Public Care (IPC) was commissioned by the Department of Health Change Agent Team Housing Learning & Improvement Network, to develop a researched set of competencies for Extra Care Housing scheme managers. The following activities were undertaken in order to achieve the above outcome.

1.1 A Literature Review

A number of key documents were reviewed which offered descriptions of Extra Care Housing (ECH), including reports by government departments, provider organisations, training and accreditation agencies, statutory bodies and academic researchers. Key themes from these sources were drawn together to produce:

- A statement of the overarching objectives of ECH.
- A statement of the key outcomes of ECH, ordered under 6 domains.
- A more detailed statement of the processes required to achieve these outcomes.

1.2 Questionnaire to providers.

Thirty provider organisations were identified from the Elderly Accommodation Council database (www.housingcare.org). A total of 6 providers were approached for preliminary information on training and competencies to enable the development of a questionnaire. A further 24 organisations were then asked to complete questionnaires, either by telephone interview or via email. Fifteen were able to do so in the time available, including 5 of the original 6. The questionnaire is attached at Appendix 6 and a list of respondents is attached at Appendix 7. One respondent completed 2 questionnaires, as the organisation provides both a general manager and a care manager for each scheme, making a total of 16 completed questionnaires.

The providers selected for inclusion represented a broad geographical spread, range of sector, and size. Results from these questionnaires were used to validate and expand the information about training needs of scheme managers and gaps identified through the literature review.

1.3 Scheme Visits

Four ECH schemes were visited, and discussions were held with a total of 24 occupants[1], and 7 staff members, including the 4 scheme managers. The characteristics of the schemes visited are attached at Appendix 2 but included those provided by a local authority, an independent sector provider, and one by a Registered Social Landlord (RSL).

At each scheme two sets of discussion took place, one with occupants and one with staff. The questionnaire and responses from occupants are attached at Appendix 3 and 4 respectively. The questionnaire used with staff/managers is attached at Appendix 5. In two of the schemes, more than one member of staff was available for discussion, and in one a Local Authority service commissioner was present for some of the time. The objective of the discussions with occupants was to learn what for them

[1] The term occupants has been used throughout rather than a confusion of residents, tenants, owners and leaseholders

was the most valued element of the service, and what were the difficulties. For the discussions with managers, the objectives were:

- To understand the range of tasks for which they take responsibility.
- To learn whether they have training in undertaking these tasks.
- To understand the extent to which their role has developed through the exercise of skills learnt in previous posts.
- To hear their views on potential training gaps.

It was hoped that information learnt during the visits would:

- Serve to validate the objectives for Extra Care identified during the course of the Literature Review.
- Draw attention to gaps in training provision identified by scheme managers.

At all schemes except Scheme 3, the scheme manager was present at least some of the time during the discussion with occupants. Moreover, the visits were arranged at short notice and respondents were self-selected – often members of committees or social clubs. Probably the most representative group of occupants was at Scheme 3.

1.4 Other Discussions

Discussions were also held with senior managers from provider organisations and from the Centre for Sheltered Housing Studies, and with three local authority managers. The project also had a reference group comprising a range of providers, central and local government representatives and training bodies.

1.5 Database of National Occupational Standards

The statements of overarching objectives, outcomes and processes developed via the literature review were matched against existing National Occupational Standards (NOS) and their associated competencies, as set out on the various Sector Skills Councils Web sites. This was systematised via the development of a database of existing NOS, and a number of gaps in standards identified for each domain heading.

1.6 Findings and Conclusions

A review of overall issues, our analysis of specific gaps and a checklist of key skills required by ECH managers is available in this report. In addition an abbreviated summary of the set of competencies for Extra Care Housing Managers is available on the Change Agent Team Website under Fact sheets in the Housing section.

2 THE POLICY CONTEXT OF EXTRA CARE HOUSING

2.1 The Development of Extra Care Housing

Whilst a number of sources quote long historical antecedents for the development of extra care housing years (see Tinker (Royal Commission, 1999b Ch.5) few doubt that it has recently received a major impetus, and that government now regards it as a central plank of its resources, in developing services and accommodation for older people.

"….Most older people want services that allow them to retain control over their daily lives with support delivered as and when they need it. What they don't want are rigid and traditional models that take for granted an inevitable and progressive path from living independently to being cared for. Our increasing recognition of housing related services, and extra care housing in particular, - backed up by extra investment and new approaches to housing with care - is part of our policy to deliver this choice and control."

Stephen Ladyman, Secretary of State July 2003

Part of that impetus has come from the support of funding delivered through the Department of Health (DH) and from The Housing Corporation. ECH is seen as a way of delivering a number of key government objectives. The DH initiative alone will have provided 3,076 new units of accommodation between 2004-2006 at a total of £87 million. However as part of the funding round the same department received requests for funding totalling £317 million. Contributions towards the development of ECH have not only come from financial sources but also from identifying good practice. Bodies such as the DH funded Housing Learning and Improvement Network (LIN) have supported the practical application of new housing policies for older people.

Finally, The new Green Paper on Adult Social Care, *Independence, Well-being and Choice* (DH, March 2005) emphasises the dual objectives of offering choice to frail or disabled people, as well as preventing unnecessary hospital admissions among older people and facilitating early discharge. (Section 9.10). The potential of ECH to deliver both these elements has made it central to the new agenda for supported accommodation in non-institutional settings for older people and those with a disability. The challenge now will be to ensure that the ethos of ECH as a major contributor to improved quality of life for older people is retained and enhanced as the model becomes part of mainstream service delivery.

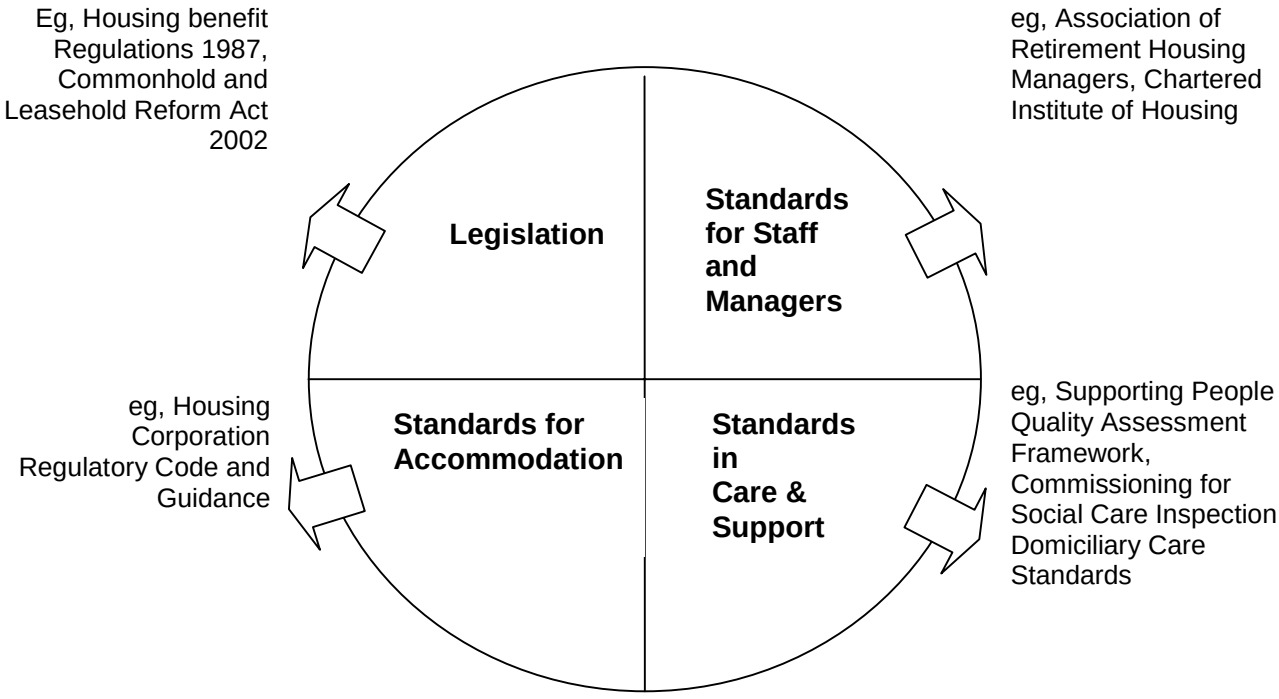
If Extra Care Housing is to be developed effectively it also requires the leadership of a new group of housing managers. This study has taken place at a time of rapid change both in training opportunities, and in recruitment methods for ECH scheme managers. For example:

- In terms of housing, The Centre for Sheltered Housing Studies, in association with the Chartered Institute of Housing, is developing new courses for ordinary sheltered housing staff, and has now added a module to its training outline, and an appendix to its accreditation scheme, which relates to Extra Care Housing**.**
- In terms of social care, the TOPSS study 'Redesigned and Redrawn' (see Bibliography), which examined some 67 new roles which deliver services on ordinary life principles, is due to report shortly. Meanwhile, the newly set up Sector Skills Councils, including the Skills Agency (formerly TOPSS), are developing additional National Occupational Standards and training models for the social care sector.

The role of an ECH scheme manager is potentially wide and diverse. Therefore, it of little surprise that providers increasingly recruit from a range of housing, health and social care backgrounds in order to secure managers who are skilled in managing staff and budgets, who are financially aware and comfortable with the idea of caring for older people in non-institutional settings. Scheme managers have to deal with issues surrounding personnel, police checks and finance, and those responsible for recruitment are seeking out people who can manage staff with the wide range of skills needed to deliver a successful Extra Care Housing scheme. Personal qualities required include leadership skills, interpersonal and communication skills, problem solving, decision making, and influencing skills. Often, it is these personal qualities that are seen as the minimum essential requirements for recruitment, and most providers have in-house training programmes or arrangements with training organisations to fill gaps in skills and knowledge.

2.2 Standards for buildings and care and support.

ECH provision falls within the remit of a number of bodies in terms of; legislation, regulation, standards and professional development as the following diagram depicts.



Not only is there a wide variety of regulatory and standard setting bodies but there is also a considerable degree of overlap between the various standards and the distinctions between people and property presented above are not always clear cut. Little surprise that one extra care scheme manager when asked to comment if they thought there should be special regulations for extra care housing commented

"Why do we need more, I am subject to 22 standards and regulation requirements already".

IPC Interviews

2.3 Positioning Extra Care Housing

Whilst the various regulatory and standard setting bodies define the boundaries of good practice they don't necessarily define the essence of, or rationale behind, the key features of a service. Much of that, as the literature review below describes, comes from a variety of sources but can briefly be described as falling between two extremes of a continuum:

- At the one end is ECH as a narrow predominantly state provided service that acts as an alternative to residential care. Access is mainly through a persons need for care and support.
- At the other end is a form of housing provision available to all older people regardless of whether they currently do or do not have care needs, provided by a wide variety of providers, offering purchased, leased or tenanted properties of variable size and in premises which provide a range of different facilities.

On balance the range of descriptions within the literature review veer towards the more all embracing end of the continuum as compared to the specialist. There are a number of advantages to this broad approach to the development of ECH:

- A flexible approach to the delivery of care and support can reduce costs, as occupants receive only those services which they need, whilst additional services can be provided quickly to meet a crisis and withdrawn when the crisis ends.
- The nature of the accommodation tends to be more conducive towards families and friends continuing to provide care and support.
- Additional funds can be brought into the scheme by owner occupiers and receiving assistance does not cause the same loss of equity as does residential care.
- Schemes that provide balanced communities of occupants mean that the more able occupants often play a part in supporting and assisting those occupants who have less capacity.
- The current experience is that most occupants of ECH are very positive about this form of service delivery (Oldman 2000), that care and support needs may diminish on entry to ECH (Hanover Housing), whilst occupants may require fewer hospital bed days than people of the same age in the wider community (Retirement Security).

However, the implications in terms of defining competencies are that the wider the description of ECH then the greater the range of skills and competencies required to deliver the service.

3 THE LITERATURE REVIEW

The purpose of the literature review is to bring together from a range of key sources a variety of descriptions of extra care housing and relevant services that an extra care housing manager may either be expected to deliver or have knowledge of in order to facilitate its delivery. The list of sources is not exhaustive and indeed given the growth of the sector tends to be added to week by week. However, it is possible to identify common and repetitive themes within the various documents.

3.1 Names and Descriptions

The development of the model of service delivery which is now generally known as ECH can be traced through a number of name changes, from Category 2.5 sheltered housing, via Very Sheltered Housing, to Extra Care Housing or Assistive Living. The application of the name is still subject to differing interpretations: for example, in Suffolk, Very Sheltered Housing is the name given to what is generally now known as Extra Care Housing, whilst Extra Care in Suffolk is a term reserved for people with dementia. Very Sheltered Housing is still a term preferred by a number of organisations. However, Extra Care Housing is the term used by the Housing Learning and Improvement Network and the Department of Health Funding programme, and hence presumably by the large numbers of potential providers who have recently submitted bids for funding as well as those seeking alternative public and private funding sources (Housing Corporation Social Housing Grant, Private Finance Initiative etc).

Not only does the name differ: so do the different components of the various models. The 2004 Application Guidance Notes for the Extra Care Housing Fund state that;

"G*ood extra care housing is as much to do with its philosophy, as it is to do with bricks and mortar*."

The purpose here is to decide which of the many elements gathered under the different headings are actually definitional of ECH, and which are contingent: for example, the availability of 24 hour care and support is definitional, whereas whether accommodation and care are delivered by the same or different organisations is merely contingent, and either model is consistent with a definition of ECH.

3.2 Aspirations of Older People

The DH Guidance note quoted above brings the preferences of older people to the centre of service development. But older people are individuals, as diverse as the wider population, and with similar aspirations. The Audit Commission, in partnership with Better Government for older people, set out some of those aspirations gleaned from a number of different consultation exercises, as:

- Having choice and control over how they live their lives.
- Opportunities to contribute to the life of the community, and for that contribution to be valued and recognised (inter-dependence).
- Comfortable, secure homes.
- Safe neighbourhoods.
- Friendships and opportunities for learning and leisure.
- The ability to get out and about.
- An adequate income.
- Good relevant information.

- The ability to keep active and healthy.
- Tackling ageism.
- Being involved in making decisions.
- Joined up services.

Source: Audit Commission 2004: Older People: Independence and Wellbeing

Most of these preferences relate, not to individual service quality, but to quality of life. Thus a philosophy of ECH would refer to its place as one element on a continuum of preventative services, designed to enable all older people to experience a good quality of life for as long as possible, by providing care and support which is of high quality, but which may be merely an essential preliminary to meeting these aspirations rather than an end in itself. Within ECH schemes, this has to do with creating the conditions whereby these aspirations can be met in fully accessible, non institutional settings, with the help of staff trained in the full range of relevant skills.

To reflect these preferences, any statement of ambitions for ECH should include reference to such elements as choice and control, interdependence, safety and security, leisure and community, accessibility both inside and outside the scheme, opportunities for healthy living and lifetime learning, empowerment, involvement, and joined up service delivery.

3.3 Standards, Regulation and Accreditation

3.3.1 The Housing Corporation

In April 2004, the Housing Corporation published a regulatory circular in which they set out definitions of housing association supported housing and housing for older people. This was to ensure appropriate regulation and funding of housing association stock. Three types of housing for older people were defined:

- Housing for older people (all special design features).
- Housing for older people (some special design features).
- Designated supported housing for older people.

Housing for older people (all special design features) is the most likely to equate to ECH schemes. It is defined as:

"Remodelled or purpose built grouped housing that has all the basic facilities and all special design features intended to enable people to live there for their lifetimes."

For example, requirements include:

- **Basic facilities** – laundry for occupants and/or washing machines in living units or provision for washing machines to be installed, as well as a communal lounge.

- **Special design features:**
  1. The whole scheme must be designed to wheelchair accessible standards.
  2. Living units must have walk in showers or bathrooms adapted for people with mobility problems or wheelchair users.
  3. Bathrooms in living units that are wheelchair standard must meet the criteria for adapted bathrooms.
  4. Living units must have kitchens that are designed to wheelchair standards.
  5. The scheme must have a bathroom with provision for assisted bathing.

6. If there is more than one storey there should be a lift.

Whilst the definition developed by the Housing Corporation is useful, it relies for its meaning on a summary of what constitutes all basic facilities and all special design features. This clearly only deals with the housing and accommodation aspects of ECH.

The Housing Corporation also issues a regulatory code and guidance which covers all housing provided by RSL's. Much of this is also relevant to the role of extra care housing managers who work in that sector. Of particular relevance are the following sections:

Table 1 Relevant Aspects of the RSL's regulatory code and guidance.

2.5	Housing associations must seek and be responsive to residents' views and priorities:
2.5.1	reflecting these interests in their business strategy;
2.5.2	giving residents and other stakeholders opportunities to comment on their performance;
2.5.3	enabling residents to play their part in decision-making;
2.5.4	providing opportunities for residents to explore, and play their part, in how services are managed and provided.
3.4	Housing associations must develop and manage good-quality homes that seek to meet people's needs and preferences now and in the future, ensuring that:
3.4.1	the homes their residents live in are well maintained and in a letable condition;
3.4.2	maintenance is carried out effectively and responsively and in ways that reflect residents' preferences;
3.4.3	necessary investment in the future of their stock is made a key priority;
3.4.4	standards of new development provision are met.
3.5	Housing associations must provide good-quality housing services for residents and prospective residents:
3.5.1	by seeking to offer a choice of home, while giving reasonable preference to those in priority housing need;
3.5.2	by offering the most secure form of tenure compatible with the purpose of the housing and the sustainability of the community;
3.5.3	with agreements that clearly set out residents' and landlords' rights and obligations;
3.5.4	by being responsive to the individual characteristics and circumstances of residents;
3.5.5	by using lettings policies that are fair and reflect the diversity of their client groups;
3.5.6	by providing high standards of customer care.

3.3.2 The Chartered Institute of Housing

The Chartered Institute of Housing (CIH) is a long established body which grew out of a desire of local authority housing managers to prescribe and regulate their profession. CIH offers nationally recognised awards at levels 2, 3 and 4, for a range of staff involved in housing as well as awards that involve occupants. Some courses are run by CIH others by accredited course providers. The courses at level 3 and 4 include options concerning sheltered housing. For example the level 4 Certificate and Diploma awards contain the following elements for Sheltered Housing Managers.

Certificate level:

- Housing Policy.
- Housing Practice.
- Managing and Measuring Performance.
- Housing and the Law.
- Community Support and Community Care.
- Specialist Option.

plus for the Diploma:

- Finance and Financial Management.
- Managing Tenancies.
- Community Development and Sustainability.
- Networking To Joint Working.
- Promoting and Marketing Housing.
- A Further Specialist Option.

3.3.3 The Centre for Sheltered Housing Studies

The Centre for Sheltered Housing Studies (CSHS) has developed an accreditation framework for Sheltered Housing. Accreditation as a service provider is the first of two stages necessary to providing services under the Supporting People regime. In addition, each scheme will be subject to review under the Quality Assessment Framework. The Code of Practice developed by CSHS is accepted by ODPM as a key element of accreditation, and also maps onto the Supporting People Quality Assessment Framework. There is an Appendix within the Code of Practice which relates to ECH, and CSHS is now working in partnership with the Department of Health to extend this code so that it covers both the public and the independent sector. Appendix 1 displays the 10 Standards within the Code of Practice and the Extra Care Appendix. In summary the Standards cover:

- Equality of Opportunity and Diversity.
- Rights and Responsibilities.
- Confidentiality.
- Independence and Empowerment.
- Service Delivery, Review and Continuous Improvement.
- Professional Role and Responsibilities.
- Collaboration and Community Development.
- Trained and Supported Staff.
- Policy and Legislation.
- Physical Environment.

In partnership with the CIH, CSHS is developing a Good Practice Guide for Sheltered and Retirement Housing. This will summarise the relevant codes of practice, appraisal tool-kits and inspections, chart the changing role of the scheme warden, and set out a number of good practice examples.

3.3.4 Regulations governing the provision of domiciliary care

All agencies including local authorities are required to register as providing domiciliary care services. The guidance defines the need to register as those who provide the first two of the following four categories of care:

1. Assistance with bodily functions.
2. Care falling just short of assistance but still involving physical touching.
3. Non physical care, eg, reminders to take medication or to bathe.
4. Emotional and psychological support.

Extra Care Housing Managers will need to be familiar with the regulations and their part in meeting the requirements of regulation. Whilst the care component will vary from scheme to scheme of particular relevance to some EC managers would be:

- Standard 2. Understanding the component parts of an assessment.
- Standard 6. Having staff that are reliable and dependable and able to respond flexibly to the needs and preferences of service users.
- Standard 9. Personal care and support is provided in a way which maintains and respects privacy, dignity and lifestyle.
- Standard 10. Managers and care and support workers enable service users to make decisions in relation to their own lives providing information, assistance and support when needed.

Domiciliary Care National Minimum Standards: Regulations
Care Standards Act 2000

3.4 Advice

3.4.1 Department of Health, Housing Learning and Improvement Network briefing papers

Nigel King (2004) notes that Extra Care housing does not have a precise definition and that it has a number of different names. He lists features which tend to characterize Extra Care Housing as:

1. Self-contained flats or bungalows – a defining feature distinguishing ECH from residential care. Dwellings will incorporate design features and Assistive Technology to facilitate independence of frail older people and provide a safe environment.
2. Provision of an appropriate package of care, in the individual's own dwelling, to a high level if required.
3. Catering facilities with one or more meals available each day.
4. 24 hour care and support available.
5. More comprehensive and extensive communal facilities than Category 2 sheltered – restaurant, lounge(s), activity room(s), library, health suite, computer suite, consultation room.
6. Staff offices and facilities, domestic support services including help with shopping, cleaning and possibly making meals.
7. Specialist equipment to help meet the needs of frail or disabled occupants – laundry, assisted bathing, sluice, hoist, also charging and storage facilities for electric wheelchairs/scooters.
8. Social and leisure activities/facilities and additional individual or shared services – a shop, hairdressing, chiropody, massage, alternative therapies, cash machine, post box.
9. Mobility and access assistance for example communal buggies or shared pool car.

Of these, King regards the first five or six as definitional, the others as characteristic. However, it could be argued that at least the first seven items listed are definitional of ECH, and probably all of them.

The Housing LIN publication *Extra Care Housing for Older People: an introduction for commissioners* (2003), also notes that there is currently no single definition of ECH. The publication offers a number of lists of defining features from different sources and notes that differentiation between the models offered by different providers is largely through the definition of roles, particularly that of the scheme manager. They conclude that the role of the senior member of staff on site is a crucial one, because all scheme managers exercise some degree of influence in the delivery of care to the occupants. This finding is supported by other research (IPC 2003, Counsel and Care 2004). In a number of models the scheme manager is involved in the initial allocation of places, thus playing a crucial role in maintaining a balanced community in which the more able occupants are active in promoting leisure activities and in supporting the less able occupants to take part. Moreover, in many schemes the scheme manager will be responsible for allocating a fixed number of care and support hours across the scheme – a piece of fine tuning which relies on a good understanding of the care and support needs of occupants in general, and on an ability to adjust an individual's care package quickly and decisively on the basis of a step-up step-down approach, with the understanding that an individual's needs may increase in the face of a crisis – and equally they may diminish when the crisis passes.

In such an arrangement the Manager provides a single point of accountability to funder/commissioner and to the tenant …the flexibility of such an arrangement allows for cost effective outcomes of high quality

Counsel and Care 2004

Therefore, although some scheme managers (as in Hanover Housing) are primarily estates managers with no responsibility for delivery of care, nevertheless the principle of flexible packages of care with the possibility of swift changes to the volumes of care delivered – both augmenting and diminishing – , however achieved, should be regarded as definitional of ECH.

In *Developing and Implementing Local Extra Care Housing Strategies* (2004) the authors identified the following as defining elements of ECH:

- Living at home – not in a home.
- Having one's own front door.
- The provision of culturally sensitive services delivered within a familiar locality.
- Flexible care delivery based on individual need – which can increase or diminish according to circumstance.
- The opportunity to preserve or rebuild independent living skills.
- The provision of accessible buildings with smart technology that make independent living possible for people with physical or cognitive disabilities, including dementia.
- Building a real community, including mixed tenures and mixed abilities, which is permeable to the wider community and benefits from the variety of provision available to all citizens.

This list places more emphasis on the community development and citizenship elements of ECH than do other sources, and so brings the model closer to the service aimed at improving the well being of all local older people, that is so central to the Joseph Rowntree initiative. This list is substantially the list offered in the DH Extra Care Funding Application Guidance, (2004): the Application Guidance also lists basic design features, including:

- Self contained flats with kitchen and bathroom facilities that support and enable independence and the delivery of care services.
- Staff facilities – office and sleep-over room.
- Barrier free spaces that are accessible and aid occupants' mobility.
- A range of areas for services such as hairdressing, laundry etc.
- Communal areas – dining facilities, lounges and day rooms.
- Guest facilities.
- Good links with the local community.
- Staff on site to manage and maintain the building and manage the delivery of care and support services.

Additional facilities for staff, a shop, storage for wheelchairs and scooters and the provision of social, educational and recreational facilities.

3.5 Research

3.5.1 Joseph Rowntree Trust (JRT)

Joseph Rowntree Trust along with the Economic and Social Research Council and others have provided a range of recent research relevant to the provision of Extra Care Housing and the skills that ECH managers require. Askham et al (1999) found that whilst most older people much prefer to be owner occupiers they are fearful of the burdens such as property maintenance and upkeep that go alongside that role. These older people may be natural candidates for ECH which can maintain the former whilst alleviating responsibility for the latter.

Oldman (2000), undertaking research for the JRT, found that only 5% of all sheltered units in England could be described as Very Sheltered, but that, despite the small numbers, there was considerable variety in terms of aims, size and physical design, funding mechanisms, care and support services, delivery patterns and so on. She identified the most important distinguishing features as:

- A home for life or at least ageing in place, ie, a rejection of the old 'continuum of care' policy.
- Care and support services available to all occupants.
- A barrier free environment.
- Flexible support services.
- An alternative to residential care.
- A better quality of life, delivered through the provision of extensive facilities and stimulating environments.
- A community resource.
- Your own front door.
- Separate charging for rent (or equity) and service charge, living costs and care costs – therefore very sheltered housing resident can exercise more choice.

The last point is particularly important, as it is omitted from many lists, but matches the aspiration of older people for choice, control and an adequate income. Care home occupants pay a blanket fee to cover all their costs, and do not receive housing or other benefits. Often they will be left only with pocket money for their own purchases. It will be important to preserve the greater financial choice exercised by occupants of ECH, and not allow it to be whittled away by lack of choice such as in the blanket provision of meals, or in the demands of Supporting People budgets. The availability of Direct Payments in ECH may be another way of preserving the financial choice and autonomy of occupants.

3.5.2 Hanover Housing.

Research commissioned by Hanover Housing (Bartholomeou 1999) defines ECH in terms of a list of amenities, none of which is exclusive to Extra Care, but of which other service models, or the experience of living at home, provide only some, whilst ECH provides them all. Here the list has been grouped into themes in order to help with arriving at a more manageable definition.

Table 2 The Hanover list of essential characteristics of Extra Care Housing, sorted by domain.

Philosophy /ethos	Barrier free environment	Care and support	Facilities	Community	Staff amenities
Assisted independent living	Level access showers throughout	Staff sleep-over suite	Guest suite	Local community access	Staff day room
Non-institutional care	Lift to all floors	Incontinence service	Activities room		
Self-contained apartments	Access to assisted bathroom	24 hour on-site care	Hairdressing salon		
	Fully fitted kitchens, accessible to wheelchairs	Laundry	On-site shop		
	En suite facilities		Residents' restaurant		
			Residents' lounge		
			Laundry for residents' use		

Set out in this way, the list comprises 6 domains, all of which are important to the development of ECH. The sixth element concerning staff facilities or amenities relates to the necessity of providing an environment in which staff can work safely and effectively, and which contributes to morale and team working.

3.5.3 Housing 21

Housing 21's marketing literature for Very Sheltered Housing is actually entitled *Your Own Front Door*. The organisation affirms a commitment to promoting independence and choice for older people through quality housing, care and support services. Under the heading Flexible Approaches, Independent Living and an Enabling Environment, they list a range of options including:

- A direct alternative to residential care for older people with high levels of physical dependency.
- A mixed community of both active older people and frailer older people with high care needs.
- A complete service where the care is provided by our own experienced teams.

- A partnership initiative where care needs are met by other providers.
- A setting for a range of services for older people in the surrounding community.

Benefits for occupants include:

- Accessible self-contained flats, rights as tenants and a home for life.
- A safe and secure living environment.
- A range of communal facilities, care staff on site providing care and support tailored to individual needs and following an enabling philosophy of 'doing with' rather than 'doing for'.
- Systems for progressive privacy.
- Choice as to level of community involvement.
- A chance to live life to the full and have fun.
- Continued relationships with family, friends and being part of the local community.

The final point is not stressed in all statements about ECH, but it is of major importance. Institutional solutions separate spouses, with the result that spouse carers may continue to care in the community under exhausting circumstances so that the couple can stay together. Extra Care Housing can provide accommodation for couples, benefit from the carer's expertise and support him or her to continue caring. If the cared for person dies, the carer can remain in their accommodation, perhaps as one of the less frail members of the community who contribute to its vitality

3.5.4 Counsel and Care

In 2004, Counsel and Care published the results of a study based on 50 interviews, mainly with occupants of Very Sheltered Housing. The report is presented via the categories of the main regulatory standards and guidance that now apply. At the outset, they address the question of what constitutes quality in Very Sheltered Housing. From their interviews, they identify two aspects to peoples' needs:

1. What care and support is given (the range and comprehensiveness of care and support available in the scheme).
2. How care and support is given (the kindness, sensitivity, thoroughness and skill with which care and support are given.

The authors propose that support should include the addressing of psychological and social needs, and that these needs are widely unmet in Sheltered Housing, and sometimes in Very Sheltered Housing. Amongst their sample, they found that some older people in Very Sheltered Housing were also experiencing rushed or casual support, although all the scheme managers were widely appreciated. The authors concluded that a 'customer service' ethos could help to encourage staff to respect occupants' standards and preferences. They argue for a critical mass of well-intentioned, flexible and committed personnel, and for scheme managers being involved in the recruitment process for scheme staff.

3.6 Other sources of influence

Some areas of practice are either so new they have not really had a chance to be integrated into training courses or else represent the more specialist end of ECH provision. Two examples are given below:

3.6.1 Dementia

Most ECH schemes will have occupants with some cognitive impairment, some schemes have specialist wings or housing units for people with dementia, some local authorities provide 'dementia only' schemes. The Suffolk Extra Care/Dementia Design and Management Guide, 2004 provides a list of areas that scheme managers and staff should receive 'comprehensive and ongoing training' in:

- Person centred approach to working with people with dementia.
- The role of the family/carers in supporting occupants and informing staff.
- A knowledge and understanding of the physiological and psychological effects of dementia.
- Skills in the management of relationships.
- Stress recognition and management, including loss/grief counselling.
- Equality and diversity.
- Management of behaviour that challenges the service.
- Assessment and Care Planning.
- Communication skills.
- Rehabilitation (including encouraging occupants to adopt and rediscover new skills).
- An understanding of housing issues (eg benefits and welfare rights).

3.6.2 Assistive Technology

The Housing LIN guide "Assistive Technology in Extra Care Housing" gives recognition that Assistive Technology is not an area that all staff accept or understand.

"Assistive Technology (AT) can be challenging to deal with. Lack of technical understanding of how things work is made worse by language and terms used. An assumption that social care practitioners are familiar with AT and explanations are unnecessary may be understandably misplaced."

Assistive Technology in Extra Care Housing, Factsheet 5, Housing LIN

The guide goes on to suggest four categories of Assistive technology:

- Property based technology.
- Monitoring Technology.
- "SMART" technology.
- Security and communication technology.

3.7 Bringing the descriptions of ECH together

Points arising from the different sources have been isolated and summarised in Table 3 below in order to provide a comprehensive list of the values, ambitions and objectives of ECH as set out by Government, providers and researchers. Whilst many of the individual sources listed provide only a partial picture of the service, together they reflect the essential characteristics of ECH.

The list is ordered in terms of the domains identified in Table 2.

- Barrier free environments.
- Care and Support.
- Facilities.
- Community.
- Staff.

Underneath each domain there is a sub category, a description of the characteristics which define the category and the outcomes that the set of characteristics should be delivering.

Table 3: Grouping key headlines from the literature review.

Domain 1 A Barrier free environment		
Category	**Characteristics**	**Outcome**
A home for life	1. Level access, fully accessible to wheelchairs. 2. Financial/insurance arrangements to ensure that people can afford more intensive packages of care as they get older. 3. Flexible care and support provision offered on a step up step down basis. 4. A culture of *whatever it takes*, co-ordinating service delivery within the scheme as opposed to transferring responsibility to other agencies.	Accommodation in which both the physical environment and the arrangements for the delivery of care and support enable people to remain at home until the end of life.
One's own front door	1. Secure tenancies (Assured shorthold tenancy agreements), ownership or shared equity in the property.	Security of tenure: the right to refuse entry to visitors, the right to return home after hospital inpatient stay.
High quality buildings	1. Dwellings should be spacious, fully accessible, and the layout of the scheme should incorporate features which assist occupants with orientation. 2. Adequate space for living, entertaining guests, and storage. Individual units should be a minimum of 50 m^2, and should incorporate cabling for Assistive Technology. 3. Wide corridors, high quality finishes, and the incorporation of natural light. The use of colour and the management of environments inside and outside to assist mobility and orientation. 4. Outside spaces which are accessible, attractive, secure and well lit, and which include sufficient parking for staff, occupants and visitors. 5. Fully accessible kitchens and bathrooms.	Scheme design should incorporate the best practice principles of designing for older people and people with sensory and cognitive impairments, maximising independence and the creating a barrier free environment.

Domain 1 A Barrier free environment		
Category	**Characteristics**	**Outcome**
Security & Safety	1. Choice of site /location. 2. Design for progressive privacy, ie, public spaces which are separated by security systems from private flats, front doors which open onto a lobby rather than directly into people's living spaces, arrangements for visitors signing in. 3. Locks on downstairs windows etc, building facing inwards in some areas. 4. Design minimise risk of falls, prevent accidents. 5. Staff training and recruitment measures.	Freedom from the fear of, and the actuality of, crime, and from abuse. Able to maximise mobility and utilisation of the facilities of the dwelling/scheme.

Domain 2 Care and Support		
Category	**Characteristics**	**Outcome**
An alternative to residential care	1. Spouses remain together and carers continue to care. 2. Generous space standards. 3. Flexible care and support provision offered on a step up step down basis. 4. Staff training and recruitment methods. 5. A culture of *doing with* rather than *doing to*. 6. Income/saving used to pay for care, only have minimal daily living expenses.	The provision of non-institutional care delivered in ordinary life settings, which fosters independence, choice and control for occupants.
An adequate income	1. The availability of benefits advice 2. Person centred services delivered on the basis of need rather than the demands of the organisation, 3. A variety of approaches to financial planning to enable occupants to pay for future care and support. 4. Implementation of initiatives such as Fairer charging and Direct Payments schemes.	Occupants are financially autonomous and exercise choice over how their income is spent.
Choice and control	1. A community which contains occupants with a range of levels of	A person centred service that enables older people to live the

	dependency. 2. The provision of culturally sensitive services. 3. Equal rights and the encouragement of citizenship and diversity. 4. Support for independence and interdependence. 5. The provision of regular information for occupants, their families and carers, and mechanism for ongoing consultation and feedback**.**	life they choose.
A person centred service	1. The availability of 24 hour care and support. 2. Flexible care and support offered on a step up step down basis. 3. The involvement of families and informal carers in care and support plans. 4. Care and support delivered with kindness and sensitivity. 5. An emphasis on improved quality of life for individuals, rather than service driven objectives, as the goal of care and support. 6. Partnership between agencies as a means to delivering person centred services. 7. Good quality preventative and, rehabilitation services.	The delivery of services which are sufficient and appropriate to meet the needs of ECH occupants, their carers, and the wider communities.

Domain 3 Facilities		
Category	**Characteristics**	**Outcome**
Facilities designed to promote independence	1. Laundry. 2. Facilities for washing soiled bed linen. 3. Specialist bathing equipment and hoists, and staff trained in their use. 4. Transport, scooters and the facilities for charging batteries. The potential for maintenance, for example checking tyre pressures. 5. Assistive Technology.	Housing which has all the facilities necessary to enable people to remain at home until the end of life.
Facilities designed to promote choice and ordinary life	1. Restaurant and café/bar for use by occupants and their guests. 2. Availability of shops, post office,	The proximity of those services such as a restaurant, pharmacy or post office which enable occupants to manage their daily

	health suites, pharmacy etc, either close to the scheme or actually on site. 3. Leisure facilities, for example a greenhouse, pottery, sewing room and craft room, computer access and library. 4. Guest room	affairs as independently as possible.

Domain 4: Community		
Category	**Characteristics**	**Outcome**
A Balanced Community	1. Allocation policies designed to create a balanced community. 2. The promotion of friendships and activities. 3. Encouraging occupants to organise their own activities and social events/networks. 4. Staff trained in community development skills.	A real community, including mixed tenures and mixed abilities.
A resource for use both by scheme occupants and local people	1. The provision of communal facilities for use both by scheme occupants and local people. 2. Access to Lifelong learning, Sport for All and other local initiatives.	A resource which is permeable to the wider community and benefits from the variety of provision available to all citizens.

Domain 5: Staff		
Category	**Characteristics**	**Outcome**
A safe and facilitative working environment	1. Staff day room. 2. Staff training room. 3. Rooms and facilities for staff providing waking and sleep-in night cover. 4. The provision of a safe and attractive working environment.	A working environment which attracts and keeps high quality staff, and contributes to morale and team building.
Trained and supported staff	1. Well paid, well trained staff with a definite career pathway. 2. Clear lines of management and financial accountability. 3. An understanding of one's own role and that of others.	Support for the expansion of a skilled ECH workforce committed to empowerment of older people and the provision of a high quality of life.

4 QUESTIONNAIRES TO TRAINING MANAGERS/PROVIDER ORGANISATIONS

4.1 Scheme manager background.

In the organisations contacted, scheme managers had been recruited from a number of different backgrounds, including residential care, ordinary sheltered housing, social services and health backgrounds, but also from the hotel and leisure industry, catering, the police, and banking. Whatever the background, all organisations stated that scheme managers must have good people skills and be responsive to the needs and individuality of older people.

4.2 Minimum essential requirements for new scheme managers

Table 4 illustrates the wide variety of minimum essential requirements for new recruits set out by providers. All respondents (16) cited interpersonal and communication skills, followed by managing staff (10), working with older people (10), managing budgets /financial awareness (5), and community consultation and empowerment (5). None cited housing and estates management as essential,

Table 4 Minimum essential requirements for new scheme managers

Minimum essential requirements	**No'=16**
Interpersonal/communication skills.	14
Managing staff.	10
Working with older people.	10
Managing budgets/financial awareness.	5
Community Consultation /empowerment.	5
Non-institutional care.	3
IT skills.	3
Health and safety knowledge.	3
Working with people from BME groups/promoting equality and diversity.	2
Recruit for the best set of skills: and for their attitudes and understanding of the issues.	2
Maintaining /managing community facilities.	3
Experience within transferable care setting.	2
Planning and organisation.	2
Problem solving.	1
Team working.	1
Customer care skills.	1
Housing /estates management.	0

Clearly interpersonal and communication skills are seen as of prime importance, and the lack of emphasis on housing and estates management is interesting, given that a number of scheme managers are from housing backgrounds. Two independent providers employ both a care manager and a general manager for their schemes (though with slightly different arrangements), and in both cases had recruited general

managers from the hotel and leisure industry, finding that this gives an insight into creating a suitable environment, managing the building and outside areas, and managing the restaurant service. As one scheme manager remarked,

"Our property owners are used to going on cruises and staying in expensive hotels, and we know how to create that environment."

IPC Interviews

Scheme managers are expected to manage or liaise with staff from a variety of different backgrounds, who bring the particular skills needed to deliver the service. Whilst in most schemes the scheme manager uses the communal facilities for the benefit of occupants and of the wider community, in some schemes they are also expected to manage them in such a way as to bring a financial return to the provider organisation. One ECH scheme visited had appointed a resource co-ordinator with the responsibility of working with the scheme manager to achieve both these objectives, and also to cover the costs of the post.

4.3 Training needs and requirements

4.3.1 Training needs at recruitment

Nine respondents cited managing finance and budgets as a skills gap in new recruits, especially those coming from health and care backgrounds. Conversely, those coming from business or industry needed training in working with older people. Managing budgets was more likely to be cited as a likely skills gap than managing staff, and housing and estates management was cited by 5 managers. In all, a total of 16 respondents cited 20 areas in which they might expect to train new scheme managers, a list which reflects the wide range of skills which scheme managers have to exercise, and which includes new legislation and directives, visual awareness training (for an RNIB scheme) dementia awareness, and bereavement and counselling skills.

One provider in particular stressed the need to change the ethos of care, particularly with scheme managers coming from a background in residential care. She remarked that it is extraordinarily difficult for ex-residential care managers to manage the balance of risk and intervention in ECH, and to refrain from 'popping in' on occupants.

4.3.2 Induction training

All the schemes offered induction to new staff, although this varied in length and intensity from 1 day to 3 weeks. At least one scheme used the TOPSS induction system. Four schemes encouraged peer group networking: whether this was possible depended on the distance between schemes. Four providers had mentoring systems for new scheme managers, 3 used shadowing and 3 used buddying systems, whilst 3 used intensive supervision. In general, there was a recognition that new scheme managers need considerable support in what is a complex and demanding role.

4.3.3 In-House Training

Information was received about in-house training from 16 providers. Of these, three did not have their own training organisation but had an ongoing relationship with an outside training organisation. Of the remaining 13, in-house training covered the following areas:

Table: 5 In-house Training

Topics covered by in-house training	No' =13
Interpersonal/communication skills.	8
Managing budgets.	6
Managing staff.	7
Working with older people.	6
Working with elders from ethnic minorities.	4
Housing/Estates management.	5
Maintaining/managing community facilities.	5
Community consultation methods/empowerment.	4
Provision of non-institutional care.	4

The major providers with a national remit vary in their approach to in-house training, from the provision of a six month in-house foundation course for new scheme managers, to an in-house induction course which uses National Occupational Standards and which is closely related to TOPSS and the Federation.

Some providers send their scheme managers on the NVQ4 Residential Care Managers Course, whilst others use training which provides general management skills. Other in-house training included support planning, risk assessment, abuse of vulnerable adults, complaints, and working in partnership.

4.3.4 Reviews of scheme manager training

Eleven out of sixteen providers were currently reviewing their scheme manager training. Future training requirements included:

- Technology for administrative purposes.
- Training in more flexible and proactive recruitment techniques.
- Risk management and the links between organisations.
- User focused care management.
- The balance between responsibility and independence.
- The protection of vulnerable adults.
- Dementia awareness.
- Mental health.
- Issues around ageing, nursing care and the management of move-on.
- Duty of Care.
- Business planning.
- Legal requirements and accountability.
- Regulations for CSCI.
- Management of stroke and diabetes.
- Skills for networking with the local community.
- Being familiar with all possible sources of help for older people.
- Managing budgets and resources.
- Skills and understanding for delivering Intermediate Care.
- Marketing.
- Community Liaison.
- NVQ4 in management and NVQ4 in care.
- Customer service skills.

- Managing anti-social behaviour.
- Health issues.
- Positive ageing.
- Monitoring Telecare.

4.3.5 Average Annual spend on scheme manager training

Eleven respondents were able to give an estimate of the average annual spend on scheme manager training, which ranged from £300 to £1,500, although the latter sum was expected to decrease. Some respondents did not include the cost of in-house training. One provider estimated about 3% of salary. Generally, however, the sums spent on training were expected to vary according the needs of individual managers.

4.3.6 Organisations providing training

Providers accessed training from a wide variety of organisations, including freelance trainers as table 6 shows. In addition, they combined training with other organisations, especially training for statutory skills requirements, which would often be shared with residential homes. NVQs might be done in-house, or through local colleges.

Table: 6

Sources of training used by agencies	No'=16
Freelance trainers.	11
Academic Centres.	7
Government Training.	3
Professional bodies.	7

Other sources of training included Universities and local colleges, the Centre for Sheltered Housing Studies, SITRA and the National Housing Federation, Age Concern, private companies, Supporting People training, and attendance at conferences.

Some training providers were of the opinion that all the necessary training for Extra Care Housing is already 'out there' and simply needs to be picked off the shelf. Whilst it is true that National Occupational Standards exist in many areas where the scheme managers interviewed identified training gaps, in the view of some training managers, these are not sufficiently focused to be of use in an ECH setting. For example, it was pointed out that Dementia Awareness training is not available at the level of NVQ 2, and the provider at scheme 4 is funding a 2 year programme which will ensure that all their workers at NVQ level 2 also receive this training, which they regard as essential.

4.4 General Provider views

Views from providers ranged from a fairly service orientated perspective, in which ECH was viewed as similar to OSH with more care, to the perspective that ECH involves a complete change of ethos in service provision for older people, with new skills relating to understanding the causes of dependence, tackling ageism and the quiescence in older people caused by internalisation of ageism by older people themselves, the value of inter-generational work, and best practice in design and support skills for people with dementia.

Respondents were asked if they felt that ECH demanded a different sort of training from other models of service provision. Their answers could be positioned upon a continuum ranging from:

a) Those who thought that essentially the training was no different from, on the one hand, residential care management training, and, on the other, training for ordinary sheltered housing scheme managers; and
b) Those who thought that delivering ECH requires a unique approach and a different set of skills.

Table: 7 Does delivering ECH require unique skills?

Evaluating the uniqueness of skills for ECH No'=15						
ECH seen as unique / not unique	Not unique – values /skills similar to other managers	Unique – focus on legislative /organisational differences	Unique – focus on staff roles /supporting staff	Unique – focus on maintaining independence	Unique – focus on quality of life issues.	Unique – changing the ethos of care
Number of responses	6	2	2	2	1	2

The following skills were identified by the 9 respondents who felt that ECH required a unique set of skills:

- Understanding legislation.
- Dealing with occupants on a day to day basis.
- Good people management skills.
- Pragmatic management.
- Knowledge and care skills.
- Training in managing budgets.
- Training in managing staff.
- Integrating role of wardens, domiciliary care schemes, effective home management.
- Enabling, prompting, counselling and managing/supporting the practitioners of these activities.
- Dealing with multiple needs.
- Mental health issues.
- Skills of maintaining independence when people can no longer do things for themselves.
- Identifying needs.
- Organisational skills.
- Promoting independence.

Two respondents cited dementia awareness training, but noted that both dementia training and training in promoting independence are available to Ordinary Sheltered Housing wardens.

The question about the value, to staff, of one's own front door contributed to the debate. One service manager, who felt that ECH is unique and involves changing the ethos of care, remarked that it is very difficult for scheme managers who have a

background in institutional care to manage the perceived risk posed by their inability regularly to pop in and check up on occupants. Another, listed at the opposite end of the continuum, felt that ECH scheme managers lose something in terms of closeness to occupants by not being able to go into their rooms. This debate gained another dimension during a discussion with the scheme manager at Scheme 1 who was looking forward to new arrangements whereby she would be managing an in-house care team, because this would give her better contacts with the team and more insight into how occupants were faring. This scheme manager found it very disempowering not having this element of control, but feeling responsible. Her issue, however, was not one of not seeing enough of the occupants, as she regularly attended their meetings and functions, it was about where her responsibilities lay, both for early warnings of a resident failing, and also for health and safety within the flats. And this latter concern was shared by the respondent who was attempting to change the ethos of care which residential managers bring to the scheme, because, in her view, people of her occupants' generation are simply not tuned in to the sort of health and safety issues that scheme managers must address all the time.

This debate drew attention to a number of grey areas which scheme managers experience currently and which need to be clarified:

- The tenure arrangements of ECH, as well as the ethos of promoting independence, are such that scheme managers cannot keep popping into flats to check up on occupants. New recruits from institutional backgrounds may need training and support to help them to deal with this.
- Scheme managers need to be supported by policies and procedures, and contracts with occupants, which give absolute clarity about their roles and responsibilities, and their powers to intervene. These would include a clear statement of the occupants' responsibility for health and safety within their own flat.
- The principle of identifying when older people begin to fail, and negotiating appropriate interventions, is a long established principle of preventative services, including ordinary sheltered housing. In schemes where the scheme manager does not directly manage the care provision, close and formally agreed links between the care provider and the scheme manager are essential.

5 DISCUSSIONS WITH OCCUPANTS

Occupants were first invited to comment on the most valued elements within their scheme, and then on what they would like to see improved. Not all respondents agreed with one another: for example, at Scheme 3 one younger woman who had been isolated and in poor health when living in the community expressed her appreciation of the regular healthy meals provided, and pointed out that simply eating in company rather than alone had improved her appetite. Older respondents in this group were far less happy with the meals provided, and complained that the vegetables were undercooked. This may be a simple cultural difference arising from the difference in age, rather than an indictment of the meals.

In Scheme 4, occupants in flats were unable to control the heating and found the flats too warm, whilst those in bungalows could regulate the heating independently.

In Schemes 1 and 3, the issue of outings was important, because these had previously been a feature in both schemes but had been discontinued, largely because of an absence of staff to support frail occupants. Scheme 4 continued to provide regular visits to theatres and events further afield, whilst occupants in Scheme 2 arranged their own events via the occupant run social committee.

The tables below summarise the unprompted responses of occupants to the two introductory questions:

- What do you value most about living here?
- And what would you like to see improved?

Table 8 Characteristics of ECH as defined by occupants.

What do occupants value about ECH = √	**Scheme 1**	**Scheme 2**	**Scheme 3**	**Scheme 4**
Peace of mind for self and family.		√	√	
24 hour access to care.	√	√	√	√
Company.			√	√
Links with internal and wider Communities.	√	√		√
Security.			√	√
A proper meal.			√	
Building quality.	√	√	√	√
Activities.		√	√	√
Proximity of services.	√	√		√
Enjoyed the food: healthy eating.	√	√	√	
Balance of care and support with independent living.	√	√		√
Confident in ability to return home after hospital admission.	√	√		

What do occupants value about ECH = √	Scheme 1	Scheme 2	Scheme 3	Scheme 4
Support for carers.	√	√		√
Good relationship with PCT.	√			
Learning new skills.				√
Role of occupants in decision making.		√		
Qualities of scheme manager.	√	√		
Good continuity/communication between different staff members.		√	√	
Responsive staff.	√	√		
You can shut your door if you want to.	√	√	√	√

Table 9 Improvements desired by occupants.

What would occupants like to see improved? = √	Scheme 1	Scheme 2	Scheme 3	Scheme 4
Proximity of services.			√	
Would like more outings.	√		√	
Didn't enjoy the food.			√	
Too many very frail people moving in.				√
Flats too warm – occupants can't control heating.				√
Buildings/layout.		√		

Generally, occupants presented a very positive picture of the four schemes they lived in, although no doubt it would have been possible to find individuals whose experience had been less positive. More detailed comments from the occupant interviews are contained in Appendix 3. Valued elements which respondents tended to cite first included:

- Company.
- Security.
- Balance of Independence and support.

Occupants from one of the RSLs visited had developed their own vision for ECH during a consultation and participation event. This vision was:

Our homes, our future – the care comes to us: we do not go into care.

This positive view accentuates the centrality of the user, and the rejection of institutional solutions. Unprompted responses from occupants on what they valued most from ECH included:

- Peace of mind for self and family.
- 24 hour access to care.
- Company.
- Links with internal and wider communities.
- Security.
- A proper meal.
- Quality of the buildings.
- Activities.
- Proximity of services.
- Healthy eating.
- Balance of care and support with independent living.
- Confidence in ability to return home after hospital admission.
- Support for carers.
- Good relationship with GPs and nurses.

6 DISCUSSIONS WITH SCHEME MANAGERS

6.1 Scheme manager employment backgrounds

Scheme managers interviewed brought a wide range of skills to the job, and identified training gaps in areas outside those skills. Table 10 below shows the background and self-identified training gaps for each manager.

Table 10 Scheme manager employment backgrounds and training gaps.

Background of each manager by scheme	**Scheme 1** Community development, housing, social services	**Scheme 2** Hotel and leisure industry, day care	**Scheme 3** Community psychiatric nurse, domiciliary care manager	**Scheme 4** Social services
Training gaps for each manager identified by √				
Domain 1: A barrier free environment.				
Designing for disabilities /awareness of buildings issues.	√		√	√
Rights and responsibilities of occupants and managers.	√			
Maintaining security.		√		
Domain 2: Care and support.				
Early warning signs for medical conditions including dementia.	√	√	√	
Basic knowledge of medication		√		
Understanding the need for dental and foot care.		√		
Supporting People training.	√			
Care and Support Plans.	√			
Data control.	√			
Payments and the use of agency staff.	√			
Who controls practice between different staff groups.	√			
Understanding terms such as independence and deskilling.	√			
Emotional support and mental health/dementia issues for occupants.	√	√		
Working with relatives.	√	√		
Domain 3: Facilities.	Not recorded			
Domain 4: Community.		√	√	

Background of each manager by scheme	**Scheme 1** Community development, housing, social services	**Scheme 2** Hotel and leisure industry, day care	**Scheme 3** Community psychiatric nurse, domiciliary care manager	**Scheme 4** Social services
Fostering community spirit.		√	√	
Tenancy issues.			√	
Domain 5: Staff.			√	
Management training.			√	√

6.2 Issues

A number of issues arose from these discussions as set out below.

6.2.1 The high level of expectation that occupants have

All the schemes encountered problems whereby some of the expectations of residential care were carried over into ECH. Although new occupants and their families are given information about the scheme, some people expect and demand a higher than provided level of support. It was generally agreed that new occupants take some time to settle in, perhaps as much as six months, and during this time they may get used to summoning help via the pull cord. In a number of cases this makes difficulties for the provider, as it is not clear who pays for these extra support needs and the provider may bear the cost. Some providers are now thinking of itemising these demands and asking that occupants pay for them, if only to throw the responsibility back on the user and encourage them to be more independent.

There were also issues in the schemes around building communities, ensuring that one group does not become cliquey and exclude others and preventing confrontations from arising. It is not clear that training exists to support staff in this role. Scheme 1 had dedicated a new post to maximising the use of communal facilities, and expected that a range of issues and training needs would arise from the development of this role.

6.2.2 Rights and responsibilities

There was a debate around the provision of skills related to early identification of failing older people, and a basic understanding of the more common conditions such as stroke and diabetes. Whilst scheme managers would like to have those skills, there was a definite policy decision made by the providers of Scheme 3 that it was not appropriate for scheme managers to have those skills, although the scheme manager differed. However, this policy applied to all of this local authorities' ECH schemes.

Scheme managers in Schemes 1 and 2 both felt to some degree unsupported by their organisation, and spoke of 'grey areas' and the need to develop their role on the basis of their own experience.

In Scheme 1, where the scheme manager did not manage the domestic or care staff, there was an issue about her responsibilities in a work environment where she had no reason to go into occupants' flats, and no direct link with carers which would supply her with information. Although she had good links with occupants via the occupants' meetings and social occasions, she would prefer to manage the domestic staff so that

they report back to her if a tenant is failing. The level of choice exercised by occupants is disempowering for scheme staff inasmuch as they don't always know when to intervene. In some cases families are helpful with this. The scheme manager feels that she could pick up, for example, incontinence if she was managing scheme staff. The RSL is in the process of setting up a new care and support agency, with a care manager who will manage the care hours, whilst the scheme manager will help identify needs, an innovation which she greatly welcomes.

This scheme manager identified a need for occupants responsibilities in terms of health and safety in their flats to be clearly set out. She would also welcome more training around her own rights and responsibilities, to clarify the expectations of her own performance, and to clarify the responsibilities of a scheme manager in environment in which occupants exercise choice. This scheme manager expressed a wish for clear policies and procedures, and these are currently being developed by the Local Authority in Scheme 3 – an acknowledgement of the changing demands of the role.

6.2.3 Administering medication.

At the schemes visited, support staff prompt occupants to take their medication, but as one user put it 'they are not allowed to take the pills out of the box'. Users seemed to accept this as just another bureaucratic eccentricity. This was often explained as a practice which stems from the desire of the schemes to avoid being registered as a care agency.

6.2.4 Qualifications

All the scheme managers visited interpreted their roles widely and were prepared to exercise skills learnt in previous professional roles for the benefit of occupants. Two of them felt, to some degree, unsupported by their organisations, in the sense of being unsure of their remit, of the limits of their responsibility in an environment which prioritised occupants' independence. The ethos of maintaining an 'ordinary life' environment for occupants of Extra Care means that scheme managers from a wide range of backgrounds will have something to offer, with training provided to fill knowledge gaps. Interpersonal skills, empathy with the goals and values of ECH, and a willingness to solve problems fast, are basic qualities which all ECH providers would be looking for in their scheme managers. Whilst some organisations had a longish list of minimum essential requirements for new recruits, others expected to identify knowledge gaps and fill them by providing training.

The manager of Scheme 1 would like to see community development skills given to the day centre workers. This was because the emphasis on rehabilitation tends to exclude those older people who simply need social contact, leaving a big gap. The manager of Scheme 4 received a comprehensive in-house training from the provider. In his view, skills for Extra Care Housing scheme managers are such as to require a dedicated qualification. However, he stressed that in his role as manager he expected his staff to bring a variety of skills to their different posts, and that it was up to him to get the best out of them.

However, both the scheme manager and the service commissioner interviewed at Scheme 4 identified a need for a dedicated qualification, aimed at Extra Care scheme managers. They saw recruiting the right individual as key, with training only part of the story. Training through NVQ alone, they felt, was insufficient. Associated with this was the conviction that ECH scheme managers must show vision and leadership, and a commitment to the possibility of empowering all older people, however frail.

7 NATIONAL OCCUPATIONAL STANDARDS AND SECTOR SKILLS AGENCIES

In 2002, the Sector Skills Development Agency (SSDA) was set up to develop skills across a range of businesses and service organisations. These skills are listed as National Occupational Standards, which encapsulate a range of relevant competencies. Staff attain National Vocational Qualifications through courses which consist of various groupings of National Occupational Standards, and they are required to demonstrate that they possess the range of competencies needed to achieve these standards.

A number of employer-led Sector Skills Councils have been set up with the support of the SSDA. These Sector Skills Councils are at different stages in the process of identifying key skills and competency frameworks for the relevant workforce. Some skills may be duplicated across sectors, and this is likely to be particularly the case for skills relevant to ECH, which may encompass skills relating to care, support, housing and estates management, design for independent living, customer care and hotel skills, lifelong leisure and learning, the management of volunteers, and neighbourhood and community development. The future direction of ECH may be influenced by the Sector Skills Council to which it is assigned. Sector Skills Councils relevant to ECH include:

- Skills Agency, formerly TOPSS (Social Care).
- Asset Skills (Housing).
- Skills for Health.
- SkillsActive (Active leisure and learning).
- People First (Hospitality, leisure, travel and tourism).
- GoSkills (Passenger transport including community transport).

A total of 191 National Occupational Standards were identified from the Housing, Health and Social Care Sectors. Of these National Occupational Standards, 176 were linked to the outcomes and processes developed from the literature. The table below shows, for each domain, the number of associated NOS.

Table 11 Matching National Occupational Standards to the Domains.

Domain	**Number of relevant National Occupational Standards**
Barrier free environment.	6
Care and Support.	118
Facilities.	2
Community.	23
Staff.	27

This table suggests that while some of the domains which define ECH provision are well represented in current standards from the main Sector Skills Councils, this is not so much the case for others and in particular those relating to the creation of a barrier free environment and the development of facilities in ECH.

7.1 Provider organisations use of National Occupational Standards

Although outside the interview brief, discussions were held with a number of senior staff in provider organisations, including one service commissioner.

Respondents were as follows:

- Training officer, CSHS.
- Service Commissioner, Metropolitan Borough Council.
- Service Commissioner, Shire County.
- Assistant Director, independent provider.
- Senior manager, TOPPS England.

In the Metropolitan borough ECH had developed as part of a wide range of services for older people, predicated on a raft of good practice principles aimed at empowering and involving older people. These principles may be helpful in bridging the gap between the ethos of ECH and the skills and knowledge needed to deliver it. They include:

- Tackling ageism.
- Participation.
- The giving of information.
- Partnership.
- Understanding the causes of dependence.

Amongst these skills, competencies exist for community consultation and involvement (see Asset Skills H29, H36, H42 and H45), but they may not be suitable for older people or people with special needs. In addition, CSHS provides training in the community focus of the sheltered scheme as part of their Professional Update course for sheltered housing providers, as well as an optional module on Extra Care. Thus there are courses which provide skills in participation, the giving of information, and partnership issues, although some respondents felt that these courses would need to change and become more specialised in order to meet the needs of Extra Care Housing. Currently no specific courses exist in the two areas of tackling ageism and understanding the causes of dependence, both key to the delivery of Extra Care.

The Shire county visited is developing a number of training schemes in-house, including a course in Promoting Independence based on National Occupational Standards. Table 12 shows the NOS which form the basis of this training.

Table 12 Promoting Independence Course linked to National Occupational Standards

Linked National Occupational Standards	**Code**
Promote effective communication and relationships.	CL1
Promote communication with individuals where there are communication differences.	CL2
Promote communication with those who do not use a recognised language format.	CL5
Promote communication and the development of relationships with individuals who lack development of social understanding and imagination.	CL7
Promote communication through the use of technology.	CL8
Contribute to the development and effectiveness of work teams.	CU9

Linked National Occupational Standards	Code
Prepare and provide individual development activities for clients.	X2
Prepare and restore the client and environment prior to and following physiotherapy programmes.	X8
Assist with and carry out agreed physiotherapy mobility and movement programmes.	X10
Prepare equipment for, and support clients during, occupational therapy.	X14
Assist clients to develop self and environmental management skills.	X15
Prepare, implement and evaluate agreed therapeutic group activities.	X16
Enable clients to maintain and improve their mobility through exercise and the use of mobility appliances.	Z6
Support inter-disciplinary teams in delivering individualised programmes of care to clients.	NC4

Thus by identifying key NOS, providers can build the training courses they need. However, the number of NOS available will need to be expanded, and the content of existing ones more closely tailored to the needs of older people.

7.2 Scheme manager training and National Occupational Standards

Most training managers were of the opinion that the NVQ system is fairly comprehensive in terms of the topics covered, with the exception of skills concerning the provision of Assistive Technology. However, the question for some senior managers and commissioners was whether the NVQ system is the right one to meet the skills required, and whether the training it offers is sufficiently in depth or demanding.

Comments about the relevance of NVQ training to the range of skills needed by Extra Care Housing scheme managers include:

- *There aren't any gaps. We work closely with TOPSS to find training.*
- *You can find anything if you shop around.*
- *We can generally find what we want from what is available.*
- *We need to rethink all these and start new.*
- *There needs to be a dedicated training programme for ECH scheme managers, which would be more searching and more critical than NVQ, which is too easy to achieve.*
- *We don't use NVQs because we are a national organisation and assessment requires too many resources.*
- *We train all staff to NVQ 3 – NVQ2 translates poorly to ECH.*
- *Warden training is useful but not sharp enough.*
- *We use the CSHS Extra Care appendix as a basis for additional training round liaison roles with other services, which is a gap.*

Specific skills gaps identified included:

- Skills relating to Assistive Technology: knowing what is available and for whom it is suitable.
- Meeting specialist needs, including people with visual impairment, especially when managers have not had that experience previously.
- Making the links with housing and Supporting People.

- Working in a diverse standards community.
- Making imaginative use of internal space.
- Advocacy and liaison.
- Dealing with friends and family.

One respondent was concerned that there is no dementia awareness module within NVQ2, and this provider has a 3 year programme to provide dementia awareness training to all their staff.

8 FINDINGS AND CONCLUSIONS

8.1 Introduction

Given that Extra Care Housing is a growing and developing area and one where there are a variety of views about the future role and importance of this provision it is of little surprise that there is a lack of consensus as to what training and development is appropriate for extra care housing managers. This concluding section puts forward some overall issues, looks at particular training gaps that have been identified from the study and then provides a checklist of key skills

8.2 Overall issues

8.2.1 It is clear that extra care schemes are influenced by three key factors:

- The ethos that provider organisations ascribe to extra care.
- The purpose that the provider organisation wants a scheme to achieve.
- The background that a manager brings.

It was noticeable for example that if the manager came from a residential care background then training and development was needed which emphasised the distinction between the independence and re-ablement approach underpinning extra care as distinct from the care and dependency roles that schemes offered.

8.2.2

The converse of the above situation is that if extra care does offer a home for life, does provide accommodation for people who would otherwise be in residential care and does provide for people with more advanced dementias then staff need specific training and support in understanding and managing risk. Failing to provide this could mean that some extra care schemes just drift towards being residential care in flats. The discussion with providers and scheme managers at the end of section 4 is a good illustration of this concern.

8.2.3

There is clearly a need to develop training in the community development aspects of extra care housing and build manager skills in working in partnership and on a multi-agency basis.

8.2.4

Given the range of skills required for extra care it seems highly likely that various organisations may develop qualifications specifically in ECH management. It will be important that such courses draw on the work of the Sector Skills Councils and National Occupational Standards. There may be a need for further national work to ensure that there is a matched set of NOS for extra care.

8.2.5

In the absence of such a defined set of skills or new qualifications then it will be important for employers in interviewing and in developing induction programmes that they review people's skills and qualifications against a checklist of what is required. It

would be hoped that the list in the key skills part of this conclusion can perform such a function. It is also the intention of the Department of Health Change Agent Team to develop a computer based system which will allow for the self assessment of skills and types of extra care housing.

8.2.6

The independent sector will play a vital part in developing extra care housing given that between 75-80% of older people own their own property and wish to continue doing so but without the anxiety that this can sometimes cause. It would be hoped that the new guidance/code of practice for managers being prepared by the Association of Retirement Housing Managers will reflect the goals and values behind extra care as well as the practical tasks and requirements involved in managing schemes.

8.3 Specific training gaps

8.3.1 The management of communal and leisure facilities

Some issues here include methods of funding laundry services eg coin operation or service charge, costing the depreciation of equipment and providing for its replacement. Issues around whether restaurant meals should be optional or included in the rent. These are some of the elements of ECH which are contingent, but not definitional, and so subject to the discretion of scheme managers

8.3.2 Security

Training in security could centre on such issues as maintaining progressive privacy,* managing a service for vulnerable people which is accessible to people from outside, liaising with local Community Safety Teams to ensure that occupants can safely visit shops and local amenities

8.3.3 Adequate income

Training in this area would be concerned with offering benefits advice, understanding financial packages for shared equity arrangements and insurances against future costs of care provision, retaining choice in service provision, for example, ensuring that warden services are offered on the basis of need and not to meet the demands of block contracts.

8.3.4 The provision of non-institutional care

Training and support for scheme managers/wardens exists in the form of the CIH Supported Housing and Wardens' Certificate and training provided by the National Wardens Association. Many of the larger providers have comprehensive in-house training schemes. Some providers encourage their scheme managers to undertake an NVQ in Residential Management for adults. ECH Scheme Managers operate at the intersection of these two disciplines, but with a far broader remit than either, and it is this emerging role that will need to be reinforced by new training.

8.3.5 Partnership working

The range of services and agencies involved in maintaining older people within the community is becoming more diverse and spread across the state, voluntary and

* Progressive privacy is the system which ensures that, although the communal areas are accessible to people from outside the scheme, the private living areas remain secure.

independent sectors. Scheme managers will need to be skilled not only at managing diversity but also where schemes wish to manage balanced populations, become skilled at negotiation and assessment.

8.3.6 The provision of culturally sensitive services

BME Housing Associations play a crucial role, not only in accommodating people from black and minority-ethnic backgrounds, but also by acting as a model for non-specialist associations, many of whom still do not do enough to make their services culturally sensitive. (Lupton and Perry 2004) Their experience will be needed to develop competencies in this area.

8.3.7 Design elements

If ECH is to provide an alternative to institutional care for older people, then it will be important to understand the role of the building, and the provision of facilities to maintaining independence. This includes elements such as level access, appropriate outside areas, well lit corridors etc. In some cases, scheme managers are recruited at the planning stage of ECH. Making sure that scheme managers have this understanding, and the confidence to impress it upon builders, designers and architects, may mean bringing in NOS from other Sector Skills Councils, or developing new ones relating to design for older people, currently the subject of research at the University of Sheffield. (See Torrington 2004)

8.3.8 The provision of Assistive Technology (telehealth and telecare)

DH has set aside £80m funding for AT for 2006/08, in parallel with £60m from ECH for the same period. The successful delivery of AT is associated with a range of new skills. Some providers (Cumbria County Council is an example) are placing an increasing emphasis on AT to help with supported independence. Training will be needed in assessment, provision and maintenance of these systems, possibly delivered via Community Alarm services and their suppliers. Competencies in this area could be developed in partnership with ICES (Integrating Community Equipment Services), and with the Skills Agency New Roles project of which one of the pilot schemes is a workforce redesign project to develop and implement strategic delivery of AT across Norfolk, and another a project which seeks to implement the World Health Organisation model of innovative care for chronic conditions. (See www.icesdoh.org.uk)

8.4 Key skills

From the questionnaire responses, the documentation from providers, and from discussion with occupants and staff, a set of key skills for ECH has been drawn up as the basis for developing competencies for ECH scheme managers. These are skills listed in Table 13 below.

Table 13 Key skills for ECH scheme managers.

Domain	Key skills for ECH scheme managers
Buildings and a Barrier Free Environment	Housing/Estates management and lettings, licence or tenancy agreements.
	Understanding waiting lists and referral systems.
	Contracts with occupants re roles and responsibilities.
	Skills in negotiating with other professionals, eg architects.

	Basic knowledge of designing for older people, people with dementia and sensory impairment, and people with disabilities.
	Understanding Assistive Technology, its availability, assessment methods and ethical issues.
	Skills in promoting and explaining the scheme to visitors.
	Health and safety /fire regulations.
	Managing budgets.
	Understanding the contribution of aids and adaptations to independent living.
	Repairs and maintenance.

Domain	**Key skills for ECH scheme managers**
Care and Support	Understanding the causes of dependence.
	Promoting independence through an enabling approach.
	Improving quality of life for older people.
	Positive ageing.
	Advocacy.
	Managing risk.
	Promoting care by families and friends in ECH.
	Recognising failing older people.
	Bereavement counselling.
	Working in partnership and working with other agencies on behalf of occupants.
	Basic understanding of medication for conditions such as stroke and diabetes.
	Basic understanding of the management of conditions such as dementia.
	Understanding anxiety and depression.
	A person centred approach to working with people.
	Understanding Eligibility Criteria, Allocation, Assessment, care and support planning.
	Rehabilitation and reablement– encouraging occupants to adopt and discover new skills. The role of prevention in the care of older people, including the role of dental and podiatry services.
	The provision of activity based care.
	Understanding welfare benefits.
	Managing care staff /liaising with care providers/ managing contracts.
	Understanding the role and potential of intermediate care.

Domain	Key skills for ECH scheme managers
	Protection of adults from abuse and the duty of care.
	Supporting People training.
	Understanding the physical, psychological, social, emotional, cultural and spiritual needs of occupants.
	An understanding of the operation of Direct Payments and Fairer Charging.
	Understanding new legislation and accountability, registration and accreditation requirements including Supporting People Quality Framework, Single Assessment Process, CSCI registration etc.
	Customer care skills.

Domain	Key skills for ECH scheme managers
Community	Community Liaison.
	Community development.
	Managing anti-social and challenging behaviours.
	Working with people from black and minority ethnic groups.
	Promoting equality and diversity.
	Managing relationships with neighbours and with the wider community.
	Community consultation and empowerment – encouraging, listening to and responding to the views of older people.
	Spoken and written communication which meets the needs and styles of a wide range of people and situations, and the ability to use and respond to alternative forms of communication.
	Skills relating to Intergenerational work and reminiscence therapy.
	Understanding community transport systems and supporting occupants in accessing the wider community.
	Working with people from leisure services, Age Concern, and other statutory, voluntary and independent sector organisations which provide leisure activities to older people in order to increase the range of activities available.
	To support service users' involvement in their social networks and local community.
	To promote positive attitudes to old age.
	Promoting the principles of lifelong learning.

Domain	Key skills for ECH scheme managers
Facilities	Management and maintenance of communal facilities for the benefit of occupants, the local community, and the provider.
	Management and maintenance of communal laundries and bathing arrangements.
	Management of catering facilities and the provision of particular foods and diets for particular conditions.

Domain	Key skills for ECH scheme managers
Staff	Interpersonal/communication skills.
	Planning and organisational skills.
	Skills relating to influencing and negotiating with other people.
	Managing under pressure/problem solving.
	Understand the limits of one's own responsibility.
	Promoting ones own professional development and that of others.
	Identifying training needs and accessing training.
	Managing budgets/financial awareness.
	Recruitment and retention of staff.
	Exercising leadership and facilitating team building.
	Appraisal skills.
	Presentation skills.
	Understanding roles and responsibilities of other professionals.
	Understanding the Care Standards Act 2000.
	Understanding the complaints policy and accident reporting mechanism.
	Business planning.
	Creating a safe working environment.
	IT skills.
	Understanding confidentiality and data protection.
	Understanding the operation of police checks.
	Staff development.
	Personal development.
	Understanding the ethos of ECH.
	Working with volunteers.
	Understanding personnel and payroll issues.
	Understanding staffing establishment and rotas.

IPC
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BIBLIOGRAPHY

Appleton N. and Porteus J *Extra care housing for older people: an introduction for commissioners*. Department of Health: Housing Learning and Improvement Network. 2003

Ashkam J, Nelson H, Tinker A and Hancock R *The bond between older people and the homes they own.* Joseph Rowntree Foundation. 1999.

The Audit Commission in partnership with Better Government for Older People *Older people – Independence and Well Being: the challenge for public services*. London. 2004

Bartholomeou J A *View of the Future: The experience of living in Extra Care*. Hanover Housing Group. 1999

Brooks L. Abarno T. and Smith M *Care and Support in Very Sheltered Housing.* Counsel and Care. 2003

Croucher K, Pleace N and Bevan M., *Living at Hartrigg Oaks: Residents' Views of the UK's first continuing care retirement community*. Joseph Rowntree Foundation. ISBN 1 85935 132 8. : 2003

Department of Health*, Extra Care Housing Fund: Application Guidance Notes*. 2005

Department of Health, *Domiciliary Care, National Minimum Standards: Regulations*. 2003

Kerslake A, Stilwell P. *Very Sheltered Housing in South Gloucestershire*. Institute of Public Care, 2003.

Kerslake A, Stilwell P. *Developing and Implementing Local Extra Care Strategies*. Department of Health, 2004.

King N, The Housing and Support Partnership *Models of extra care and retirement communities.* Department of Health, Housing Learning and Improvement Network, Factsheet no. 4. 2004

King N, The Housing and Support Partnership *Assistive Technology in Extra Care Housing.* Department of Health, Housing Learning and Improvement Network, Factsheet no. 5. 2004

Lupton M, Perry J, *The Future of BME Housing Associations.* Chartered Institute of Housing, 2004

Oldman C *Blurring the Boundaries: a fresh look at housing and care provision for older people*. Joseph Rowntree Foundation, Research into Practice. Pavilion. 2000

Riseborough M, Fletcher P and Mullins D. *The Case for a Common Currency: Clearer definitions and descriptions for sheltered and supported housing.* Centre for Urban and Regional Studies, School of Public Policy, University of Birmingham, with the Housing Corporation. Housing Research at CURS: No 6. 2001

Suffolk County Council Social Services. *The Suffolk Extra Care/Dementia Design and Management Guide*. 2004

Tinker A. *Royal Commission on Long Term Care Alternative Models of Care for Older People*, Royal Commission on Long Term Care Research Vol 2, Cm 4192-11/2. London: The Stationery Office. 1999b

Torrington, J. *Upgrading Buildings for Older People* RIBA Enterprises, London. 2004

Waddilove D. *Redesigned and Redrawn – developing new roles in social care. Interim report of the Topss England 'new roles' task and finish group after the first year of the project*. TOPSS England, July 2004.

Wanless D, HM Treasury Health Trends Review Team *Securing Our Future Health: Taking a Long Term View, Final Report*. 2002

APPENDIX 1

The Centre for Sheltered Housing Studies Code of Practice for Sheltered Housing, and Extra Care

Standard	Sheltered Housing Code of Practice	Extra Care Appendix	
1	Equality of Opportunity and Diversity		
2	Rights and Responsibilities	2.7	Care and support roles – consultation and participation.
3	Confidentiality		
4	Independence and Empowerment	4.2	Support planning – commitment to service users ownership of needs assessment.
		4.3	Community Involvement: service users are given opportunities, and encouraged to engage with the community outside the scheme.
		4.4	The promotion of choice within the provision of meals to ECH service users.
5	Service Delivery, Review and Continuous Improvement	5.1.1.	Service objectives – there is a clear statement of service objectives that are specific to the EC service.
		5.3.1.	Commitment to the involvement of EC service users and their families/advocates in the scheme and service review process.
		5.4	Service delivery parameters contained in a specific Extra Care Manual /Handbook (or section).
		5.5	Inter-agency protocols.
6	Professional Role and Responsibilities	6.3	Protocols enable all staff/agencies to be clear about their own roles and those of others.
		6.4	Registration with the General Social Care Council (GSCC) by care provider.
7	Collaboration and Community Development	7.3	Collaborative working.
		7.4	Community development.
8	Trained and Supported Staff	8.1.1.	The organisation has included issues likely to affect EC clients within its training plan – eg mental health and dementia awareness, use of specialist equipment and facilities, Fairer Charging.
		8.4	Commitment to staff training by the care provider.

Standard	Sheltered Housing Code of Practice	Extra Care Appendix	
9	Policy and Legislation	9.2	Registrations relevant to EC Service Providers.
10	Physical Environment	10.4	A barrier free environment.
		10.5	Provision for assisted bathing.
		10.6	Provision for incontinence laundry services.

APPENDIX 2

Characteristics of schemes visited

	Scheme 1	Scheme 2	Scheme 3	Scheme 4
Type of provider	RSL	Independent sector	Local Authority	Charitable Trust
No of units	30 one bedroomed flats	90 two bedroomed flats, built over 2 blocks	44 one bedroomed flats	60 one and two bedroomed flats and 18 bungalows
Accessibility	Some wheelchair accessible	All fully accessible	4 fully accessible	All fully accessible
Locality	Small market town bordering large scenic rural area	South coast resort /retirement destination: – very high local house values	Large market town	Urban area with strong local identity: industrial communities disrupted by factory closures in the eighties.
Build date	1990	1997	1984	1995
Support	24 hour care team	24 hour care team	24 hr access to care and support via pull cord	24 hour care team
Tenure	Rented	Owner occupied	Rented	Rented
Scheme manager manages care staff?	No	Yes	No	Yes
Scheme manager background	Housing, SSD and community Development	Hotel and Leisure industry	Community Psychiatric Nurse, Domiciliary Care	Social services
Occupants interviewed	7 occupants including 3 men, two of whom were caring for their wives	3 occupants, one man (caring for his wife) and two women.	9 occupants, of whom 2 were in wheelchairs. Two men and 7 women.	5 occupants, of whom 4 were women
Staff interviewed	Scheme manager, Communal facilities co-ordinator	Scheme manager, Duty manager	Scheme manager	Scheme manager, Service Commissioner

APPENDIX 3

Extra Care Schemes: conversations with older people
Topic Framework

Approach:

The purpose of this discussion with occupants is to find out what elements of Extra Care they value most, and what if anything they feel is missing. We will then use this information in our discussion with scheme managers, to establish which of the valued elements are supported by specific training, and which depend on the background and qualities of individual managers.

- Use existing consultation methods and forums as far as possible so as not to be too disruptive.
- About 8 occupants would be ideal – fewer is ok – probably not more.
- One hour is enough.
- Funnel shaped – ie ask a general question first, use what comes out of it to focus on the detail that we ask for later.

The framework and the prompts are for guidance only. There may be topics in individual schemes that form the basis for a useful conversation without much intervention from us. On the other hand if people aren't sure what we want them to discuss, the prompts will help.

Introductory comments:

Thank you so much for agreeing to meet us. We are looking at the skills and training which Extra Care scheme managers need to make Extra Care work, and we want to hear what you have to say about (*name of scheme*), about the aspects of living in Extra Care that you particularly value, and about any improvements you would like to see. . We will be talking to the scheme manager as well later, to hear her views on what is special about working in Extra Care housing, about the training she receives now, and the training she would like to receive in the future.

Lots of new Extra Care Housing schemes are being planned across the country, and we want to use our conversation with you to make sure that these new schemes support their scheme managers to do a good job by offering the best possible training to meet the needs of the people who live in the schemes.

Go round the room asking people to introduce themselves, how long they have lived in (name of scheme) and where they lived previously.

If we use a tape recorder – ask permission. Otherwise: ask permission to take notes.

My first question is:

From your point of view – what do you most value about living here?

Next,

Could you name three things that you were surprised and pleased with when you first came into the scheme?

Was there anything that you were surprised to find wasn't available when you first moved in?

And finally, from your point of view, what are the qualities that you think are most important for an Extra Care scheme manager?

Points arising from this conversation can be used to discuss occupants expectations of the scheme, whether they are met, and ways in which the scheme has exceeded expectation. Use the following prompts if necessary.

Prompts	
Do you feel that you know the different members of staff at (name of scheme) pretty well?	
Do you know who to go to if you need more help, or less help?	
Do you find it easy to get repairs done?	
Do your family and friends feel welcome here, and do they share in decisions about the help you get?	
Do you get the right amount of care and support, so that you can get on with doing the things you want to do?	
Do you ever feel you get help when you don't really need it?	
Are there times when you need help and its not there?	
Can you get advice on your benefits entitlements?	
Are you able to choose how you spend your money, and what services you get?	
Have you had advice on finance schemes, for example planning for any care needs you might have in the future?	
From the point of view of the people here, which are the staff you have most contact with?	
What sort of tasks are you most likely to need help with?	

Is it fairly easy for you to see a doctor, if you need to?
Is it fairly easy for you to get help with a bath or shower
Can you get help with taking tablets, if you need it?
Can you get help to stay independent – that is, help with shopping, preparing meals, housework?
Does anyone here need help to get about – for instance, to get to the restaurant or to reach the communal facilities? Is that help there when you need it?
Do you find it easy to find your way around inside the building?
Is it easy for you to get about outside the building?
Do you get support when you want to visit or entertain friends?
Do you depend on staff to arrange social activities?
Do you get encouragement and support if you want to take part in social activities
Have you taken up a new hobby or interest since you have lived here?
Do you feel more confident in your own skills since you moved here?

APPENDIX 4

Occupants detailed responses to discussion

Domain	Outcome
A Barrier Free Environment	**A Home for Life** Occupants at Scheme 3 were the most physically frail of the groups we interviewed. Help was available for getting about the building, and there were benches for sitting outside – but no garden. The walk into town, though managed by the more able, was steep. One lady in a wheelchair was still doing all her own cooking which clearly gave her enormous pleasure – her son shopped for her every day. Schemes 2 and 4 were on level sites with easy access to local services, whilst the local community transport service was based at Scheme 1. Scheme 4 had an arrangement with Age Concern which provided two fully accessible minibuses and drivers for shopping and outings.
	High Quality Buildings All respondents appreciated the design and quality of the buildings. Most felt safer not on the ground floor: however, they were aware that they were very dependent on a functioning lift, and all the schemes (and some respondents) incurred the cost of a very expensive service contract to ensure its continued working. In Scheme 2, the 90 flats are built in two tower blocks, and occupants need to move between them to access communal facilities: they felt this could have been arranged differently, and suggested that the second block could have been a nursing home. In Scheme 3 there was general agreement that the layout of the scheme was not ideal, and new occupants needed guiding for a while. The scheme manager, who had a background in mental health, had had no training in building issues, personalising corridors or colour coding routes, and would have welcomed such training.
	One's own front door Respondents appreciated the independence implied by being able to shut their front door – and to take part in social activities or not, according to preference. The manager at Scheme 3, situated in a large town, noted that occupants tended to keep their doors shut and never visited each other in their flats, whilst at another scheme for which she has responsibility, situated in a small rural community, the doors are always open and people visit each other regularly.
	Security Respondents appreciated both the physical security and the response to health issues at the schemes. At Scheme 4, most respondents had been worried about crime when living in the community: indeed, containers planted outside the scheme by occupants had been stolen 2 years running, which was discouraging, but all felt safe within the scheme.
Care and Support	**A Home for Life** Respondents clearly appreciated the 'home for life' principle, although they described it in terms of their confidence in being able to return following hospital in-patient stay. One respondent from Scheme 2 (still driving) had suffered an accident, but returned home after discharge and was cared for by staff. She is certain that, had she not been resident at the scheme, she

	would have been placed in residential care.
	An Adequate Income All respondents had access to benefits advice, although this was not necessarily provided in-house. At Scheme 2, the management agency provided detailed financial advice on request. Respondents at Schemes 1 and 2 were well aware of the financial autonomy provided by ECH as opposed to residential care – one tenant at Scheme 1, previously an owner occupier, was funding his granddaughter through university. At Scheme 3, only one tenant was self-funding, and she was worried because the care agency was late sending out bills. She also found Council Tax and Water rates quite significant. At Scheme 4, a fixed weekly amenity charge covers these costs, which may reduce anxiety for occupants.
	Security All respondents welcomed the 24 hour responsiveness of staff and the availability of a pull cord. Two of the carers had experienced emergency hospital admission, a constant dread for elderly carers, and were enormously benefited by the knowledge that their wives were not at risk.
	An Alternative to Residential Care Some respondents made explicit reference to residential care as a comparison, and felt that ECH offers the right balance of independence and choice with security. In particular the respondent at Scheme 2 who was caring for his wife, and who had spent some time in residential care prior to entering the scheme, felt that the balance at the scheme met their needs better.
	Choice and Control None of the respondents felt that they received unwanted care, or lacked care when it was needed. Respondents at Schemes 1, 2 and 4 clearly felt involved in decisions around social activities in the main. Occupants at Scheme 1 had elected to have a social club but not a occupants' forum: the scheme manager respected this choice, but regretted it as a occupants' forum would have attracted much practical support from the RSL.
	Person centred Services All respondents knew who to go to if they needed more help – or less help.
Community	**A Balanced Community** One respondent at Scheme 4 thought that too many very frail occupants were being offered places. Whilst two of the scheme managers reported issues around cliques amongst occupants, (see below) these were not reported by occupants. . Occupants felt that the level of activities at the scheme had diminished over the years. Some of the respondents were part of an enthusiastic card playing group, but it was felt that activities such as pottery and flower arranging classes were less frequent than before. Occupants did not feel able to access groups using the communal facilities, although the scheme manager said that this was not the case and that occupants were welcome at all groups.
	A Resource for use by Occupants and Local People All the schemes except Scheme 2 operated as a resource for local older people. Occupants at Scheme 1 who were local to the town maintained their community networks, either by visiting friends locally or by attending

	the day centre and luncheon club located in the scheme. One respondent from this scheme had learnt of it via the day centre. The scheme was also a focus for health interventions such as flu injections and the monitoring of people with diabetes – a function much appreciated by occupants. A dedicated worker had recently been appointed at this scheme to maximise the use of the communal facilities for the benefit of occupants and local occupants, and also the RSL. At Scheme 3, some occupants felt excluded from the groups using the communal facilities, other than the Arthritis Club which everybody belonged to. This may have reflected the fact that the town in which the scheme was sited did not have such a strong sense of community. At Scheme 4, creative use of communal facilities had encouraged their use by a wide range of local groups, including older people from the African Caribbean community, and the sharing of skills and friendships across the communities. Without dedicated staff time, it is difficult for ECH schemes to provide outings for frail older people, and it is possible that this is an area in which some ECH schemes perform less well than some residential schemes. Occupants at Scheme 1 had in the past been taken out by a volunteer driver, who worked alone and did not meet health and safety standards, and who has now retired. This raised a number of issues about the scheme manager's responsibility in an area in which occupants make choices, which are of great importance to the delivery of ECH and which are discussed below.
Facilities	**Designed to promote choice and an ordinary life** Flats at Scheme 2 had very generous bathroom accommodation, with both a bath and a walk in shower. Staff had encountered problems with the baths however as standard adaptations did not fit them, and there was no communal bath facility. All kitchens were large, fully accessible, and with low work surfaces. At Scheme 1, a specialist bath purchased 3 years ago had proved unsatisfactory, and a replacement had been purchased which met the needs of occupants. In this scheme there was a treatment room which was situated such that a stretcher would not go through the door, which was harder to put right. Occupants at all schemes were able to book a bath at short notice. Occupants at Scheme 3 were waiting for a video player for the communal lounge. This contrasts with the situation at Scheme 4, in which the scheme manager and commissioner both felt very strongly that a television set has no place in the communal lounge, which is for interactive occasions. Occupants can watch television at home.
	Designed to promote independence All the schemes had a restaurant providing lunchtime meals, as well as space for communal activities. Scheme 1 had continued to provide two hot meals a day for occupants all over Christmas and New Year, which was much appreciated. In addition, one tenant had entertained 7 guests in his flat, with food provided by the restaurant. In addition, all provided communal laundries, with the option of having ones own washing machine plumbed into the kitchen. Care and support workers also used the communal laundries on behalf of occupants.
Staff	Respondents at all the schemes claimed to know the staff well, although a high staff turnover was reported at Scheme 4. Occupants at Scheme 2 remarked that the staff were the greatest attribute of the scheme,

APPENDIX 5

Developing Competencies for Extra Care Housing Schemes Managers: Conversations with scheme managers
Topic Framework

Approach.

The framework is designed to establish whether there are areas of work which characterise the unique qualities of Extra Care Housing, but for which there is no particular training or set of competencies defined. It is ordered in terms of the following topics:

- Facilities.
- Community.
- Care and Support.
- A barrier free environment.
- Staff.

The prompts can be used if respondents cannot readily find examples. The questions explore:

- Whether there are areas of work for which no training is offered or competencies defined.
- Whether these areas are being raised in consultation forums with staff or occupants.
- Who is ultimately responsible for these areas of work.
- Whether the respondent can identify training gaps, or is aware of training on the subject which has not been offered by the organisation.

Introductory Question.

What do you think are the most important characteristics that set Extra Care Housing apart from other models of service for older people?

Feed back results of conversation with occupants.

Prompts /exploratory questions

Facilities

1) What do you see as the main issues around running communal facilities?

Prompt: payment, financing repairs, maintenance and replacement of machines and furnishing, managing demand – (eg waiting times for assisted bathing, queues for washing machines). Managing large communal spaces to promote privacy and interaction.

2) Have you had training in how to tackle these issues?

3) Whose responsibility is it to manage problems arising from running the communal facilities?

4) Have issues about management of communal facilities been raised in any consultation forums, by either staff or occupants?

5) Do you think there is a need for developing a set of competencies in this area?

6) Do you know of any training that provides these skills?

7) What do you identify as the main training gaps in this area?

Community

8) What do you see as the main issues regarding community development in the scheme?

Prompt: supporting good relationships both within the scheme and between occupants and the local community, resolving disputes, involving carers and families, ensuring no-one becomes isolated, managing challenging behaviour, maintaining a balanced community, suiting activities to the needs of individuals.

9) Have you had training in how to tackle these issues?

10) Who is responsible for community development within the scheme, and between the scheme and the locality?

11) Have issues about community development been raised in any consultation forums, either by staff or occupants?

12) Do you think there is a need for developing a set of competencies in this area?

13) Do you know of any training that provides these skills?

14) What do you identify as the main training gaps in this area?

Care and Support

15) What do you see as the main issues regarding the delivery of care and support within the scheme?>

Prompt: quick response to changes in care needs, continuity of staff, team building, registration, staff awareness of other professional roles, resident awareness of staff roles, promoting independence and personal development in older people, including people with cognitive or sensory impairments.

Training in managing contracts and the delivery of care: arranging cover.

16) Have you had training in how to tackle these issues?

17) Who is responsible for managing care and support staff within the scheme?

18) Have any issues around the delivery of care and support within the scheme been raised in any consultation forums, either with staff or occupants?

19) Do you think there is a need for developing a set of competencies in this area?

20) Do you know of any training that provides these skills?

21) What do you identify as the main training gaps in this area?

Buildings /environment

22) Have you ever been asked to comment on the design of a new ECH scheme, or to contribute to changes to this one? Have you had any training relating to scheme design or designing for dementia?

23) Have you had any training around personalising and differentiating corridors and other spaces in the building?

24) Is there any pressure from occupants to ensure that that happens? ‘

Prompt: for instance, do they come to you if they can’t get their wheelchair through a door for any reason? Or if they get lost on the way to the restaurant?

25) Have issues about access or internal route finding been raised in any consultation forums, by either staff or occupants?

26) Do you think there is a need for training for ECH scheme managers, and perhaps developing a body of competencies around maintaining a barrier free environment and assisting orientation through signage, colour, and design /decorative features?

27) Do you know of any training that provides these skills?

28) What do you identify as the main training gaps in this area?

Staff

29) What do you see as the main issues regarding training and support for staff in this scheme?

Prompt: lack of training facilities, lack of time for team building, joint training etc., lack of amenities for staff

30) Have you had training in how to tackle these issues?

31) Who is responsible for managing care and support staff within the scheme?

32) Have issues about staff support and training been raised in any consultation forums, either by staff or occupants?

33) Do you think there is a need for developing a set of competencies in this area?

34) Do you know of any training that provides these skills?

35) What do you identify as the main training gaps in this area?

Other topic

36) Can you identify any other issues where you think there are training gaps – either because the training doesn't exist, or because it isn't offered?

Prompt: assessment /allocation/ use of AT, security issues, any other issues.
Understanding medical issues and concerns
Understanding need for dental and foot care
Basic knowledge of medication
Care of people with dementia
Emotional support and mental health issues
Working with relatives

37) Have any of these issues been raised in consultation forums, either by staff or occupants?

38) Do you think there is a need for developing a set of competencies in any of these areas?

Thank you for your help in answering these questions.

APPENDIX 6

Developing Competencies for Extra Care Housing Managers

Questionnaire to training officers/Providers: for telephone interview

Thank you for agreeing to help us by providing information to complete this questionnaire.

1 2 3 4 5	Name of organisation Contact name Contact job title Date of telephone interview… Time of interview			
6	How many Extra Care scheme managers does your organisation currently employ? ☐			
7 ☐ ☐ ☐ ☐ ☐ ☐	From what employment backgrounds do your scheme managers come? (Please give numbers in each case)	Prompt	Residential care Sheltered Housing Community Development Learning Difficulty Health Services Other (please specify) …… …… ……	
8 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	What are the minimum essential requirements for new recruits?	Prompt	Interpersonal /communication skills Managing budgets Managing staff Experience of working with older people Experience of working with people from minority ethnic groups Experience of housing /estates management Maintaining /managing community facilities Community consultation /empowerment Provision of non-institutional care Other: please specify …… …… ……	
9 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	In your experience, in which skills do new scheme managers usually need training	Prompt	Interpersonal /communication skills Managing budgets Managing staff Promoting equality and diversity Working with older people Housing /estates management Maintaining /managing community facilities Community consultation methods /empowerment Provision of non-institutional care Other: please specify …… …… ……	
10	How are newly appointed scheme managers supported in your organisation?	Prompt	For example buddying, mentoring or shadowing arrangements, induction training etc, intensive supervision.	

11	What formal appraisal schemes do you conduct with scheme managers?			
12 ☐☐☐☐☐☐☐☐☐	Can you identify key ECH skills for which no National Occupational Standards currently exist?	Prompt	The management of communal and leisure facilities Maintaining a barrier free environment Maintaining security – progressive privacy, design for security. Information for occupants on the subject of benefits, financing future care needs, and equity stakes. The provision of non-institutional care The provision of culturally sensitive services Design for older people Allocating, installing and maintaining Assistive Technology. Other: please specify …… …… ……	
13	Do you feel that ECH demands a different sort of training from other models of service provision?	If yes, prompt	Which are the skills that make ECH unique?	
14 ☐☐☐☐☐☐☐☐☐	Do you have your own in-house training for EC Scheme Managers? If so, in which of the following areas is training provided?	If yes, prompt	Interpersonal /communication skills Managing budgets Managing staff Working with older people Working with elders from ethnic minorities Housing /estates management Maintaining /managing community facilities Community consultation methods /empowerment Provision of non-institutional care Other: please specify …… …… ……	
15	Are any reviews of scheme manager training currently being conducted in your organisation?			

16	In your view, what might be the future training requirements for ECH managers in your organisation?			
17	What is the average annual spend on training for each scheme manager?			
18 ☐ ☐ ☐ ☐ ☐ ☐	From which organisations do you buy training?	If yes, prompt	Provided In-house Freelance trainers Academic Centres Government training Professional bodies Other: please specify …… …… ……	

Thank you for completing this questionnaire.

APPENDIX 7

Organisations providing documentary or questionnaire information on training programmes.

Contacted
Circle 33 Housing Group
South Somerset Homes
Sedgemoor District Council Housing Dept
Cumbria County Council
Heritage Care
Orbit Housing
Guinness Trust
Anchor Trust
Housing 21
Hanover
ExtraCare Charitable Trust
Retirement Security Ltd
Audley Court Estates
Goldsborough estates
Wolverhampton
Jephson Homes Housing Association
Norfolk and Norwich Association for the Blind
Heritage Care

Other Housing LIN publications available in this format:

Factsheet no.1: **Extra Care Housing - What is it?** *(28.07.2003 updated August 2004)*

Factsheet no.2: **Commissioning and Funding Extra Care Housing** *(28.07.2003 updated August 2004)*

Factsheet no.3: **New Provisions for Older People with Learning Disabilities** *(23.12.2003 updated August 2004)*

Factsheet no.4: **Models of Extra Care Housing and Retirement Communities** *(04.01.2004 updated August 2004)*

Factsheet no.5: **Assistive Technology in Extra Care Housing** *(20.02.2004 updated August 2004)*

Factsheet no.6: **Design Principles for Extra Care** *(26.07.2004)*

Factsheet no.7: **Private Sector Provision of Extra Care Housing** *(21.07.2004)*

Factsheet no.8: **User Involvement in Extra Care Housing** *(24.08.2004)*

Factsheet no.9: **Workforce Issues in Extra Care Housing** *(04.01.2005)*

Factsheet no.10: **Refurbishing or remodelling sheltered housing: a checklist for developing Extra Care** *(04.01.2005)*

Factsheet no.11: **An Introduction to Extra Care Housing and Intermediate Care** *(04.01.2005)*

Factsheet no.12: **An Introduction to Extra Care Housing in Rural Areas***(04.01.2005)*

Factsheet no.13: **Eco Housing: Taking Extra Care with environmentally friendly design** *(04.01.2005)*

Factsheet no 14: **Supporting People with Dementia in Extra Care Housing: an introduction to the issues** *(04.01.2005)*

Factsheet no 15: **Extra Care Housing Options for Older People with Functional Mental Health Problems** *(04.05.2005)*

Factsheet no 16: **Extra Care Housing Models and Older Homeless People** *(06.06.2005)*

Case Study Report: **Achieving Success in the Development of Extra Care Schemes for Older People** *(July 2004)*

Technical Brief no 1: **Care in Extra Care Housing** *(29.06.2005)*

Technical Brief no 2: **Funding Extra Care Housing** *(08.07.2005)*

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