Care Services Improvement Partnership CSIP

Housing LIN

Individual Budgets, Micro-Commissioning and Extra Care Housing

Sue Garwood raises concerns about the potential damage to Extra Care housing and outcomes for residents, of the blanket application of individual budgets to commission the care and support in Extra Care

Introduction

The objectives of self-directed support are very welcome: the right of individuals to choose/direct/manage/employ their care/support provider if they wish, and, whether they choose to go down that route or not, the right to determine exactly how their needs and aspirations should be met.

However, micro-commissioning is not the only - or necessarily the best - way to achieve personalisation for all people, in all situations.

The overnment, in addition to introducing this big transformation agenda, is also promoting Extra Care housing as a key alternative to more institutional forms of care. Whilst there is some disagreement on the defining features of Extra Care, most agree that the key feature to differentiate it from sheltered housing is the availability of round the clock care and support. It is this feature which enables people who need planned or emergency care, day or night, and would otherwise be in residential care, to move instead to Extra Care housing.

Round-the-clock Care in Extra Care

Night care - especially regular, planned night care - is very rarely available in the wider community. Some might argue that with the advent of IBs new night care services might burgeon. This seems unlikely, except perhaps in densely populated urban areas. It is expensive to provide a comprehensive service across a wide area: distances are a problem and sole working an issue. The fact that in Extra Care there is a concentration of people who need/potentially benefit from the availability of night care on one site, and it is provided by a single provider, makes it more financially viable.

Equally, during the day, a single on-site provider enables care to be delivered flexibly, responsively and in an emergency – as well as economically.

A number of providers of Extra Care housing have reported that commissioners are no longer willing to block contract or underwrite the care in Extra Care schemes, wanting to leave it to micro-commissioning. There are a number of issues with this approach.

It is unclear how each authority plans to calculate an individual's IB. However, if it is based on the likely cost of a care package, it may prove insufficient to cover the additional cost of round-the-clock cover in Extra Care, even if pooled, because the 24hr provision fills the gaps between the planned care episodes. However, pooled IBs are much more likely to cover this cost if a single provider delivers the majority of care plans, than if these are dispersed between several providers.

One could seek to limit Extra Care to those people whose individual budgets were at the high end – equivalent to residential care – but at a stroke that would undermine the preventative function that a scheme can fulfil, making it much more reminiscent of residential care without the vibrancy of a mixed community.

However, of perhaps greater concern is that without some degree of advance commitment from the local authority, many providers will not be prepared to risk setting up an on-site careand support team – even assuming they are registered to do so. This has usually come from Adult Social Services who have block contracted some or all of the care, in return for a say in the eligibility criteria and allocations to the scheme. An on-site care service needs to exist in the first place for residents to be able to choose it.

Without round-the-clock care and support, arguably a scheme would not be Extra Care housing, and the pool of people able to move to it would reduce considerably. There are very few domiciliary care providers - or family members, friends and neighbours - who could deliver a round-the-clock emergency response service, or even night-time planned care. So we might be left with expensive buildings and a service not much better than traditional sheltered housing.

There is another issue here. If the provider is compelled to provide the round-the clock care team, and directly charge service users for that element, there is a much greater chance of the development being seen as "accommodation and personal care provided together" and therefore be deemed registrable as a care home.

Core and Add-on Approach

A half-way model of a core and add-on approach has been suggested in which the round-the-clock cover is block contracted, with individual planned care and support purchased via individual budgets, either from the on-site provider or an alternative.

This is better than a totally micro-commissioned approach because at least it would ensure that the round-the-clock care is provided. It would be best if Adult Social Care were willing to block commission that service, in addition to providing IBs to residents for additional services, because in that scenario, Social Services would be contracting for the care.

There is also, in theory, the possibility of residents clubbing together, pooling their budgets, and acting as a co-operative employing the care provider to deliver the round the clock service - if the individual budget were large enough to cover this cost, and if the residents wanted to take on that responsibility. That might work in an established scheme but would not resolve the problem for a new scheme – or when the resident population changed.

But, if the core only includes the emergency response, it is not a very cost-effective model, because unless it is a very large development, staff time would not be fully utilised. It could be agreed that residents could choose to use their IBs to buy planned care and support

from the on-site provider. Then the question is how much of the 24hr cover should be devoted to planned care and support, and how much should be left floating for emergency cover and flexible, responsive care. And of course the care provider needs to be geared up for the unpredictability of what is, in effect, spot-purchasing by individual residents. At least in an Extra Care scheme there is logic to using the on-site service if one is available. This should provide a degree of comfort for the provider, but the problems in the 90s when domiciliary care services tended to be spot rather than block-purchased from providers should not be forgotten.

Synergy and Co-ordination

24hr care is not the only issue. Important too are co-ordination and financial viability of the range of on-site provisions. Synergy and cohesion do not have to be synonymous with one-size-fits all. In fact quite the opposite. There are extra care schemes which deliver a very holistic, person-centred, empowering service - care, support, housing-related support, health promotion, activities to lead or take part in etc - tailored to individual needs, and this is made possible partly because there is a single provider doing it all. The more different providers providing similar services, the greater the risk of fragmentation, communication lapses, lack of responsiveness and flexibility - and ultimately non-viability of the service.

A key benefit of Extra Care housing is the opportunity for community involvement, social interaction and group activities. If, for example, micro-commissioning were applied to activities, and there was no-one co-ordinating or facilitating community activities on-site, then these would simply not exist for the individual to take part in. In some schemes, there may be residents able and altruistic enough to do it for others. But this cannot necessarily be relied upon in Extra Care schemes where many people are quite frail, and especially if all residents were frail. A significant benefit would be lost if individuals were only able to pursue solitary interests. They could become lonely and isolated, yet again the opposite of what IBs aim to achieve.

In the midst of some conscientious, but blinkered, promotion of IBs, people seem to roll together facets that are actually separate. Firstly, they seem to equate choosing how care is delivered with micro-commissioning a provider. These two are not synonymous and many older people may choose the former but not the latter. Secondly, a leap seems to be made from having choice and control over one's own individual services, to wanting to develop and manage services at a group or organisational level. Some older people may want these things, but there is concern that the system will impose elements on people that they don't actually want - the very opposite of choice. Whilst having the opportunity is welcome, imposition is not.

Possible Way Forward

All of this really depends on how rigidly the concept of micro-commissioning is interpreted or imposed, but early indications are worrying. With regard to care, the ideal would be for Social Services to still procure a significant amount of it, whether expressed as a grant or a block contract, and enable individuals to opt into that block as now, or use their IBs to call off the block. Individual budgets should also be made available to any residents who wish to go off site for their care.

Adult Social Services might make the contracts cover a shorter period and review the size at regular intervals in order to balance a degree of predictability for the provider, with some flexibility for the commissioner(s). It is important that providers are clear and transparent about what is on offer at the scheme, what the costs cover and the advantages of using the on-site services. They also need to ensure that on-site services are delivered in a person-centred, individually-tailored way. In this model, if individuals were free to choose, probably only those who wanted something very specific – a small number - would choose to go off-site. If many chose to go off site it might be a sign that the on-site services were not up to scratch in which case the provider probably deserves what they get - a significantly reduced contract or removal of the contract.

Individual Budgets need to be implemented intelligently and selectively. To apply the approach to all commissioning is to throw the baby out with the bathwater, with the risk of people having less choice, and services being less responsive, person-centred and flexible in settings such as Extra Care. It would be a tragedy to see the destabilisation or demise of Extra Care and the positive outcomes it delivers for many people.

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