healthwatch Salford

Care and Extra Care Housing

SUMMARY Report of all Enter and View visits

June – October 2018 Programme

Contents

1.1 Introduction

Extra Care Housing (the model of Extra Care)

Extra care housing schemes are self-contained flats within a communal housing scheme that enable older people over 55, and others who require extra support, to continue to live independently with flexible support and the security of 24/7 emergency response and care from on-site staff.

Extra Care is defined by having 24-hour care presence in the building to meet the care and housing support needs of tenants in the scheme. Extra Care housing is often classed as independent living with some supported living, like the mid-day meal being provided as part of the tenancy. Support is tailored to the needs of the individual, as part of their care package, to enable people to live in their own home as independently as possible.

Schemes incorporate community-based facilities and visits by professionals from the community i.e. communal spaces and facilities such as an activities room, hairdresser, restaurant/dining area, visiting priest for a monthly service and others.

All properties are self-contained with a fitted kitchen, bathroom with walk in shower *[level access wet-room],* one or two bedrooms, a lounge and their own front door.

Extra care housing schemes operate under a model of having a third of tenants with high care needs, a third with medium care needs and a third with low care needs. As people age sometimes their care needs increase and they are reassessed by social services to ensure it is still appropriate and safe for them to stay on at the scheme. Although 'a home for life' is encouraged sometimes this can lead to more than a third of people living at the scheme with high care needs, which requires more staff time and care.

The size and model of Extra Care varies across Salford. Some are purpose built schemes and others have been converted from other types of housing. In some schemes the housing provider is responsible for activities and in others it is the care provider. As well as variation in contract specification and models, schemes are also shaped by their size and layout and what resources they have available.

Healthwatch Salford

Healthwatch Salford is the independent consumer champion for children, young people and adults who use health and social care services in the City of Salford.

Healthwatch Salford:

- Provides people with information and support about local health and social care services
- Listens to the views and experiences of local people about the way health and social care services are commissioned and delivered
- Uses views and experiences to improve the way services are designed and delivered
- Influences how services are set up and commissioned by having a seat on the local Health and Wellbeing Board
- Passes information and recommendations to Healthwatch England and Care Quality Commission

Healthwatch Salford have statutory powers that enable local laypeople to influence Health and Social Care services under the Health and Social Care Act 2012. One of these statutory powers is to undertake Enter and View visits of publicly funded adult Health or Social Care premises. The Health and Social Care Act allows local Healthwatch Authorised Representatives to observe service delivery and talk to service users, their families and carers on premises such as hospitals, residential homes, GP practices, dental surgeries, optometrists and pharmacies.

Enter and View visits are undertaken when Healthwatch Salford wants to address an issue of specific interest or concern. These visits give our trained Authorised Enter and View Representatives the opportunity to find out about the quality of services and obtain the views of the people using those services.

Healthwatch Salford also produces reports about services visited and makes recommendations for action where there are areas for improvement. Information gathered and reported on is referenced against information from health and social care providers, commissioners as well as national and local research sources.

1.2 Acknowledgements

Healthwatch Salford would like to thank the two Care Providers and three Housing landlords and their staff who were a part of this Enter and View programme. With thanks also to tenants and relatives for their responses and participation during the Enter and View visits.

Thanks also to the Healthwatch Salford volunteers and staff involved in this project.

1.3 Disclaimer

Please note that this report relates to findings and observations drawn from all the visits undertaking to the six Extra Care schemes on specific dates and times, with visits lasting on average 3 hours. This report summaries cross-cutting themes from the programme of visits and puts forward further recommendations. It is not a representative portrayal of the experiences of all tenants, family members and staff, only an account of what was observed and contributed during this programme of Enter and View visits.

1.4 Executive Summary

The context

There is a shift across national and local health and social care services to renegotiate the relationship between healthcare and the service user. A change in relationship to enable more independence and allow people to take back control and responsibility for their own health and care. The model of Extra Care, if effectively run and resourced, should fit well into this new model of reablement, independence and personal responsibility. For details of this see Salford's locality plan, 'Start well. Live well. Age well.'

However, like with other parts of the social care system there are challenges to operating this model both from an operational point of view and tensions from service user expectations when renegotiating responsibility of care.

Healthwatch Salford is interested in the tenant's perspective of Extra Care and if this model enables and provides wellbeing, social inclusion through activities and appropriate communication.

Care and Extra Care Housing

The six Extra Care schemes are all operating under slightly different contractual arrangements, resource constraints, size and environmental differences and variations in the number of tenants with high, medium and low care needs. Therefore, comparisons across schemes would be hard to do fairly, although themes and key findings across schemes will be made here.

Many of the schemes had more than a third of tenants with high care needs. As care is commissioned by the hour on contract this allows flexibility to increase the hours to meet this higher need and also decrease care hours based on the care and support needs of each tenant, as assessed by social services.

Relationships between the care provider and extra care housing landlord were largely cooperative and supportive, although some areas still needed to develop and mature around things like shared communication to tenants and shared working around other elements such as things like activities and mealtimes.

All care providers and housing landlords were going above and beyond contractual specification and funding, providing additional services, activities and support to tenants.

There was clear evidence of both the care provider and the housing landlord encouraging and supporting independence and choice appropriate to this model of independent living. There were also several examples of a tenant's care being managed down from high to medium and sometimes low care need, increasing independence and reducing their need for care.

In this report

This summary report will be exploring recommendations from the six enter and view reports, provider responses and crosscutting themes, key findings and statistics, along with lessons learned, further recommendations and next steps.

2.1 Visit Details

Providers and Scheme Address:	Visit dates, times	Authorised Representatives
Comfort Call [care provider], **City West** [housing landlord], **Monica Court**, Half Edge Lane, Ellesmere Park, Eccles, M30 9AR	Monday 13th August 2018, 13pm-16pm	Safia Griffin Mark Lupton Phil Morgan Vania Burnell Ruth Malkin
Comfort Call [care provider], **City West** [housing landlord], **Astley Court,** Astley Road, Irlam, Salford, M44 5DW	Wednesday 15th August 2018, 13pm-16pm	Safia Griffin Mark Lupton Vania Burnell Ruth Malkin
Comfort Call [care provider], **Retail Trust** [housing landlord], **Moores House**, Shelmerdine Gardens, Salford, Lancashire, M6 8PF	Wednesdays; 22nd 14pm-16pm and 29th 10:30am-12:30pm of August and 5th 14pm-16pm September 2018	Safia Griffin Mark Lupton Vania Burnell Sue Fisher
Comfort Call [care provider], **Mosscare St Vincent's Housing Association** [housing landlord], **Mount Carmel Court**, Oldfield Road, Ordsall, Salford, M5 3LU	Monday 3rd 13pm-15pm and Tuesday 4th 14pm-15:30pm September 2018	Safia Griffin Faith Mann Sue Fisher
Comfort Call [care provider], **City West** [housing landlord], **Amblecote Gardens**, 2 Amblecote Drive West, Little Hulton, Salford, M38 9AA	Wednesday 12th and Thursday 13th of September 2018	Safia Griffin David Backhouse Faith Mann
Care Watch [care provider], **City West** [housing landlord], **Bourke Gardens**, 18 Alfred Street, Worsley, Salford, M28 3UX	Monday 24th of September 2018	Safia Griffin David Backhouse Ruth Malkin Mark Lupton

2.2 Purpose and Objectives

Rationale - purpose of Enter and View programme into Extra Care Housing

- The care provided is regulated by the Care Quality Commission (CQC) but the facility itself is not inspected i.e. the areas managed by the housing landlord
- Commissioners are in the process of reviewing these schemes and our engagement would provide an opportunity for the voice of tenant to be heard more fully in this process
- Healthwatch Salford wants to understand how care is experienced by tenants and dignity and choice is maintained within an extra care housing scheme
- Little is known about whether schemes of this type support the reduction of social isolation and loneliness and/or promote social interaction
- To assess whether communication is fully accessible for tenants

Objectives

- To assess the impact of the variation in care, as rated by the CQC, on tenants
- To evaluate the capacity of Extra Care housing to reduce indicators of loneliness and social isolation
- To capture and share areas of good practice and examples of where things are working and rated more highly by tenant, family and care staff
- To determine whether communication is being conducted effectively
- To recommend areas for improvement

3. Methodology

The project

This programme of Enter and Views focused on the Extra Care Housing scheme context and the two care providers who deliver care in these settings in Salford, Comfort Call and Care Watch.

All six Extra Care Housing Schemes were visited:

1. Amblecote Gardens in Little Hulton – managed by City West Housing Trust
2. Astley Court in Irlam – managed by City West Housing Trust
3. Bourke Gardens in Walkden - managed by City West Housing Trust
4. Monica Court in Eccles – managed by City West Housing Trust
5. Moores House in Claremont and Weaste – managed by the Retail Trust
6. Mount Carmel in Ordsall – managed by St Vincent's Housing Association (Mosscare)

Due to the cross-over of some responsibilities in some schemes and variation in Extra Care models and because the care is being provided within a scheme that is managed by another company (the landlord), both the care provider and landlord, where relevant, were surveyed and reported on in the Enter and View visit reports.

Healthwatch Salford staff met with the three Extra Care landlords and care providers at the end of June to discuss this programme of Enter and Views and their involvement.

After this first meeting a three-way meeting at each of the schemes was arranged between Healthwatch Salford, the housing manager and the care manager and care coordinator. Where visit dates were confirmed and the Enter and View process was discussed in more detail.

All visit dates were announced and pre-arranged with both the landlord and the care provider.

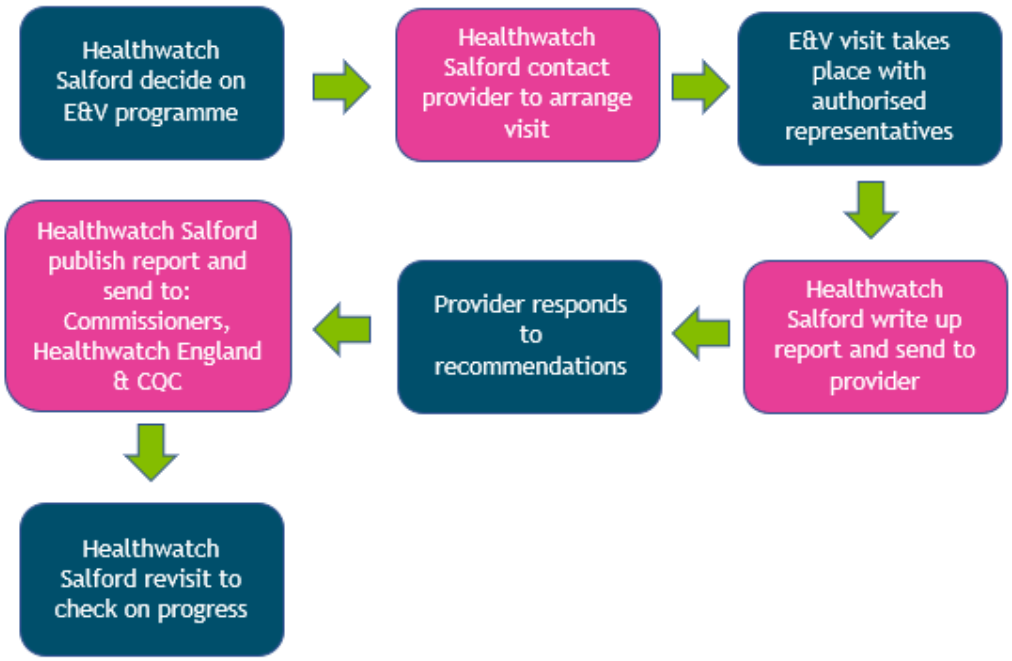
The Project steps:

- Met with commissioners, social services and local CQC officer to brief on intention to Enter and View Extra Care Housing schemes and the care providers
- Commissioners introduced Healthwatch Salford to the scheme and care managers to gain the full cooperation of the providers in this Enter and View process
- Project lead met and briefed housing and care managers
- Project lead arranged visits around meetings, meals and communal activities at the schemes
- Visits undertaken, and Enter and View reports written for each of the six schemes

Timeline:

- June – Commissioner, social services and CQC meeting
- July – meetings with scheme and care managers
- August-September - Enter and View visits
- October – Enter and View reports
- November – report summary, presentations and commissioner meetings
- January-February – Follow-up meetings / telephone calls to review recommendations based on the visits

Overview of the Enter and View (E&V) Process – diagram (simplified)



The visits

All visits were announced Enter and View visit to the six schemes. The Enter and View visit dates were arranged around when most staff would be available and around tenant meetings and activities.

Due to the nature of Extra Care Housing, both the care provider and the housing provider were involved in the Enter and View visit, with staff from both the care and housing provider being surveyed.

In total 115 people were surveyed, with the number of people in each group surveyed listed as:

- Tenants x 49
- Care staff x 37
- Housing staff x 13 (and 1 catering staff member)
- Relatives x 9
- Care Coordinators x 7 (and the Care Watch Branch Manager)

Survey questions were written to assess:

- the effectiveness and responsiveness of communication from the provider to the tenant
- provision of social activity within the schemes, with a focus on social inclusion
- the quality and type of care provided

A proportion of each visit was observational, involving the authorised representatives walking around the public/communal areas and observing the surroundings, using their senses. A checklist was prepared for this purpose.

Some staff referred to people as residents and others tenants. For consistency in terminology the word, 'tenant' will be used throughout this report.

When wording is included in square brackets [ ] it has been added by Healthwatch Salford for clarification.

4. Summary of Recommendations

Across the Enter and View visits to the six schemes there were 46 recommendations made, with corresponding responses from the providers. The care providers had 21 recommendations and the housing providers had 25 recommendations between them.

The themes from the 21 care provider recommendations were:

- **Activities** = 6 recommendations
- Inclusion and variety
- Supporting role in activities

- **Information and communication** = 5 recommendations
- Who is who
- Communication, involvement and feedback
- Tenant privacy and data access consent

- **Staffing** = 6 recommendations
- Staff hours
- Busy and rushed
- Having a say (morale and conditions)

- **Food and mealtimes** = 1 recommendation

- **Relationships between providers** = 2 recommendations
- Shared office space
- Developing relationships at all levels

- **Care review** = 1 recommendation

The themes from the 25 housing provider recommendations were:

- **Activities** = 10 recommendations
- Inclusion and variety
- Involving volunteers
- Staff and activities

- **Information and communication** = 4 recommendations
- Feedback, 'you said, we did' board
- Noticeboards
- Name badges
- Tenant meetings and feeding back

- **Relationships between providers =** 2 recommendations
- Shared office space
- Developing relationships at all levels

- **Physical accessibility** = 2
- Wheelchair accessibility
- Noticeboards and large print

- **Maintenance** = 1 recommendation

- **Dementia friendly** = 3 recommendations
- Signage
- Colour and background

- **Standards and appearance =** 3 recommendations

Recommendations cover several different areas, with some overlap between the care and housing providers. Activities and information and communication had the most recommendations, with some recommendations regarding the relationship between the providers and the environment and accessibility.

The fact that both providers had similar levels of recommendations shows the importance of engaging with the housing provider, not just care, regarding Extra Care Housing. Both impact massively on tenants and it would have been difficult to only engage with care and influence change to the same extent, with housing playing such a big part in tenant's lives and managing the environment in which care is delivered.

The powers of Enter and View only extends to care and so it was important and very positive to have got the invitation and cooperation from the housing provider to speak to them and their staff and involve them in the process.

There were areas surveyed where providers were operating to good and higher standards, as related by those surveyed and observations, and this was reported on in individual reports largely through the feedback given.

Through the Enter and View process and highlighting good practice areas and points for improvement has encouraged providers to review practices and work differently together in some of the areas surveyed. Examples of this are the reviewing of communication methods and activities and shared approaches around such things as staff name badges and tenant meetings.

5. Summary of Provider Responses

All three housing providers and both care providers responded to our recommendation and were cooperative and professional throughout the Enter and View process. Responding in their own words to the report and recommendations demonstrates an openness to direct feedback and ability to listen constructively to criticism. Enter and View can be a critical and challenging process, so it is positive how involved and responsive all providers were throughout this process.

All five providers were sent the report for each enter and view visit, along with an evaluation form. Follow-up meetings with providers next year will be scheduled in to review the influence of the recommendations and provider actions taken following our Enter and View visits.

6. Key findings from the Enter & View Reports

Key challenges and the independent living model

Even with flexibility of contracted care hours there were still challenges to providing responsive and effective care in some of the schemes, especially in schemes where there were more tenants living with more advanced dementia and physical disability, both often reducing and impacting on independence.

Some tenants and relatives had different expectations of the extra care model from what is actually provided under this model of 'independent living'. Services, care and the environment were more geared to this model of independent living, although care could be increased, and the physical environment adapted for those small minority of tenants who require care that would be classed as 'supported living'. This mismatch in expectations and reality sometimes created tension in schemes and led to housing and care staff being unfairly criticised and challenged i.e. in Amblecote Gardens members of the public would bring wondering tenants living with dementia back to the scheme and shout at care staff, believing that the tenant was not being cared for properly. At Moores House some relatives of tenants that were fully able would be rude and critical of care staff if they did not clean and order their relatives belongings in a certain way. At Mount Carmel Court two of the tenants we spoke to had requested daily showers when they were assessed by social services before moving into the scheme but got showered once a week and had daily wash downs.

For almost all schemes this mismatch of expectations was more apparent in some tenant discontent around activities and disengagement from formal feedback mechanisms such as tenant meetings. Tenants who more readily accepted the limits and boundaries of independent living were often more positive in their outlook and in their comments about the scheme, staff and care.

There is inherent tension between the aim of extra care housing providing 'a home for life' and being set up as an 'independent living' model. With increasing instances of dementia and physical disability there are challenges in some tenants being able to retain independence and utilise the benefits of an independent living model. More resources will be required, and service reviews will be needed as schemes home an increasing number of tenants with complex needs and advanced dementia, with subsequent impacts on staffing hours and skill requirements.

The tenants themselves in some schemes were also aware of tensions between a home for life and independent living. Some tenants were frustrated and made negative comments about how many tenants there were with higher care needs, more often about those living with advanced dementia. Some tenants were more distressed and tried to advocate on their behalf and others were more critical and did not think that the scheme was living up to its claim of independent living.

Care staff are being paid minimum wage, but this does not reflect the levels of responsibilities, duties, experience and dedication of these care staff. Care staff are required to provide all aspects of personal care, *[except feeding],* medication, moving and handling and increasing levels of companionship but this is not valued by and reflected in the level of pay that they receive i.e. some care staff had worked in care for more than 20-40 years and were still being paid minimum wage. The Living Wage is one of the local authority's objectives and would go further than just conversations with providers about paying fair wages, which has not resulted in providers raising wage levels. Although there will be challenges in funding this there are also costs associated with

staff turnover, loss of experience from the sector *[with staff leaving care work to get jobs in retail because it pays more]* and low morale.

Quality and choice of food came up again and again in the different schemes. The three new build schemes provide an on-site restaurant for lunchtime meals and mostly comments were fine, apart from Bourke Gardens were there had been ongoing issues with the food since the scheme opened about 18 months ago. The other three schemes that use Appetito *[pre-prepared cooked meals in bulk that get heated through at the scheme]* had mixed comments from tenants about the food. The main concerns with prepared and heated meals were lack of fresh foods and salads, quality and choice and having to decide on menu choices a month in advance.

Feedback from several tenants and some staff reported their concerns around tenants dying or becoming ill and going into hospital and the scheme policy of not informing anyone except family. Some seemed to disagree with this policy and tenants reported some distress and upset about not even knowing if someone was just ill, in hospital or had died because no information around this was disclosed. This would suggest that this policy needs to be reviewed sensitively and something be introduced to allow all tenants to give informed consent to inform others if they fall ill or die.

In the community when there is a death or illness the community will get to hear about it and will often offer support. Extra Care housing brings people together as a community and yet its systems and protocols do not allow others to get involved or know about someone's death or illness. This restriction understandably causes some stress to staff and distress and upset to tenants. The Extra Care model needs to find some way to develop and honour the communities that form within this type of housing, while retaining some control and systems around data consent and privacy. Tenants often develop close ties to each other and staff, often seeing them more than family. These relationships are crucial to that 'community' feel when living in an Extra Care housing scheme. Policy that restricts or works counter to this might inadvertently damage these emotional ties and make people feel less at home and less in control of their own lives.

Care and staffing

Tenants are assessed individually by social services for their care package. Those with low needs would normally have a daily intercom call but no other carer support. Those that fell into the categories of high and medium need would be allocated a certain number of hours of care. This meant that care hours would fluctuate from week to week, month to month and sometimes it was necessary to allocate staff across more than one scheme to make up their hours.

Based on the size of the scheme and number of high and medium need tenants one or two staff would be onsite overnight. For the schemes where only one staff member was onsite there were some concerns raised by both staff and relatives about this practice i.e. if there was a fall at night and two people would be needed to move the person safely or if several tenants fell ill and needed assistance.

Mobility, health and disability impacted on how able some tenants were to make the most of 'independent living' and enablement that Extra Care housing is supposed to provide to tenants. This was partly due to health and partly due to the resourcing and capability of support within the scheme i.e.

- activities were provided that did not meet all needs or adapt enough to different abilities and if the care provider was responsible for activities within the scheme they often had to prioritise care over activities.

- tenants who could not go out on their own, would have to pay for a private carer to take them to appointments or out to anything and those without family or friends and mobility issues struggled to even leave the scheme or maintain outside interests.
- Tenants with dementia need more prompting and lose independence as their condition progresses.

Carers were very busy at all schemes and really seemed to value the teamwork and support of colleagues. There were a mix of staff experience and abilities at the schemes and schemes that had a more established core group of care staff seemed to work more efficiently and more supportively, with older carers often lending their experience and insight to newer and younger carers. Where there was a higher staff turnover and less skilled workforce there were often more instances and comments around being rushed and busy, in some cases with care staff reporting feeling stressed and undervalued.
Some saw care as a job, others is a vocation but when they get too busy all staff felt less satisfaction in their roles, upset about lack of time to actually talk to tenants and would more likely 'do' to tenants rather than 'ask'. Despite this, most staff reported enjoying their roles and getting a lot of satisfaction in their interactions from tenants.

At all schemes care staff were based onsite and were not insured or allowed to escort tenants to anything outside of the schemes. If tenants needed to go out and get to an appointment, they would have to do this by themselves, have friends and family take them or the scheme could arrange for community transport. If they wanted a carer they would be allocated a private carer and be invoiced for this as an additional charge. Some tenants paid for private carers, but others might be less able to afford this extra charge or not be eligible and might be less likely to get out and retain outside interests because of this.

It was interesting to note that some of the schemes homed people under 55 with care and support needs and providers seemed very open to this when discussed at some of the pre-visit meetings. There were two examples were these proved to be successful placements and beneficial to others at the scheme:

- A young man with learning disabilities at one scheme was well liked and got on well with other tenants, reportedly he brought a liveliness to the scheme and cheer to other tenants
- A young woman with a physical impairment feeling content and settled at the scheme, with her care needs being met well physically while still being able to live independently

It would seem that the Extra Care model allows for some diversity and flexibility in housing different people together. With evidenced research to some of the benefits of intergenerational interactions and living it would be positive to see more of this and how the extra care model could accommodate more diversity in housing.

Activities and social inclusion

The model of Extra Care is for activities to be tenant led and more responsibility falls on them to organise, raise funds for and run them. Communal spaces at each scheme are provided for activities and socialising, with some provider support given around the organising of activities and fundraising.

In many of the schemes where we asked the question about how tenants were involved in running and organising activities it was clear that few schemes were successfully running a tenant led programme of activities, most providers were organising them and taking the lead themselves.

There were many different and sometimes overlapping reasons for activities not being tenant led:

- Physical disability and mobility reducing the opportunity for tenants to do the things they used to enjoy and so less interest and involvement in many of the activities and less motivation to run anything themselves.
- High instance of reduced mental capacity meant that not everyone could easily get involved and organise things for themselves and others.
- Tenants choosing not to get involved, wanting to be fully retired from 'work'.
- The belief that the provider is responsible for activities and should provide them.
- Lack of funds and suggestions being met with 'there isn't enough money for that'.
- Busy staff and lack of capacity to always support tenants to run and organise activities.
- The housing landlord historically taking the lead and wanting to ensure that a varied programme of activities and events were consistently delivered.
- Tenants with low care needs having their own interests and many outside contacts being less likely to join in with scheme activities and sometimes perceiving them as something for those that couldn't go out to do.

Some providers were contracted to provide an hour's activity each day and others two health related activities each month. Most providers had taken it upon themselves to provide more activities and social events than they were contracted for.

When and where schemes were involving voluntary and community groups to broaden interests and activities this proved very successful. Good examples of this is the involvement of Incredible Edible at all the schemes in putting in raised planters and running gardening sessions in the summer with tenants and local historians giving talks.

For tenants who do not have contacts or interests outside of the scheme *[and quite a lot of tenants in some of the schemes didn't]* there is a risk of low levels of any physical activity, social interaction / stimulation. This will impact on a tenant's sense of wellbeing and loneliness, if the scheme is unable to provide these crucial relationships, support and activity within the scheme itself.

For those who were mentally able, fitter and more mobile they would often take part in activities and combine this with outside activities and social contacts. Many who were less able and mobile expressed comments about missing out and being upset about not being able to go out or access outside activities.

Only one of the six schemes were fully inclusive and successful in their activities programme, as reported by those surveyed.
Retail Trust, the housing landlord managing Moores House has put considerable effort, resources and funding into their activities over many years. Their successes would not easily be replicated in other schemes, not without a similar level of effort, resourcing and funding but lessons and learning could be taken from this and transferred to future models of Extra Care and any new builds to be developed. This scheme was also one of the schemes that had also been successful in making the scheme feel like a community. Other schemes were less successful in this but not necessarily from lack of trying or resources.

It is important to be clear that new builds and older schemes were having similar issues around creating a community feel and in fully integrating into the community and that new schemes were not necessarily performing better than older schemes.

Communication

In initial conversations during pre-visit meetings with providers it was suggested that the care provider and housing landlord share communication methods and processes for most stakeholder relationships. Although there were often clear and robust processes for communication between the two providers, this was not always the case for communication from providers to tenants, and to relatives.

There were several areas where communication could be shared and some standardisation introduced. For example:

- In some instances, there was duplication of information and different forms being used to gather the same information from tenants.
- In suggesting that a data consent form be introduced for tenants the provider did not first think to check with the other provider and come up with some shared protocol and standardised form, until prompted and suggested by us.
- If one provider was responsible for a method of communication, the other provider was often not sharing this method or was less involved than you would expect from a partnered relationship of this type.
- Lack of shared communication was most common on things like information noticeboards and in newsletters.
- Tenant meetings led by one provider would have some presence from the other, but this might only cover one agenda item, or the rep from the other provider might not speak up, making it more likely that their presence would go unnoticed by some tenants and un-noted. Active participation was sometimes lacking, with points not always fed back to tenants on areas that were important to them.

Efforts were made in new build schemes to display photos and roles of all staff, of the housing landlord, the care provider and the onsite caterer.

GDPR and its interpretation may be making it harder for data sharing but with the correct systems and protocol in place and appropriate use of categories of lawful basis for data use, this should not prevent data sharing where it makes sense and also reduces the burden on tenants to repeat themselves and duplicate copies being kept.

Expectations and information given out at initial assessments and meetings for placement at a scheme also needs reviewing to prevent and reduce instances of things like:

- Families reportedly withholding information about their relative's mental capacity and physical ability to ensure a place within a 'cheaper' Extra Care scheme, instead of a care home
- The mismatch of expectations that is prevalent about what Extra Care is and what support is given within this independent living model
- Unhappy placements and discontent that spreads to other tenants
- Disparity between the care plan from the initial assessment by social services and what is provided at the scheme by the care provider i.e. frequency of showering
- Confusion of responsibilities and who is who between the housing landlord and care provider by tenants

Although there are strong processes in place there are gaps and shared communication still needs developing. Communication could be improved by some standardisation and learning from the good practices of some of the providers.

Key Statistics:

• 32 of 49 tenants felt enabled to stay on at the scheme as their care needs change	- *that's 65% of tenants we spoke to*
• 28 of 49 tenants considered the scheme a home for life	- *that's 57% of tenants we spoke to*
• 35 of 49 tenants felt happy at the scheme (wellbeing)	- *that's 71% of tenants we spoke to*
• 37 of 49 tenants thought that living in an extra care scheme was of benefit to them and their health	- *that's 76% of tenants we spoke to*
• 45 of 49 tenants thought their care needs were being fully met	- *that's 92% of tenants we spoke to*
• 42 of 49 tenants were able to still do things for themselves and retain some independence	- *that's 86% of tenants we spoke to*
• 45 of 49 tenants felt like all staff treated them with dignity and respect	- *that's 92% of tenants we spoke to*

Quoted

"I couldn't be in a better place. I was very lonely at home on my own"
Tenant response

"Staff are excellent. They should all be on a lot more money. They do so much"
Tenant response

"There is always room for improvement. Can't take anything as negative. We always try and see how we can improve the service"
Care Coordinator

"If the team are happy, then the clients are happy"
Care Coordinator

"I go to bingo. I like to talk. I am a social person"
Tenant response

"Happy but frustrated because it could be so much better"
Tenant response

"It's an emotionally draining role and it can affect your health if you get too stressed…"
Care staff member

"Most tenants want to stay independent and social. We encourage them to come out of their flats"
Care staff member

"It is difficult here because you have to prompt so much. Not many tenants are able"
Care staff member

"When one of us goes into hospital though staff won't tell us, and I find that very difficult"
Tenant response

"Yes. I feel happy and secure"
Tenant response

Conclusion

Social contact, how well tenants got on with and were supported by staff, communication and responsiveness and the activities provided were often indicators of levels of content / discontent, happiness / unhappiness and of tenants thinking that living in an extra care scheme was of benefit to them and their health and if they felt enabled to stay on at the scheme as their care needs changed. This was consistent no matter if it was a new purpose built scheme or converted older scheme.

The extra care model lends itself to flexibility in housing different types of people together and in doing so increasing the diversity of those living at the schemes. However, there is still going to be tensions between independent living and a home for life. Adding another factor such as intergenerational housing might impact on this but there are also many potential benefits. It will be interesting to see if future models of Extra Care evolve to include a wider diversity of people being housed and how this new model might be commissioned.

Commissioners should in their contract specification and management be covering areas such as activities and social inclusion more clearly, going beyond just compliance and care, to set standards and manage these crucial but often less prioritised areas of Extra Care housing.

The Extra Care housing in Salford enables many to retain some independence, while providing communal and social spaces. There is a lot of will to succeed and experience across the six schemes and with more community involvement, resources and good practices that retain staff these schemes will be in a better place to develop on their strengths and improve on this model.

It is hoped that commissioners will support providers in this and take on the feedback gained from this Enter and View programme and points made in this summary report.

7. Further Recommendations

1. **Staffing levels and care.** Care staff at all six schemes mentioned being rushed and busy at times or not having enough time, with staff in some schemes also reporting higher levels of stress and staff absences. Some care staff also reported not having the time to talk to and provide companionship to tenants. Commissioners should consider this feedback and have conversations with care providers about staffing levels and raising the number of hours of care, if necessary, to ensure that staff are not overworked and to allow time for less prioritised tasks such as activities and social interaction.

2. **Care staff wages.** Most care staff were being paid the minimum wage, even after gaining decades of care experience. Issues of staff turnover, low morale and devaluing of care as a career choice will continue unless something is done about this by commissioners and providers to raise wages and the working conditions of care staff. This would also be in line with work undertaken by Salford's Health and Wellbeing Board to support a health and social care system which pays the Living Wage.

3. **Future proofing the layout and environment for ageing tenants.** Whether a new purpose built scheme or converted older property, schemes should be developed and invested in to ensure that as tenants age that the layout and environment of the scheme is as accessible and pleasant as possible. This should be within the scheme itself, not just a tenant's flat.

4. **Activities should be part of the contract and funded.** In all schemes but one, activities were a lower priority and less well resourced than other areas of care and housing practice. As activities and social interaction is so crucial to people's health and wellbeing they should be more fully funded and part of the contract to providers.

5. **Involve more voluntary and community groups in schemes.** The involvement of Incredible Edible is a good example of levering in voluntary and community support. More relationships should be built between Extra Care schemes and the community. Commissioners should be prepared to commission from communities directly to enable this.

6. **Explore diversifying the Extra Care model to include different types of people being housed, such as those under 55.** Some examples of this show that it can already be done within the current flexibility of this model. There should be some formal recognition of this to capture what and why this has worked as part of exploring how the Extra Care model could evolve to include more diversity in tenants.

7. **Tenants having to pay for carers to escort them outside of the scheme may discourage some that are less mobile and able from going out.** Equity. Through lack of means, ability or support some tenants are less able to make the most of independent living than others and this creates a lack of equity between tenants. This should be explored further to understand the effect of this and if it is in fact having a negative impact.

8. **Tenant privacy and informed consent.** The policy of not informing other tenants when a tenant falls ill, goes into hospital or dies needs to be reviewed sensitively in light of the wishes of some of the tenants we spoke to about sharing this information. Consideration around announcements and who to notify for funeral arrangements should also be discussed with tenants and their family and formally noted.

9. **Managing inherent tensions between an independent living model and a home for life.** Commissioners and providers should consider how to sensitively manage these tensions.

8. Challenges and Lessons Learned

Healthwatch Salford found that there were some challenges to implementing this programme and some things they would do differently or again, as lessons learned.

Challenges

Speaking to relatives

We anticipated that speaking with relatives would be challenging due to the nature of Extra Care housing and with the timing of our visits being during the day when many relatives might be working or be responsible for children.

Great efforts were made to reach relatives of tenants living at each of the six schemes. Healthwatch Salford:

- Asked providers to email relatives and add our intention to visit the scheme to their newsletter
- Posters were displayed at each scheme of the date and time of our visits
- We asked management to speak to relatives as they saw them and ask them to speak to us
- An online version of the relative's survey was created, and link circulated and promoted

Through these efforts and help from the schemes, we spoke to relatives from three of the six schemes and managed to get some useful feedback from the nine relatives we did speak to.

Privacy

The layout and free space available at some of the schemes meant that at times when speaking to people there was not as much privacy for them as we had hoped. At some of these schemes' conversations took place in communal lounges, dining rooms and staffing rooms. At other schemes, mainly the purpose built schemes, there were separate rooms and enough space to hold conversations on a 1-2-1 and more privately in communal areas. Tenants and relatives were fine with the arrangements, but some staff were more conscious about the possibility of being overheard.

Lessons learned

- **Number of visits**

All teams were led by a member of staff and were organised to maximise the opportunity to speak to the different groups we wanted to survey. This also meant arranging longer visits if only visiting that scheme once and shorter if arranging a number of visits. One or two visits to each scheme worked well, especially in being able to capture more responses from each of the groups surveyed. The one scheme that was visited on three occasions could have been arranged over two, but it did give all the groups surveyed more opportunities to talk to us.

- **Team numbers**

Team numbers could have been reduced where there was more than one visit to a scheme, as the groups to be surveyed were split over two days. On most visits this was managed but on one or two occasions there were times when a team member was left waiting to speak to someone.

However, this also demonstrates the efficiency and experience of the different teams. With varying levels of experience, some teams were newer and some more experienced and so bigger teams allowed for pairings where one person asked questions and the other took notes and observed until newer members felt more confident to speak to people on their own. It also allowed the team to all take their time with each person surveyed and not rush the conversation.

- **The timing of the visits**

The timing of the visits meant that fewer relatives were at the schemes when the Enter and View teams were there. In the future we would consider an evening or weekend visit, if the scheme and staff were available and willing.

- **Pre-visit meetings**

All providers met with the project lead for a pre-visit meeting and this proved successful in gaining full cooperation, building understanding and gaining insight into how each scheme worked and the differences between them. This greater understanding also helped in briefing the Enter and View teams.

- **The survey and questions**

The number of questions and areas covered seemed right, with conversations flowing quite easily. Some questions were difficult for tenants to answer, such as 'feeling enabled to stay on at the scheme as their care needs change' and the scheme being 'a home for life'. This was a crucial question to ask, which gave some insight into the principle of Extra Care being a home for life. The nature of Enter and View and questions asked might cause distress to some and so the team were all experienced in engagement and understand how to handle any distress sensitively and respect the person's right to take a break or end the conversation. No one would ever be left distressed and the team were all aware of their safeguarding responsibilities.

- **Commissioners and social services introducing providers to Healthwatch Salford**

Having the commissioners and social services with a well established relationship with the providers introduce us helped in the initial stages of this new relationship. It meant we were guaranteed an audience with the providers, who were more willing to listen and cooperate from the first meeting. Saving us time and reducing any instances of initial resistance to the process.

9. Next Steps

All Extra Care housing schemes in Salford have had an Enter and View visit, with corresponding reports written for each scheme. These reports and their key findings have been shared widely to influence providers, commissioners and inform the public.

The main part of this project has been completed and come to a close. Now there are only a few further steps to be taken:

- Circulate the summary Enter and View report widely.
- The methodology and materials will be shared with other Local Healthwatch organisations to encourage more Enter and Views into this area of care and housing.
- Dialogue with commissioners about how the Enter and View reports and findings can influence and support the review and development of Extra Care schemes will continue.
- Follow-up meetings with managers from each provider to review recommendations and actions in the New Year will be arranged.

Appendices

a) Further information and useful resources:

Recruiting volunteers for support in care homes and Extra Care schemes

- Volunteer Wellbeing Champions (Care Homes)

Salford CVS, Michael Carroll, 0161 787 7795 (ext 211), Michael.Carroll@salfordcvs.co.uk
https://www.salfordcvs.co.uk/wellbeing-champions-community

Involving the community in running activities

- Creativity in Care

START, Michelle.Dennett@startinspiringminds.org.uk, 0161 351 6000
https://www.startinspiringminds.org.uk/our-projects/start-over-fifty/

Music therapy

- Singing with Dementia

Singing with dementia, 0161 788 9053
http://www.singingwithdementia.co.uk/

Dementia communication training

- Empowered Conversations

Six Degrees Social Enterprise, Emma Smith, 0161 212 4981 or email emma@empowered-conversations.co.uk
www.empowered-conversations.co.uk

Healthwatch Salford

- Further information about the project and Enter and View reports

Contact the project manager, Safia Griffin, 0161 960 0318, safia@healthwatchsalford.co.uk
https://healthwatchsalford.co.uk/extra-care-housing-enter-and-view/

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