



April 2013

DISCUSSION PAPER

Improved Personalisation in Older People's Housing with Care?

Introduction

In her Housing LIN Viewpoint, *It's the Quality of Care that Determines the Benefit of Extra Care Housing*¹, Christine Bentham emphasises the central importance of care and cohesive services in delivering the key benefits of housing with care (HWC)². I agree with her, and in this paper want to explore certain issues in greater detail.

The way in which care³ can be procured in housing with care schemes can be visualised along a spectrum, ranging from pure "micro-commissioning" or "spot-purchasing" at one end to a block contract with no opt-out (a package holiday approach) at the other. Located between these two extremes is an approach which combines spot purchasing for individual care plans (via personal budgets where residents have eligible needs) with a block of care to provide 24/7 or overnight cover – the "core and add-on" approach.

Before the advent of personalisation and personal budgets, care in social sector extra care housing was typically block purchased from a single care provider by the local authority. This care was intended to include packages of care for individual residents as well as round the clock cover which could respond flexibly to emergencies and fluctuations of need. With the requirement by government for the vast bulk of Social Services-funded personal care to be procured via personal budgets, combined with ever-tightening local authority budgets, we are seeing a shift away from large block contracts, and the "core and add-on" model seems to be gaining traction. Within this approach there are probably nearly as many variations as there are local authorities and providers using it. Variations revolve around: what the "core" covers; how generous it is; who funds it and on what basis; who charges; and how much.

For more information on the model's variations, see the Housing LIN's *Care and Support in ECH Technical Brief 2010*⁴ pp.25-31 and the recently updated *Funding in ECH Technical Brief*. I will be updating the former later this year.

¹ www.housinglin.org.uk/pagefinder.cfm?cid=8753

² Housing with care (HWC) and Extra Care Housing (ECH) are used interchangeably in this paper

³ The terms care and support are used more or less interchangeably, although care refers to the service that requires registration with the CQC while support can incorporate more general assistance. I use the term housing-related support to mean something narrower – i.e. support which would have been eligible for Supporting People funding

⁴ www.housinglin.org.uk/pagefinder.cfm?cid=1647

Finding a way through the maze

Over the past year, I have undertaken a number of studies looking into the way in which care has been procured in housing with care schemes, what effect the procurement approach has had on delivery of care, and in turn, the quality of provision and outcomes for residents. In addition, I've spoken to a number of providers and commissioners about their experiences. However, given the range of variations and conditions across the country, it is very difficult to get an accurate overview, or work out exactly what is going on.

There are many factors at play making it difficult to disaggregate cause and effect, and apportion respective contributions to the outcomes I will be considering. Each of the following is likely to have played a part:

- The procurement approach – i.e. “core and add-on” or personal budgets per se
- The way in which personal budgets and support planning have been implemented locally
- Tightening budgets and reduced funding leading to narrower, more prescriptive specifications
- The loss of Supporting People funding in many schemes

My key purpose in writing this paper before updating the Housing LIN *Care and Support in ECH Technical Brief* is to share impressions of the current care provision and implementation of personal budgets and the “core and add-on” approach in HWC for older people, explore their impact on the quality of the service, and to test out how typical or representative they may be.

And so, I would really welcome feedback from readers on your observations, experiences and understanding of the issues. That, in turn, will help to shape any further soundings I need to take in preparation for the updating the *Care and Support in ECH Technical Brief* which, in the light of so many policy and funding changes, must be as factual and accurate as possible.

I would therefore really value people's own views and experiences on the following questions once you have read the paper:

QUESTIONS

- 1) Am I right in my impression that “core and add-on”, with Personal Budgets covering the add-on, is the approach gaining ascendancy?
- 2) Is the following perception reality or illusion: that the traditional approach using block contracts in which the entire care provision was covered, generally enabled relatively flexible and responsive service delivery?
- 3) Are the impressions outlined in this paper borne out by your experience?
 - a) Boundary issues – i.e. who does what
 - b) Service flexibility and responsiveness
 - c) Supporting people with unpredictable needs
 - d) Management and workforce issues, and continuity of provision
 - e) Care and support planning, choice, control and personalisation of service provision
 - f) Collective resident involvement
 - g) Use of Individual Service Funds and a range of personal budget deployment mechanisms
 - h) Transparency and predictability
 - i) Number of care providers

- 4) If so, what factors are at play?
- 5) I would welcome case examples which counter some of the negative practice that I've outlined in this think-piece

Flexibility, responsiveness and personalisation

One of the aspects of Housing with Care (HWC) which I have always valued and emphasised when promoting HWC was that having a care team on site 24/7 enabled people whose needs were unpredictable from day to day – those with Parkinson's, continence issues, acute anxiety or dementia, for example – to receive flexible, responsive care and support. This is also very much the view of the new trade body of retirement community operators.⁵

In my ideal scheme, the care and support delivered was personalised, although residents could choose to have their support delivered from a different provider if they wished. I am now beginning to wonder whether this image was real or illusory, but it was my perception that in good schemes, a block contract which allowed some slack in the system enabled a less rigid approach to service delivery than pertained in domiciliary care in the wider community.

The personalisation agenda is clearly to be welcomed: the focus on the health, wellbeing and broader quality of life outcomes; tailoring services to an individual's assets, aspirations and interests as well as needs; and ensuring that individuals have as much choice and control as they wish over their lives, including any support services. An important component of personalisation and self-directed support, personal budgets are intended to enable people with eligible care needs to exercise more choice and control over the support they receive, so that it is specifically tailored to their preferences in achieving agreed outcomes. This, in turn, is intended to help maximise the wellbeing of individuals needing support.

So, to what extent has the "core and add-on" approach and use of personal budgets achieved these ends? I have gained the following impressions:

1. Boundary issues

In some HWC schemes, tensions, "boundary" disputes and silo-working between commissioners and providers, and between providers of housing management, housing-related support and care have been a feature. Having a single provider delivering all three services may have reduced this risk although roles and responsibilities may still have been unclear (See Blood et al 2012⁶). But I'm wondering whether using the "core and add-on" procurement approach is exacerbating these issues.

In one scheme that I studied where this approach applied, even though the same provider was responsible for planned care, the core 24/7 care (called the "wellbeing service") and housing-related support, there were issues about which tasks fell into which of the three service categories, and a certain rigidity and inflexibility resulted. This appeared to be due in part to the way in which the services were specified by commissioners and, in part, how the specifications were interpreted in delivery. I do not know how common this is.

In addition, reduced funding, for example, because of the loss of Supporting People money, and perhaps more prescriptive specifications, seem to have led to more rigid adherence to specifications, poorer team-working and less flexibility at the edges.

⁵ www.arcouk.org

⁶ www.jrf.org.uk/publications/whose-responsibility-boundaries-housing-care

Because of the different funding and charging arrangements for the core (24/7 cover) and add-on (individual care packages based on care plans) elements of the care, there does need to be transparency and clarity as to what the core service extends to, and what forms part of the care plan, but as with all such boundaries, ideally there should also be some flexibility.

On the positive side, from what I have gleaned, the introduction of personal budgets does not appear to have resulted in the fragmentation of the service that many of us feared, in the sense of many different care providers. It appears that residents are more likely to move towards the on-site provider for the sake of convenience than opt for an external one, provided the service is good and can broadly deliver what is needed. This may change as residents get a better grasp of the ethos of personalisation and the opportunities it presents, but good providers will anticipate this change, up their game further, and diversify their offer to respond.

2. Flexibility and responsiveness

Purchasing based on personal budgets appears to have led to a greater expectation on the part of residents of visits at a fixed time for a specified duration. Perhaps in some HWC schemes this has always been the case. People have a right to know what they are entitled to, and should receive the services they are paying for, and in that respect, the “core and add-on” on model and personal budgets are a good thing. As long as entitlements under both the core and planned provision are properly explained, the approach delivers greater transparency.

But the flipside of transparency and predictability appears to be a loss of flexibility and responsiveness. While punctuality was clearly important to the residents I spoke to, and understandably, they did not want time shaved off their visits since they were paying by the hour, they also wanted staff to give them that little bit of extra time if needed, or to give them a different visit time on a particular day of the week or on an ad hoc basis – i.e. to be able to respond to fluctuations in wishes or needs, not just in an emergency. But with care procured by the hour via personal budgets, and staffing levels structured accordingly, it seems that it is only any slack allowed in the core provision that would enable such flexibility and responsiveness. As a consequence, the more skeletal the core, the less flexible and responsive the service appears to be. And many “cores” do appear pretty skeletal.

3. People with dementia and others with unpredictable needs

The area that concerns me the most about the “core and add-on” approach relates to supporting people with dementia and other unpredictable needs in HWC. As we all know, there is a growing number of people with dementia, and HWC, as referenced in the recent Homes and Communities bidding criteria for the Department of Health’s Care and Support Specialised Housing Fund, is increasingly proffered as a good option for supporting them.

Obviously, for some people with dementia, regular planned input is precisely what they need, and in an ideal world, care plans will include proactive support to help residents with dementia engage in activities to avoid becoming isolated. But whose responsibility should it be if someone at a scheme with dementia gets anxious or agitated and, for example, continually pulls the chord for assistance, or is prone to leaving the building and getting lost, or walking into others’ properties? Such residents need careful monitoring and a more responsive, flexible service. Should this be part of the core service, or part of planned care?

Assistive technology can also play an important part but has to be backed up by responders. Some needs are too intensive to be covered by the core service, yet, from what I've heard, care planning doesn't seem to extend to plans which specify budget or hours, but leave it to providers to deliver the service proactively and responsively as needed. Nor do they seem generous or imaginative enough to provide the kind of intensive, life-enhancing support that might prevent such distressed behaviour occurring in the first place (although obviously staff calibre and training also have an important part to play here).

As a consequence, within the "core and add-on" model some residents with dementia may really lose out and become increasingly isolated and distressed, until their behaviour triggers a move to a more institutional setting. I personally don't think this is good enough and, if we genuinely wish to enable people with dementia to live fulfilling lives in HWC, the service to them needs to be more truly personalised and this in turn can only happen if the approach to procuring the care, and service levels, enable it. As they appear to be playing out at present in older person's HWC, I am not convinced that personal budgets and an additional core provision is the best route to achieving this.

Of course, this is not only about a particular procurement model. It is also about service ethos, relationship- and person-centred provision, staff training and support. But all of these are much more likely to be in place in schemes where there is staff stability and continuity, and that in turn takes us back to procurement and contractual issues.

4. Workforce issues

It also appears to me that there are a number of challenges for providers within the core and add-on model:

- How much care to start off with
- How to build up staffing levels in line with demand, given the recruitment challenges in the domiciliary care market; use of agency staff is expensive and disruptive for residents
- Rotas, shifts and what contract terms to offer in order to attract and retain staff on the one hand, while ensuring flexibility to deploy staff when and where they are needed, and not having them on duty when they're not
- If there is insufficient guaranteed work for staff, turnover is likely to be high. This not only reduces continuity but also may reduce the incentive of providers to properly train staff, and they may lack the sense of commitment and belonging which marks a stable, caring and effective workforce.

Of course these challenges are no different from those faced by domiciliary care agencies in the wider community, and if the local authority block contracts a core, however skeletal, that at least provides a starting point for care providers in HWC which community agencies do not benefit from. However, the lower volumes of care required in many HWC schemes may intensify these challenges.

A number of providers seem to be responding by:

- offering a service to people living in the vicinity of the scheme, thereby spreading the infrastructure costs more widely, and employing more staff to enable greater flexibility

- offering a variety of contract hours, mostly part-time, with the offer of additional work as demand increases; with nil hour contracts not much in the way of commitment can be expected from the individual
- arranging shifts as far as possible to coincide with peak times; some use split shifts but many staff may not be willing to do these
- arranging rotas to provide residents with maximum predictability and continuity

But these workforce issues contribute to making the delivery of good quality care services, characterised by continuity, flexibility, responsiveness and personalised care more difficult.

5. Care and support planning

As highlighted in the Housing LIN Care and Support Technical Brief, personalisation is intended to usher in:

- care and support planning led, or heavily influenced, by the service user;
- plans which are more holistic and outcome-focused;
- support solutions which are potentially more imaginative and reflective of the individual's aspirations, values and interests, not just needs;
- support that is genuinely personalised and individually tailored.

From what I have seen, possibly in contrast to those developed for younger adults with disabilities, the plans developed for older people in HWC are quite prescriptive in terms of timing and length of visits and also tasks to be undertaken. There seems to be little room left for the provider and resident to negotiate the support directly to meet defined outcomes.

Care and support plans appear to focus largely on activities of daily living, and while the way in which these are delivered may well be personalised on the basis of a resident's preferences, this tends to be within the narrow confines of what is prescribed in the care plan and what can be done within the window of time allowed. Whilst I saw some evidence of support being provided to enable residents to take part in the social life of the scheme (for example by escorting him/her to an activity), this did not appear to apply to all who needed it, and this was an area which tended to fall through the gaps between the core service and planned care.

Also, this support tended to be restricted to accessing activities within the scheme. More life-enhancing and personally fulfilling approaches to achieving agreed outcomes seemed absent – for example I saw little evidence of supporting someone to access a local pub lunch rather than the on-site restaurant, or supporting a resident to prepare a meal him/herself rather than have a micro-wave meal. This appeared to be a reflection of a number of things: the more limited amount in personal budgets available for older people; the superficial and narrow approach adopted by some local authority assessors; and the way in which the care plans were written.

This may also have been the case before, and therefore may not be a function of the switch to personal budgets. But personal budgets were supposed to result in improvements in these areas, not more of the same. Many of the personal budgets were in the form of managed budgets rather than direct payments. Perhaps direct payments would lead to different outcomes. However, there appeared to be little appetite amongst residents for the increased responsibility associated with direct payments. I suspect this trend will continue unless more active support is provided to

people to manage their direct payment, and this in itself has a cost which older people's personal budgets may not be large enough to cover. (I read with interest the findings and analysis of the January 2013 TLAP report: *Improving Personal Budgets for Older People: A Review*⁷)

6. Personal budget deployment mechanisms

Guidance on personal budgets for older people talks about a range of deployment mechanisms, with varying levels of control, and that managed personal budgets should be available and enable a significant amount of choice. Yet I am aware of one local authority for example, where residents either have to accept a direct payment, with all the attendant responsibilities contained therein, or accept a "managed service". This means residents cannot choose the on-site provider without a direct payment because the local authority doesn't have a contract with that provider. There seem to be few examples in older people's HWC where Individual Service Funds are available, or a range of support to enable residents to make the most of a personal budget.

7. Changes to care arrangements in existing schemes

The need to change the procurement approach in the wake of personalisation is an opportunity to genuinely consult or involve residents and housing providers, and, even better, co-produce the new specification. Yet anecdotal evidence suggests that in some cases commissioners are introducing changes to the way they procure care in existing schemes without consulting residents, or informing them of the opportunities available from personalisation. Indeed, I came across residents notionally on personal budgets who professed to be unaware of the fact. In other words, it appears that for some local authorities, the introduction of personal budgets ticks a box and provides an excuse for reducing funding, rather than improving personalisation of services and genuinely increasing choice and control to HWC residents.

Discussion

I really do not wish to imply that personalisation and personal budgets are a bad thing, nor that block contracts are/were a panacea. Even with the security of block contracts, there were staffing problems, staffing levels may have been inadequate, and services may or may not have been personalised, flexible and responsive. A common criticism of generous block contracts was that they created a culture of dependency; as with everything else, this appeared to apply in some schemes and not in others.

The "core and add-on" approach does seem to offer the best balance between adhering to government edicts about personal budgets, and retaining the core benefits of HWC. Within this approach, there are some models where the core is more generous than others, enabling a more flexible and responsive approach, especially if the core also incorporates housing-

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www.thinklocalactpersonal.org.uk/library/PersonalBudgets/TLAPImprovingPersonal_BudgetsforOlder_PeoplePhaseOne_D4.pdf

related support and activities facilitation.⁸ However, the more generous the core provision, the more costly it is likely to be, raising affordability issues for whoever bears the cost.⁹

So these are my reflections on the implementation and impact of personal budgets in older person's HWC so far. There are of course pockets of good practice in HWC which buck the trends: seamless, well co-ordinated service provision; genuinely personalised provision; specialist programmes for supporting people with dementia in HWC schemes etc (See Blood et al¹⁰ and Croucher and Bevan¹¹). However, these don't appear to be the norm.

Perhaps what I am seeing is as much a consequence of austerity and reduced funding as the particular procurement approach or personal budgets – in all probability, both have combined to create the current picture. Either way, I am really not convinced that the way in which personalisation seems to be being introduced into HWC for older people is in fact resulting in an improved, more personalised service.

The other key point is that HWC has been seen as a model which delivers support that is different from, and better than, domiciliary care in the wider community, in the sense of supporting independent living while providing a more holistic, flexible and responsive service than is possible in the wider community. While 24/7 cover clearly still provides peace of mind and support in an emergency, which is unlikely to be available in the wider community, has HWC lost the edge over standard domiciliary care in terms of flexibility, responsiveness and holistic service provision? And if so, is this a reality we just have to live with? I sincerely hope not.

Please do look at the questions in the box on page 2 and respond to any that you have a view on. I'm really keen to find out whether what I've seen or heard about is typical. Your responses will also be extremely helpful in contributing to the updating of the Housing LIN *Care and Support Technical Brief*. Please either e-mail me at: sue@suegarwood.co.uk or via the Housing LIN at: info@housinglin.org.uk.

About the Housing LIN

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

The Housing LIN welcomes contributions on a range of issues pertinent to housing with care for older and vulnerable adults. If you have an example of how your organisation is closely aligned to a 'Living Lab' approach or a subject that you feel we should cover, please contact us.

⁸ A downside of individualised funding can be the loss of group activities, and personal budgets for planned care in older people's ECH appear unlikely to be generous enough to enable pooling of part of the budget for this purpose. However, this is not one of the issues being addressed in this paper.

⁹ Where residents pay a separate charge for the core, whether as a separate wellbeing/peace-of-mind/support charge, or as part of the broader service charge, the more units the cost is divided between, the more affordable it will be. It also makes sense for this charge to be divided between all properties, because all residents benefit from the availability of round-the-clock care, not just those in receipt of planned care. And while an hourly charge for planned care could have a small margin within it to enable some flexibility around the care plan, if it is too high it becomes uncompetitive.

¹⁰ www.jrf.org.uk/publications/housing-care-research-practice-examples

¹¹ www.jrf.org.uk/publications/promoting-supportive-relationships

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