

Housing Learning & Improvement Network

Care in Extra Care Housing - A Technical Brief

The purpose of this detailed Technical Brief is to outline some of the variations and common features, to highlight areas of good practice and provide practical pointers in determining the characteristics and staffing levels of the care service in Extra Care Housing.

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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.

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)

CARE IN EXTRA CARE – A TECHNICAL BRIEF

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Glossary of Abbreviations

CRB	Criminal Records Bureau
CSCI	Commission for Social Care Inspection
ECH	Extra Care Housing
ECHR	Extra Care housing for rent
ECHS	Extra Care housing for sale
POVA	Protection of vulnerable adults
SAP	Single Assessment Process
SP	Supporting People
SPAA	Supporting People Administrative Authority
SSD	Social Services Department

CARE IN EXTRA CARE HOUSING – A TECHNICAL BRIEF

1. INTRODUCTION

A defining feature of Extra Care Housing is the scheme-based care provision. However, there is great diversity in the way this care is commissioned, managed, configured and delivered. Despite the variety, there are also common features and good practice points which are universally applicable. For example, although care is part of the overall service, Extra Care Housing is fundamentally a housing provision. People live in their own homes and the care delivered is domiciliary care not residential care.

The purpose of this detailed Technical Brief is to outline some of the variations and common features, to highlight areas of good practice and provide practical pointers in determining the characteristics and staffing levels of the care service.

The main focus of the Brief is on care services which are eligible for funding primarily from Social Services, as distinct for example, from housing-related support services funded by Supporting People and/or by residents. The Brief is directed primarily at commissioners of the care service but also care and housing providers. It covers the following areas:

- Characteristics of care in Extra Care Housing
- Care commissioning in Extra Care Housing
- Who delivers the care?
- How much care?
- Case examples

Every effort has been made to recognise the diversity in provision, and to reflect a range of approaches. However, given the sheer number of variations, this Brief makes no claim to covering them all. The detailed information in the guide concentrates on care provision in the social housing sector – rented and mixed tenure – and for sale models which do not diverge too much from the basic principles that apply in that sector. Some “for sale” models are too different and complex to elaborate on in this Brief.

The Case Examples at the end of this Brief are intended to accomplish two objectives:

- To illustrate the variety of approaches to care provision
- To provide more detailed information on the care provision, using a common template to enable comparison between the examples

It has not been possible to provide the level of detail needed to meet the second objective in all the examples.

2. CHARACTERISTICS OF CARE IN EXTRA CARE

2.1 DEFINITIONS

Care in Extra Care can be broadly defined to cover a wide range of supportive services delivered in a holistic and cohesive manner. However, the primary focus of this Brief is on “personal care”.

Of four categories of personal care, two trigger the requirement for registration as care providers with Commission for Social Care Inspection (CSCI) under the Care Standards Act 2000: “Assistance with bodily functions such as feeding, bathing and toileting” and “care which falls just short of assistance with bodily functions but still involving physical and intimate touching, including activities such as helping a person get out of a bath and helping them to get dressed¹.” The regulations go on to describe two further categories of personal care, “non-physical care” and “emotional and psychological support.”

All these apply to care provision in Extra Care Housing. Within the latter two categories, the boundaries between care and housing-related support funded by Supporting People (SP) can be rather unclear as, in the majority of situations, housing-related support is also a fundamental service in Extra Care Housing.

“The primary purpose of housing-related support is to develop and sustain an individual’s capacity to live independently in their accommodation. Some examples of housing related support services include enabling individuals to access their correct benefit entitlement, ensuring they have the correct skills to maintain a tenancy, advising on home improvements and accessing a community service alarm².” Supporting People services are those that support the most independent living arrangements and are **not** general health or personal care services.

In this Brief, the term housing-related support will be used when referring to Supporting People services. The term “support” will be used more loosely to cover general support which may encompass care and housing-related support.

In this Brief the term “Extra Care” housing is also interchangeable with “very sheltered” housing, also referred to by some as “housing with care”.

Lastly, the term “residents” rather than “tenants” is used to reflect the variety of Extra Care Housing tenures.

2.2 WHAT SORT OF CARE?

2.2.1 Domiciliary Care not Residential Care

The care provided in Extra Care housing is domiciliary care, **not** residential care. Care is provided to residents on the basis of a care plan (or joint care

and support plan) in their own homes, as defined by the security of tenure afforded either by an assured tenancy or a range of home ownership arrangements.

2.2.2 Registration Requirement

However, the provider of the care must be registered as a domiciliary care provider with CSCI.

An exception to this may be where the care provider is directly employed by the resident. For example, in direct payments or some “for sale” models, and possibly also where the provider is already registered to deliver residential care and provides an outreach service to surrounding owner-occupied properties.

Normal “warden” services in sheltered housing which only provide “neighbourly support” based on prompting, reminding and perhaps help with some practical tasks are not defined as personal care and consequently do not require registration as domiciliary care.

2.2.3 Residential Care Re-Provision

Care should be delivered in such a way as to genuinely promote and encourage independence. In areas where residential care homes are being closed down and replaced by Extra Care housing, and the same care staff are intended to deliver the service, it is essential that staff are given appropriate induction and training in care delivery in an Extra Care setting and do not transfer a dependence culture across to the scheme(s). It is good practice for at least one or two senior members of staff to be experienced in independent supported living so they can lead and reinforce different working practices, values and culture. For further details on workforce development, download the Housing LIN factsheet number 9 on workforce issues in ECH at www.changeagentteam.org.uk/housing.

It is a matter of debate how much Extra Care Housing should be considered a direct replacement for residential care. Many leading providers take the view that if a large number of lettings at the outset are taken by people already in need of residential care this undermines the ability of extra care to provide something qualitatively different or better. Further information is provided in the Housing LIN report, “Extra Care Housing for Older People: an Introduction for Commissioners”.

2.2.4 Care not a Condition of Tenancy or Lease

Receiving and paying for care in Extra Care Housing for rent (ECHR) should not be written in as a condition of tenancy. However, being in need of care is usually included as one of the eligibility and allocation criteria agreed jointly between social services, housing department, housing provider and other partners, such as health.

In the social housing sector, the allocation criteria are normally applied through a panel of partner representatives who will jointly consider applications. They will agree an applicant's suitability and priority for the scheme, following a community care assessment. In the private sector, a multi-agency panel approach is not the norm.

The resident has a contract with the housing provider for the accommodation and related services, and should have a separate agreement covering the care. Where Social Services have commissioned the care, this agreement will usually be with them. This means that issues arising out of the care agreement cannot jeopardise the security of tenure afforded by the Tenancy Agreement, e.g. the resident refusing to pay the care charge.

The same principal applies in Extra Care Housing for sale. Where the commissioner of care is the resident rather than Social Services, as in Extra Care Housing for sale or self-funders in ECHR, the care agreement will be between the resident and care provider, but should not be part of the lease or tenancy. This should be in the form of a separate contract.

In many private Extra Care Housing for sale models, availability of care in an emergency is included in the service charge which forms part of the lease. However, any planned care is agreed on an individual basis between the provider and lessee and charged for separately from the service charge.

Keeping care and housing provision separate in this way is an important element in reducing the risk of being seen to provide "accommodation and care together" within the meaning of the Care Standards Act and therefore be registrable as a care home.

Lastly, following the Minister's explanation to Parliament during the passage of the Care Standards Bill, the existence of a genuine tenancy or lease should mean that as care is being provided in somebody's own home, there is no "establishment" to be registrable as a care home. However, the inviolability of this principle is currently being tested in the courts (see footnote on p 15).

2.2.5 Choice of Care Provider and Direct Payments

Whilst the Choice Directive applies to residential not domiciliary care, people living in Extra Care Housing schemes should legally be entitled to the same choices as others in the locality with regard to their care provider. This includes the option of direct payments. This does not mean that the advantages of using the on-site care provision cannot be pointed out to Extra Care Housing residents: a cohesive service; economies of scale; access to care in an emergency; and better building security if not too many different care providers have access. So far, in practice, the trend seems to be for residents not to opt for direct payments. The most likely scenario for pursuing that option is when someone wishes to retain their current provider when moving into an Extra Care Housing scheme.

Government policy is however to promote the direct control by the recipient of care services. Direct Payments are one way of achieving this and the arrangements for care provision need to encompass this possibility.

2.3 DISTINCTIVE FEATURES OF CARE IN EXTRA CARE HOUSING

2.3.1 24-hour Cover

The general consensus of opinion is that an important defining feature of Extra Care housing, as distinct from other forms of sheltered housing, is the round the clock presence of a care or combined care and support provider. Ideally, a dedicated team of staff delivers the care, even if the scheme is also used as a base to provide domiciliary care to people living in the surrounding community. In other words, the scheme should never be left without at least one member of care staff on site.

This is one of the main features which distinguishes Extra Care Housing from domiciliary care provided to people dispersed throughout the community. In many areas of the country, 24-hour cover is not available to them. Where it does exist, it is likely to be less immediate.

2.3.2 Flexibility and Responsiveness

Whilst care is delivered on the basis of care plans, in order to maximise the unique benefits of Extra Care housing, flexibility should be built in to enable care staff to respond flexibly to temporary and unpredictable fluctuations in need, as well as to emergencies.

An outcome-based approach to care planning (service commissioning at an individual level) will facilitate this. "Having agreed the outcomes and appropriate budget the aim should be for the service provider to negotiate the day to day details with the service user and to have sufficient autonomy to respond flexibly to the user's needs and preferences"³.

Any significant long-term changes in need will usually result in an alteration of the individual's care plan. During the scheme commissioning process, the triggers and arrangements for this should be agreed between social services, care and housing provider(s). The less restrictive, onerous and bureaucratic the process, the better for all concerned.

2.3.3 Independence Promotion

Supporting independence is central to Extra Care Housing. This means supporting people to do things for themselves rather than simply (and sometimes more easily) doing things for people. The way in which care is delivered is critical to achieving this. Staff should be trained to support independent living and care plans should be written in such a way as to enable this approach. Allowing too little time or being overly prescriptive undermines achievement of this objective.

From the outset when developing the scheme, staffing structures and levels, management, organisation, training and what, in practice, it means to achieve independence need to be properly considered. To give an example:

Restaurants are common to Extra Care Housing schemes and may be useful in ensuring levels of nutrition and social contact. However, if all meals are provided this will tend to de-skill residents and create dependency. Are residents supported to make at least some meals themselves if they wish? How will this be done? Who will do this? Does it imply a large number of part-time staff (or volunteers) at key times? Will younger staff of a different generation actually have the domestic skills to help prepare the meals requested? What training may be required? Are staff available with the knowledge to support people from specific ethnic backgrounds with particular dietary preferences?

At the time of writing, the Housing LIN is reviewing the core staff competencies for Extra Care Housing and identifying relevant training and minimum National Occupational Standards. Further information is expected in 2005/2006.

2.3.4 Team Work

The care service is just one aspect of the Extra Care Housing service configuration. Care providers are often part of a bigger team, with delivery of a quality cohesive service to residents being the common uniting goal.

Effective team-working is essential in an Extra Care Housing scheme, especially if the housing and care management structures are separate. The relationship between the care team leader and scheme manager is pivotal; there has to be very close co-operation and communication between them. The relationship should be characterised by a degree of give-and-take, and clarity of roles should be complemented by some flexibility at the edges. For example in some Extra Care Housing schemes, care staff will assist at meal times by serving meals in lieu of preparing meals for individual tenants. Or they may help to run activities by assisting residents to take part, and being available to meet the personal care needs.

2.3.5 Holistic Care

This guide focuses on direct personal care in the way commonly considered and perceived by commissioners and specialist care providers. However, in the context of Extra Care Housing the (limited) research available tells us it is the culture of the organisation and staff and how care is provided that makes a difference to feelings of well being, quality of life and mental health.

The best Extra Care Housing schemes will see social and leisure activities, encouraging independence, healthy living and life styles as all part of an overall approach to care and what good care really means. Furthermore, there will not be rigid demarcation between the different services at the point of delivery.

Whilst commissioners need to know what they are getting for their money, excessive micro-analysis, control and task definition tends to diminish the quality of the service for residents and may well result in a less cost-effective service overall.

Note: At the time of writing, the Housing LIN is in the process of developing an on-line self-assessment toolkit to help commissioners, providers and prospective residents determine, around a set of core domains (or characteristics), whether schemes can be regarded as Extra Care Housing. The Housing LIN expects to prototype this toolkit in 2006.

CHARACTERISTICS OF CARE IN EXTRA CARE HOUSING - KEY POINTS

- Care in Extra Care is domiciliary care, not residential care
- The care provider must register with CSCI as a domiciliary care provider
- Care should not be a condition of tenancy or lease
- Care and support should be available on site round the clock
- The service should be flexibly delivered
- It should be delivered in such a way as to promote independence
- Close collaborative working with other staff on site is fundamental
- Care is only one aspect of an overall approach which facilitates a sense of well-being

3. CARE COMMISSIONING IN EXTRA CARE HOUSING

3.1 WHO COMMISSIONS CARE?

3.1.1 The Social Housing Sector - Extra Care Housing for Rent and Mixed Tenure Schemes

In most Extra Care Housing schemes for rent, including many mixed tenure schemes and care villages, the care service is commissioned by social services or the authority which has social services functions, such as PCT or Care Trust. This tends to be the most common arrangement, irrespective of who provides the care. Very often it is commissioned at a macro level through a block contract rather than simply being spot-purchased for each individual separately.

3.1.2 The Private Housing Sector - Extra Care Housing for Sale and Market Rent Schemes

In most private sector Extra Care Housing, there is no third party commissioning of care at a macro level. The provider determines levels of care provision as well as assessing care needs with the resident and delivering the service. Self-funding residents purchase the care directly from the care provider.

Social Services may commission the care from the provider for individual residents for those residents who are less well-off. The essence of the arrangements is usually these:

- The individual elects to enter the scheme and purchase on whatever arrangements are offered by the landlord and/or care provider
- The care provider as part of the sales process (or offering a tenancy in a market rent scheme) assesses the care needs rather than social services. Commonly they will seek reports from the individual's doctor. A conscious decision is made to sell (or let) to the individual in the light of their assessed needs. The provider may for example decline to accept someone who already has some specified illness such as a form of dementia.
- Services are provided on a similar basis to all residents in accordance with whatever care and financial arrangements are in place at the scheme. These range from "packages" tied to a particular assessed level of need on, say, a six point scale, through to arrangements where residents pay, for example, a basic service charge for a defined set of services and then, according to care and support they actually use, on a quarter of an hour charging unit.
- However Social Services have a duty to assess and meet the assessed care needs of older and disabled, vulnerable people under the 1990 NHS and Community Care Act. Individual residents are entitled to such an assessment if they so choose. They would then be subject to the same principles of service commissioning, a Fairer Charging financial

assessment etc as those in any other domiciliary setting. It should not be assumed all owners have substantial additional resources although some may. In schemes which have been deliberately designed to cater for poorer owner-occupiers by offering shared ownership, this is particularly likely to be the case. Indeed, some housing providers operate a form of means test which ensures that shared owners purchase the maximum equity share they can afford thus leaving them with minimal free capital after purchase.

- Supporting People funds are also potentially available to provide support to less well off vulnerable owners. Supporting People is explicitly “tenure neutral”. When first introduced, the Government put much emphasis on this characteristic, heralding it as one distinct improvement on previous delivery systems such as support funding through Housing Benefit, this by definition only having been available to tenants. Residents are eligible for financial assistance from SP if they are entitled to Pension Credit.

In one model of Extra Care Housing for sale, a co-operative company of owner-occupiers employ the staff who provide a range of support services including personal care. In this model Social Services tend not to be involved in care commissioning at any level although Direct Payments could be an avenue to providing assistance with financing care within the service model.

3.1.3 Legal Relationships

The introduction of Supporting People grant means that in Extra Care Housing schemes housing-related support is commissioned separately from personal care. Supporting People can provide a significant element of revenue funding but adds a layer of complexity to contractual arrangements, reporting, inspection and monitoring. The legal arrangements in Extra Care Housing schemes can be complex and there are a number of variations.

i) Extra Care Housing for Rent – Social Services and Supporting People as service commissioners

Where Social Services are involved in commissioning the care, and the resident has had an assessment and care plan drawn up, which the care provider – hopefully with some flexibility delivers – the primary legal relationships are as follows:

- Social Services and the care provider have a contract for the care provision. The care provider acts as Social Services agent.
- The resident has an agreement, via the signed care plan with Social Services. It is Social Services, not the care provider, which has the statutory duty to provide services to meet assessed care needs and the power to alter the care plan in discussion with the resident. It is they who have the power to contract with a different care provider in schemes with a separately managed care service. Letting the contract to a different care provider does alter Social Services relationship of duty to the resident.

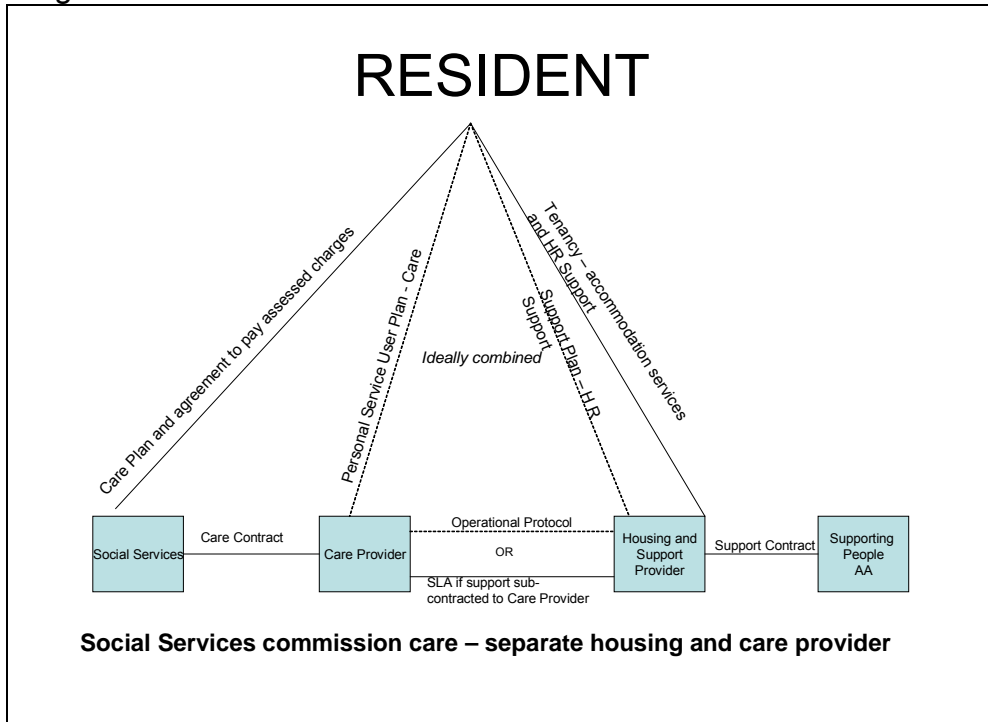
- The resident's main day-to-day contact is with the care provider. From a practical rather than legal perspective, this is the key relationship for the resident. In line with Standard 7 of Domiciliary Care National Minimum Standards, a "personal service user plan", developed within the parameters defined by the care plan, forms the framework for that relationship. Ideally, the care plan will be outcome based, giving the resident and care provider flexibility in how to meet the need.
- The resident has a separate contract with the housing provider for the accommodation in the form of a tenancy.
- In this model, housing-related support services delivered by the housing provider are likely to form part of the tenancy agreement and a support plan will be the equivalent of the care provider's "personal service user plan". However, good practice, underlined by the latest stage of the Alternative Futuresⁱ saga, suggests that even housing-related support should be covered in a separate agreement with the resident, and not be part of the tenancy or lease.
- The Supporting People Administering Authority usually has the support contract with the Housing Provider who may sub-contract some of the housing-related support to the care provider where these are separate.
- It is good practice for the support plan and personal service user plan to be combined to ensure a cohesive service.
- The Housing/Support and Care Providers, if separate, will have contracts or agreements between themselves defining each party's role. One may sub-contract some services to the other.
- Even where Social Services commission the care, the resident can usually make a private arrangement with the care provider for additional services.

In some care village models, the principles remain the same as those described above, though there may be some variations in the mechanics, for example, who collects the assessed care charge.

Where Social Services commission the care, the following 2 diagrams illustrate the typical relationships:

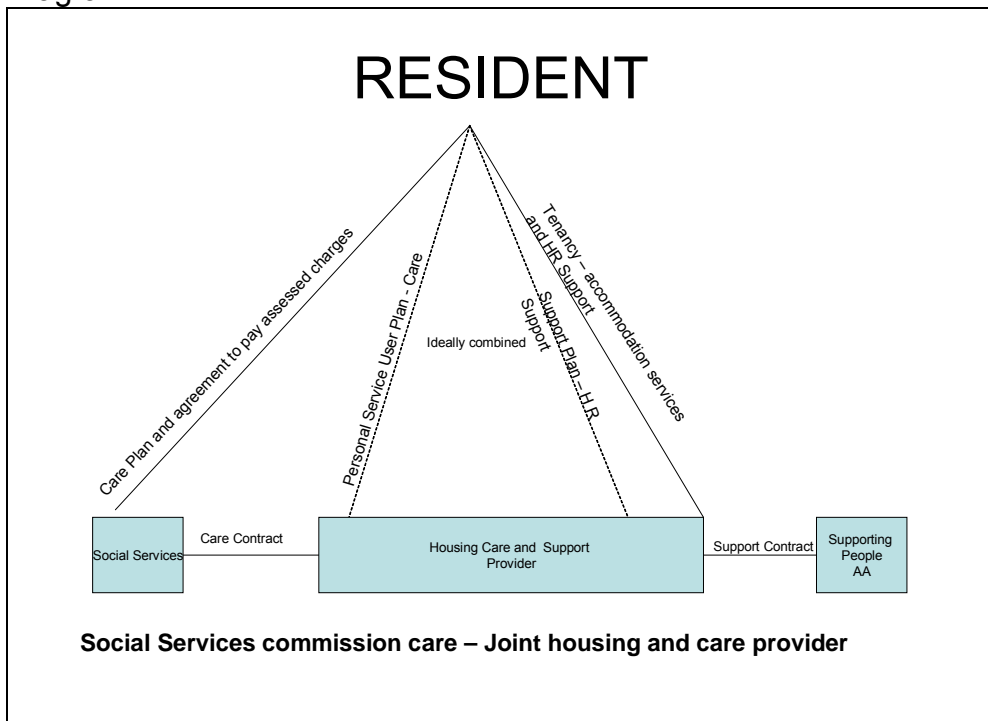
ⁱ This is a case in which the company, Alternative Futures sought to de-register a home for people with learning disabilities and issued tenancies to residents. The Care Standards Tribunal concluded that the company were still running a home. Residents took the case to Judicial Review. The judge held that the CST's decision had been correct because the tenancies covered both accommodation and services [assumed to include personal or nursing care.] Leave to appeal was given and is due to be heard in April 2005.

Diagram 1



Unbroken line = primary legal relationship or contract
 Broken line = operational relationships

Diagram 2



Unbroken line = primary legal relationship or contract
 Broken line = operational relationships

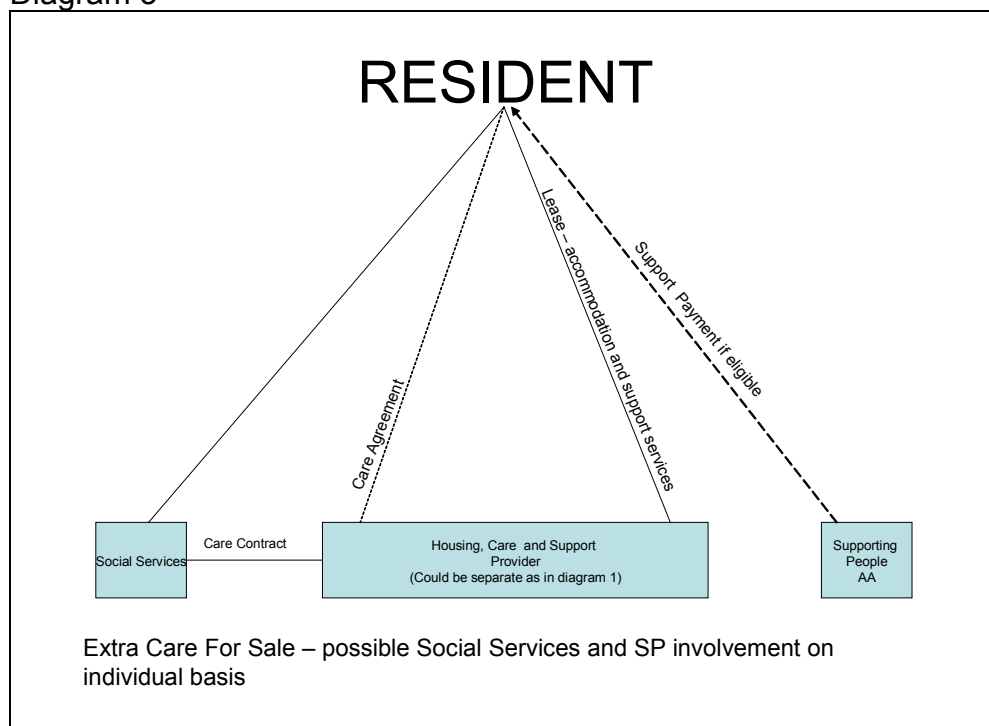
ii) Private Sector – Social Services and Supporting People involvement at an individual Level

In schemes which have no formal relationship with Social Services, the lessee (or sometimes tenant) can apply for a community care assessment and assistance from Supporting People.

In this instance, the relationships with regard to the care are the same as those in the Social Housing Sector. However, they are different in the context of Supporting People funded services. There, the owner-occupier relates directly to the Supporting People Administering Authority although their relationship is not a contractual one. Supporting People pay the resident who has the contractual relationship with the landlord and pays the landlord the Support Charge – usually part of the service charge.

In these scenarios, the relationships are thus:

Diagram 3



Unbroken line = primary legal relationship or contract
 Broken line = operational relationships
 Broken arrow = payment relationship

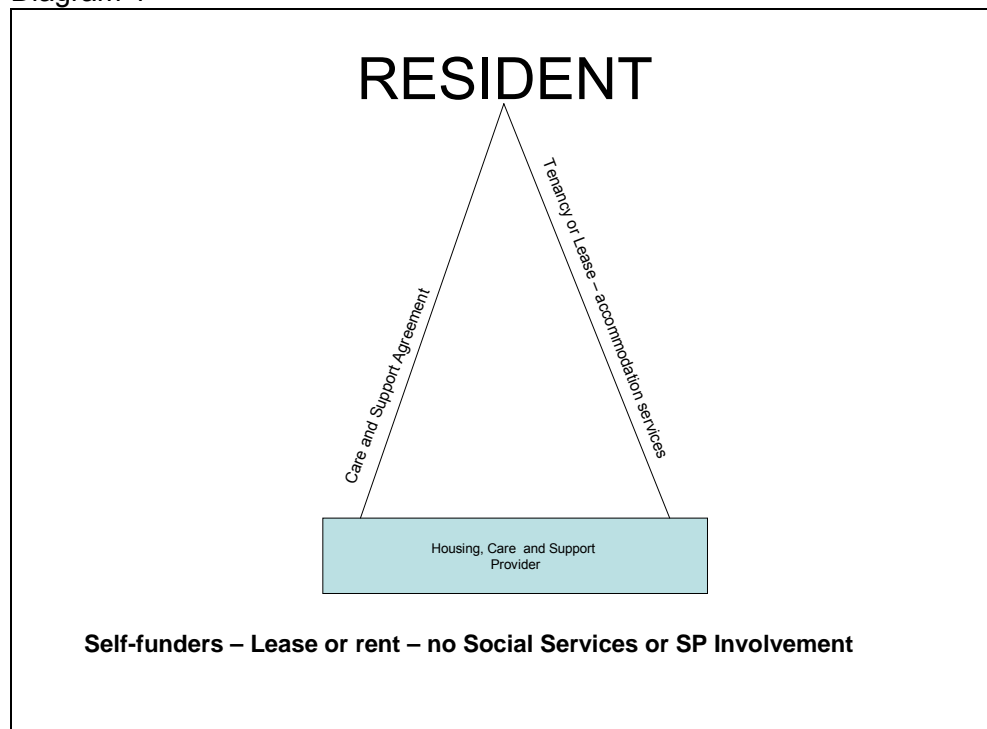
iii) Self-funders with no Social Services or Supporting People involvement

Where Social Services have had no involvement in commissioning the care, which is often the case in Extra Care for sale, and self-funders in ECHR, the primary legal relationship is between the resident and the care provider.

This should be reflected in a separate care or care and support agreement between resident and provider. It is a requirement of the Domiciliary Care National Minimum Standards (Standard 4) that “Each service user is issued with a written contract (if self-funding) provided by the agency within seven days of commencement of the service”¹

Where Social Services and Supporting People have no involvement, relationships are more simple and are as follows:

Diagram 4



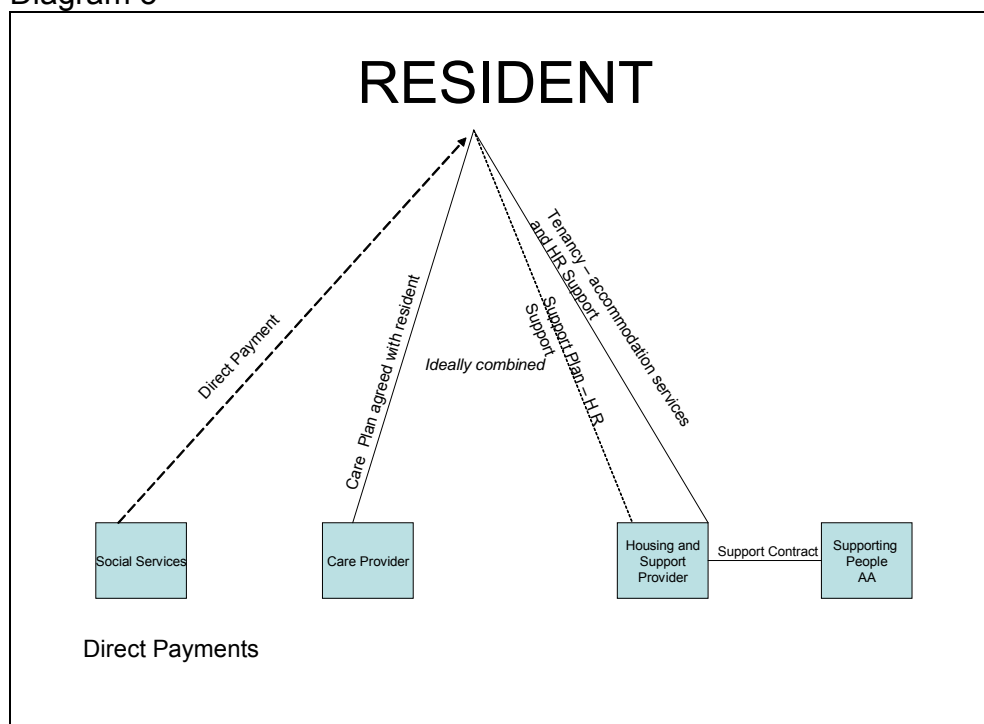
Unbroken line = primary legal relationship or contract

iv) Direct Payments

With a Direct Payment the resident will be contracting with a “Personal Assistant” or similar person for their care by offering an employment contract. They may also contract with the scheme’s normal care providers for some or even all their care and support services if they wish, assuming that the care provider is not Social Service in-house service.

The relationships are as follows:

Diagram 5



Unbroken line = primary legal relationship or contract
 Broken line = operational relationships
 Broken arrow = payment relationship

If the vision outlined in the recent Department of Health Green Paper on Adult Social Care, "Independence, Well-being and Choice" becomes reality, we are likely to see more of the relationships in Diagrams 4 and 5 and fewer in Diagrams 1, 2 and 3.

3.2 THE CARE CONTRACT

3.2.1 Contract Type

Where Social Services commission the care in an Extra Care Housing scheme, ideally it should be purchased in a block, top-sliced from an appropriate budget. It should not simply comprise the composite of residents' care plans paid for on an individual basis through the local team budget. A block usually consists an agreed number of hours but may also be an agreed lump sum, or an agreed contribution to particular posts.

A block contract enables providers to develop a stable team at a scheme which in turn delivers continuity to service users and fosters team work and service cohesion. It allows partners to work together prior to the scheme opening to plan arrangements at the interface between the care and other services.

When a lot of the care is spot purchased there may be the disadvantage of too many people coming and going, and a dissolution of the core team. Furthermore, if tied too closely into care plans, so that hours are withdrawn

even in the case of temporary absences of residents - particularly where the core hours are ungenerous - this creates problems for delivering a flexible, responsive service to residents.

In the best Extra Care Housing schemes, residents are not expected to move out simply because they need additional care. They only move if the services capable of being brought in to the scheme cannot adequately meet their increased needs. Therefore, it is desirable to work some flexibility into the contract. In some schemes, the care provider has the power to both increase and decrease the number of hours in the overall care schedule as the needs profile changes, within certain defined parameters.

The block contract can be topped up with spot purchased hours and/or additional blocks and many Extra Care Housing schemes combine block contracts with additional spot purchasing. The section called "How Much Care?" and some of the case examples will give an idea of the variations.

In care villages the large number of residents makes it more feasible to agree a block which rarely requires altering, because the changing needs of individuals more easily balance each other out.

In some village communities which incorporate a separate care home, there may be an argument for encouraging a move to a different place on the same site if care needs exceed a certain level. For example, at Hartrigg Oaks in York this applies when care needs exceed 21 hours per week (see Housing LIN Factsheet No. 4 on models of extra care housing and retirement communities).

3.2.2 Length of Contract

Where the care is the subject of a separate contract, the contract needs to be long enough for good providers to be interested and willing to invest the necessary infrastructure. Also, continuity is very important to service users as well as for relationships and team-working. However, one of the benefits of a separate care contract is being able to select a different care provider without demonstrating breach of contract if the service being delivered by the existing one does not quite match expectations.

In the light of these considerations, the contract should not be less than three years. A five-year contract with the option to extend it is preferable. The housing provider's and residents' views of the care service should be taken into account when considering whether to extend the contract or embark on a new selection process. The housing provider should be involved in the selection process (see 3.2.4). This especially critical if the care provider is contracted to the housing provider to deliver housing-related support to the residents.

Where integrated housing and care management is the chosen model, the duration of the agreement is likely to be tied in to the time taken to repay any loan on the capital investment in the scheme. Thus it may be for 20 or 25

years, but the agreement is likely to have review and termination clauses included. (See p 27 for the pros and cons of separate and integrated models)

3.2.3 A Partnership Approach

Irrespective of who provides the care and the type of agreement, a partnership approach to commissioning the care rather than a prescriptive purchaser-provider approach is much more conducive to an excellent service. This should apply to the commissioning of all social care services but merits emphasis in this Brief because very often the providers have specialist knowledge which commissioners may not possess. Each may learn from the other, and tackle problems and issues together if there is an open, trusting relationship. Such an approach is likely to deliver better outcomes for residents, and outcome-based commissioning dovetails perfectly with this approach.

3.2.4 Involvement of Housing Provider

Where the care is commissioned and provided separately from the housing service, the housing provider should be invited to contribute to the process of recruitment and selection of the care provider. The extent of involvement would need to be more limited if a separate arm of the provider organisation is one of the applicants.

There are a number of reasons why the recruitment of a care provider should be undertaken jointly:

- The housing provider owns the building. Usually they have funded the development (or a large part of it) and are bearing the long-term financial risk. This fundamental point is sometimes missed by Social Services who may act as though it is “our service”
- The housing provider’s reputation is closely bound up with the scheme. It is they who:
 - have overall responsibility for the building and everything that goes on in it
 - are tied in to the scheme long-term
 - are identified with the scheme in the public eye
- Housing providers understand better than anyone the unique features of their approach to Extra Care Housing, and can provide important information to prospective care providers to enable them to make an informed decision whether to apply to deliver the care service or not
- The housing provider will have a slightly different perspective and may be looking for certain attributes, e.g. emphasis on team working and an independence-enhancing ethos, making the selection panel more representative of the needs of the scheme
- Joint selection of the care provider gives the housing provider a sense of responsibility for the choice even though the legal contract is with social services
- Joint selection also reinforces the message of partnership working to be carried through between all parties, including care provider once selected

- Increasingly, the care provider also provides housing-related support funded by Supporting People. It is common for the housing provider to hold the contract with the Supporting People Administrative Authority for all the housing-related support at the scheme, and therefore be held responsible for the element of support sub-contracted to the care provider.

3.2.5 Information to Prospective Care Providers

In addition to the standard information included in the domiciliary care tender pack, the following Extra Care Housing specific information should be included.

- Care Specifics:
 - Setting-specific care specification details – staffing levels, hours etc (See section entitled “How Much Care?”)
 - Any specific expectations regarding activities or responsibilities not covered by standard domiciliary care specifications
 - Expectations regarding ethos and approach of care provider
 - Expected facility for varying the volume of care in response to changes in overall needs profile of tenants, on the basis of pre-specified triggers
- Scheme Specifics:
 - Details about the housing provider
 - Extra Care housing and details of their model of Extra Care – ethos, service delivery, preferred management model
 - Details about the building
 - The facilities available to the care provider
 - What equipment will be provided
 - Any expenses they may be expected to pay
- Expectations of Extra-Contract Involvement and Joint Working, for example:
 - Pre-completion meetings to agree working practices and develop operational protocol
 - Joint induction and training of staff
 - Participation in inter-agency meetings once scheme operational
 - Joint provider assessments and service delivery plans for the resident

Irrespective of the process for selecting or appointing the care provider, having this information before applying to deliver the service is likely to make the care provider better prepared, and more committed to the inter-agency processes.

3.2.6 Key Qualities

In addition to all the standard criteria for assessing prospective care providers, from an Extra Care Housing perspective, the following are important:

- An understanding of Extra Care housing – desirable but not essential

- A genuine commitment to working flexibly as part of a multi-agency team – essential
- A genuine commitment to promoting the independence of residents – essential
- Staff trained to understand and care for those with special needs, especially person-centred care in meeting the needs of people with dementia

3.2.7 Timing of Commissioning

To comply with registration requirements, the new manager needs to have the registered manager interview with CSCI, as well as have the CRB and POVA checks. New staff will require “Skills for Care”/TOPPS induction training and CRB checks. For these reasons, the domiciliary care provider – unless part of a large national service which has a CSCI Relationship Manager set-up – is advised to notify CSCI of the new service around three months before the service begins. Providers also need time to recruit new staff.

Therefore, the process being used to select/appoint the care provider – if separate from the housing provider – should begin early enough to leave the provider at least three months preparation time. Local authority tendering processes can take three months or more, so should begin a minimum of 6 months before the scheme is due for completion.

3.3 REVENUE

It is usual for the care in Extra Care Housing for rent to come from social services’ core budget or from Care Trusts or PCTs where budgets are pooled. This general statement however masks a whole range of service and funding configurations. The detail will not be explored in this Brief. The guide to Funding in Extra Care Housing will cover a number of variations.

Variations include:

- Clear demarcation – Social Services pay for care delivered by separate staff group and other revenue sources cover other staff members such as a scheme manager.
- Combined care and support – Social Services and Supporting People pay agreed contributions towards a combined care and support staff group. Care packages funded exclusively by Social Services.
- Combined housing, care and support staff group – different revenue sources contribute different proportions to different posts, e.g. scheme manager, senior care assistants/support workers, care/support staff
- There may be some residents who pay for their own package of care from their own resources. Some Extra Care Housing schemes are entirely occupied by self-payers and others have adapted a policy of letting or selling a percentage of properties to people who will pay their own way as a deliberate risk management strategy.

3.4 CHARGING FOR CARE

In most Extra Care Housing, social services commission the care at a micro as well as macro level via a Single Assessment Process (SAP) assessment and care plan. The individual resident has an agreement with social services for the care and pays charges to social services following a Fairer Charging assessment on the basis of the authority's non-residential charging policy.

This usually means that residents are charged on the basis of planned input of care, and do not contribute towards the cost of care hours which are not part of anyone's care plan. (See section on "How Much Care?")

Some social services take the view that an additional charge should be levied in recognition of the round-the-clock cover, including night care, to which people dispersed in the wider community do not have access. Thus, they add a small flat-rate charge.

This is not an unreasonable position to take, but in the context of the current regulatory framework, the guiding principle is that charges for care in Extra Care Housing should vary as little as possible from the local domiciliary care charging policy.

The greater the imposition of flat-rate charges, and the greater the variance from the standard charging policy, the more an authority may risk being seen to be funding a care home rather than housing. Whilst security of tenure and a housing contract with the occupier which is separate from the care contract should be sufficient to illustrate that Extra Care Housing residents receive care in their own homes, interpretations can differ amongst CSCI inspectors.

Another important consideration in determining the charging policy for care in Extra Care, is that it should not be structured in such a way that it militates against flexible, responsive service delivery. The latter should be driven by good practice and the needs of residents, not charges.

In some models of Extra Care Housing, the cost to Social Services is based on dependency levels and "bands". For example, the Extra Care Charitable Trust which commonly has six bands, ranging from nursing home equivalent at the top end down to no care at the lower end. Social Services charging policy is then based around these bands and a Fairer Charging financial assessment. The charge is payable to Social Services but there may be a range of payment mechanisms ranging from Social Services invoicing residents in the standard way, to the provider collecting the charge and being paid by SSD net of the amount collected.

Where Social Services have not been involved in assessing the resident's needs and drawing up a care plan, but the agreement is directly between the resident and the care provider, charges are paid direct to the care provider.

CARE COMMISSIONING IN EXTRA CARE HOUSING - KEY POINTS

- In Extra Care Housing for rent, care is commonly commissioned by Social Services at a macro (block) as well as micro (individual service user) level
- Outcome-based commissioning will enable the greatest flexibility
- A combination of block and spot contracting delivers the best value
- Where a resident contracts directly with the care provider for the care, there should be a separate agreement between resident and care provider
- Where care and housing are managed and delivered separately, the housing provider should be involved in selecting the care provider
- Attention should be paid to timing so that providers have sufficient time before start on site to fulfil registration requirements
- A partnership approach should be adopted in commissioning the care and managing the contract
- Where care charges are paid to Social Services, these should vary as little as possible from standard domiciliary care charges under the non-residential charging policy

4. WHO DELIVERS THE CARE?

4.1 WHICH PROVIDER?

Care in Extra Care Housing can be delivered by any of the following:

- In-house social services home care service
- Independent domiciliary care provider
- The housing provider

4.1.1 SSD In-House Provider

There was a time when use of the in-house service meant greater flexibility in service levels. This probably does not apply any more. There does not seem to be any clear justification for using a service whose unit costs are generally higher than those of independent counterparts. Also, because often the commissioning arrangements with an in-house service are not as robust as with an external service, there may be a risk of greater collusion between social services commissioners and providers if problems arise with the care service.

There are sometimes political pressures to commission the in-house services. In this case it is good practice to ensure using in-house services will stand up to Best Value review or other auditing. The authority should be able to assure itself that this arrangement is:

- In the best interest of residents, delivering high quality services at a cost comparable to the alternatives
- In the interest of council tax payers

4.1.2 Independent Domiciliary Care Provider

A block contract for delivering care in an Extra Care Housing scheme is often quite attractive to independent domiciliary care providers. The physical environment is usually appealing and there is no travelling between visits, a cost often carried by staff themselves. The Extra Care Housing model and ethos is good to be part of, so staff frequently derive significant job satisfaction. This makes it easier to recruit and retain staff.

4.1.3 Housing Provider

The housing provider, as long as they are registered with CSCI as a domiciliary care provider, can manage and deliver the care service within a range of management structures. For example:

- A separate care arm of the housing provider can deliver care services
- The housing provider can manage all services and facilities on site: one approach to this is for the housing provider to directly employ the care and all other staff; another variation is for the Scheme manager to manage in-house SSD care staff

- The housing and care provider can manage everything on site apart from facilities

4.2 INTEGRATED OR SEPARATE HOUSING AND CARE MANAGEMENT

A Technical Brief on Care in Extra Care Housing cannot fail to mention two distinct approaches to providing and managing the care service, as much of the service configuration in an Extra Care Housing scheme flows from which of these approaches is adopted.

Housing providers who are registered as domiciliary care providers are able to appoint a single scheme manager to manage the care and housing services at the scheme. This option is not possible for housing providers who are not registered care providers, and in their schemes, the care service has to be provided and managed by a separate organisation. Some Extra Care Housing schemes have a separate management model even though a branch of the housing provider organisation provides the care.

Section 2 of the Housing LIN Fact Sheet 9 on “Workforce Issues” in Extra Care describes these models in greater detail⁴. This Brief will briefly look at the pros and cons of each approach.

4.2.1 Advantages of Integrated Approach

Some advantages of an integrated housing and care management model (and by implication the disadvantages of a separate approach) are said to be:

- Greater cohesion between services - less risk of services falling between two stools
- More effective co-ordination of services
- More effective building cover when housing manager in separate model is off site
- Relationships are clearer and less complex –
 - Relationship between tenant and provider – “one-stop shop” for residents
 - Only one agency to work with and better understanding between purchaser(s) and provider
- The level and clarity of the scheme manager’s role provides:
 - A better negotiating platform with external service providers
 - Greater authority to provide scheme leadership

4.2.2 Advantages of Separate Approach

Some of the benefits of a separate management structure (and by implication, the downside of an integrated approach) are described as:

- Collusive and bad practice more easily identifiable if two separate providers monitor each other, with greater scope for scheme manager to act as advocate for residents

- Given that the housing provider generally owns the property and is tied in to it as landlord for at least 25 years, it is easier to re-tender the care service if that is delivered by a separate provider
- Each service provider is a specialist in his or her area. Therefore:
 - They can more easily provide the expert management needed to deliver a good quality service
 - There is less risk of housing management tasks being subsumed by care issues or vice versa
- Less resemblance to residential care management structure and less risk of registration as a care home by a misguided CSCI inspector
- Clearer link between each funding source and the services it pays for

Both models can work very well – and not so well. Effective preparation between partners during the scheme commissioning phase is fundamental, as is inter-agency liaison and quality monitoring once operational.

In a separate model, the relationship between the scheme manager and care team leader is pivotal and where it works well the effect is synergistic. It is essential for the housing and care providers to discuss and agree liaison, and a whole range of other arrangements at the interface between housing and care.

4.2.3 Working in Partnership

The importance of effective partnership working cannot be emphasised strongly enough. It really makes sense for commissioners to decide what model of Extra Care Housing they are seeking to develop, select partners who have experience in that approach and then trust them and use their expertise. Bringing together respective areas of specialism and learning from each other will produce a much better scheme than one in which one organisation, often Social Services, seeks to impose its sometimes limited vision and experience onto the project.

4.3 CARE IN THE PRIVATE SECTOR

The models of care delivery in the private sector vary hugely. They range from those which are very similar to the social housing sector approach (e.g. Raven Audley Court), through adjacent care homes providing an outreach service to lessees in surrounding properties (e.g. Close Care Homes Ltd), to lessees forming a co-operative company which employs all staff (e.g. Retirement Security Ltd schemes). What all these approaches have in common is that care is delivered on an individualised basis according to an agreed care plan.

WHO DELIVERS THE CARE? - KEY POINTS

- Care can be provided by Social Services in-house providers, independent domiciliary care providers or the housing provider if they are registered to provide domiciliary care
- There is a wide range of models for service management and delivery
- There are pros and cons to both integrated and separate housing and care management models
- Irrespective of the management model effective co-ordination and close working relationships are fundamental to a good service
- Social Services should select their housing and care providers wisely and then work in an effective partnership of mutual trust and respect

5. HOW MUCH CARE?

5.1 FACTORS INFLUENCING LEVEL OF PROVISION

The following factors play a part in determining the level of care provision in Extra Care Housing schemes and need to be looked at in combination rather than separately:

5.1.1 Number of Units

Above a core minimum level of provision, the greater the number of units the greater the level of care provision needed - all other things being equal. But all other things tend not to be equal as will become evident in the rest of this section.

5.1.2 Purpose of the Scheme

If the vision for the scheme is to replace residential care, or cater specifically for people with dementia, you would expect the care provision to be higher to reflect that.

Two other lettings decisions will similarly impact on levels of care provided, staffing levels and roles:

- Allocating a number of properties for intermediate care use
- Letting or selling properties to people with learning disabilities

5.1.3 Eligibility Criteria and Anticipated Community Mix

Related to the above point, what is the target group for the scheme in terms of individual care needs or dependency levels? For example, are you aiming to achieve a mix of need levels, say on the “thirds” principle (low, medium and high care needs) or are you targeting one particular group, e.g. those who would otherwise require residential care? If you are adopting an apportioning approach how are you defining each service level (e.g. Below 5 care hours per week, between 5 and 10, and above 10)? Do you have a minimum care need as an eligibility criterion, for example 4 hours care a week or more? Do you have an upper limit to the size of the care package on entry?

The ideal is to target a group of people through the eligibility criteria whose combined care needs justify expenditure on a reasonably generous staff structure.

Absolute statements about where this level is - and the cost-effectiveness of Extra Care Housing generally - are very difficult to make because of the wide range of factors which are relevant to the equation. These include: dependency levels; costs of care at the scheme compared to other settings; the charging policy for care at the scheme compared to alternatives; the number of self-funders vs those on state benefit; the level of care provision relative to composite needs of the resident group; the savings achieved by

economies of scale and absence of travel time; and the level of care available for those who need it compared to that available in alternative settings.

It does not necessarily follow, for example, that the higher the need levels, the more cost-effective the service will be. Because domiciliary care is purchased by the hour whereas residential care is purchased for a fixed (or range of fixed) fee(s), Extra Care Housing becomes more expensive to social services above a certain point.

But equally, targeting everyone in low dependency groups is unlikely to be cost-effective because of the basic minimum cover, including night care required at a scheme. Thus, aiming for a mix of need levels or targeting those with medium levels of need are the two approaches most likely to make the average cost per resident cost effective whilst enabling a good level of care provision.

Cost-effectiveness aside, from a good practice perspective, many Extra Care Housing providers believe that aiming for a community with a mix of need levels and domains enables a more vibrant, balanced community, and that to target only those who would otherwise need residential care risks the scheme feeling like residential care even though it is technically housing.

5.1.4 Staff Roles

Is the care provider only going to undertake care tasks or are staff going to undertake other roles with appropriate funding, such as housing-related support and housing management services? While this will not affect the number of care hours commissioned it will affect staff structures and levels.

Furthermore, there is a significant degree of variation in the tasks and activities different social services authorities will cover under the broad umbrella of care – or at least what they are willing to pay for. For example, some authorities will pay for an additional hour per resident per week to cover the cost of facilitating activities, whereas in other areas this function may be funded from Supporting People with a scheme manager undertaking the task. Individual flat cleaning may be covered by Supporting People, included as part of the care package or purchased by the resident.

5.1.5 Commissioner Priorities and Budgetary Considerations

Competing demands for limited budgets and the motivation of the commissioner in developing Extra Care Housing will influence the level of care commissioned. Some social services see Extra Care Housing primarily as a way of saving money while others propose it for quality of life reasons, to enable a home for life and prolonged well-being if at all possible. Their position on this spectrum will play a part in determining levels of care.

5.1.6 Staffing Variables Checklist

It is possible to construct quite a long list of factors that may impact on care staffing levels. A checklist of principle considerations is as follows:

- Lettings policy
 - Proportion of residents with high, medium, low needs
 - Proportion of residents with learning disabilities, dementia and other mental health problems
- Division of responsibility between housing management and care/support functions
- Practice of supporting people to make meals/require meals to be taken in restaurant, and which meals
- Use of assistive technology to substitute capital for labour/aid efficiency of support and care delivery
- How leisure, social and health based activities are arranged and managed
- Decisions on which different/distinct roles to have within an Extra Care scheme
- Direct Payments use by residents and residents' decisions on how to arrange direct support

5.2 FROM MINIMAL TO OPTIMAL COVER

Even if you accept that anything less than 24 hour dedicated care on site is not Extra Care housing, there are enormous variations in the level of cover provided across schemes in the country which do count as Extra Care. These differences are not purely a reflection of different needs levels within a scheme though this should be the key determining factor.

At the lower end of the spectrum, minimum cover could be one person on site available to deliver care at all times plus any extra needed to meet care package requirements. However, if most of that person's time is taken up delivering planned care during the day, then there is little scope for responding to emergencies or fluctuations in need. On the other hand many schemes, whether with an integrated or separate structure have three levels of care staff – care team leader or scheme manager, a number of senior care assistants and a team of care or care and support workers who are dedicated to the scheme.

5.3 WHAT SHOULD OPTIMAL COVER INCLUDE?

5.3.1 Uncommitted time

There should be an allowance of “floating time” which is not tied in to individual care packages for co-ordinating the service, supervising staff, participating in reviews, liaising with other agencies and responding to emergencies and fluctuations in need. How much time to allow varies from scheme to scheme. It should be influenced by the size of the scheme and need profile - and consequent service level requirement - of the resident group. Very often, this non-committed time is provided through a full time care team leader, or in an integrated model, the scheme manager and possibly some of the senior care assistant time, often with some administrative support.

5.3.2 Minimum day time presence

Two members of staff are preferable to only one as the minimum level at the scheme at any one time. This can include Care Team Leader or Scheme Manager so long as they can deliver hands-on care in an emergency. It allows for greater flexibility and responsiveness. Most of the time care packages will necessitate this anyway, though there may be the odd hour when they don't.

5.3.3 Flexibility

Whilst care plans will determine the planned care input, it is best if providers have the freedom to respond to fluctuating need and alter the care plan with the minimum red-tape and bureaucracy. Outcome-based commissioning will facilitate this.

5.3.4 Waking night staff

Many Extra Care schemes only have one member of care or care/support staff on duty at night and of these, a significant number only provide sleeping night cover. Some argue that to provide waking night cover reduces the cost effectiveness of Extra Care compared to other provision. On the other hand, many Extra Care schemes provide waking cover at night and some authorities and providers would not consider anything less, arguing that it cannot be a real alternative to residential care without it.

If waking night cover is not provided, any service users requiring planned care input at night are effectively prohibited from moving to the scheme since sleeping staff can only respond to emergencies. This reduces the pool of potential residents and many people who need assistance at night would be perfectly suited to living in Extra Care housing. The other implication of having only sleeping assistance is that unless the cover is upgraded to waking cover as residents' needs change, residents would have to move out of the scheme if they started to require planned care at night. Whilst it may be possible to bring in peripatetic night cover to provide this service, this is not ideal, not least because it introduces a security risk overnight.

Another benefit to the residents of having waking night staff is that they then have greater choice over bed-time if they need assistance. It is unusual to be able to arrange or extend daytime shifts beyond 10 p.m. at night and some residents prefer going to bed later. Waking night staff can use any non-contact time constructively by, for example doing the laundry for those residents who have this as part of their care plan, thereby freeing up the facility during the day for residents' use.

Some schemes achieve night cover – usually sleeping - by splitting the cost between SSD and SPAA on the basis that whilst staff are not actively delivering care, their presence is just as much about housing-related support as care. Where waking night staff undertake tasks such as laundry, they are clearly undertaking tasks within SSD remit, not Supporting People and therefore Social Services should pay. Some SPAAs appear to be trying to withdraw from funding this aspect of the service arguing that it is care. On the

other hand some CSCI inspectors view the SP contribution to the night cover as evidence that the scheme is housing not residential care.

5.3.5 Handover Time

Allowing handover time between shifts enables better communication and continuity, even if communication books are used.

5.3.6 A Dedicated Team

A consistent staff group is desirable for a host of reasons: service users prefer the continuity; it is better for co-operative working; and it facilitates better understanding of the setting and on site processes. Some consider a key worker approach to offer advantages.

5.3.7 Management Presence

It is desirable for someone with management responsibility to be on site at least during day time hours. This could be either the care team leader or one of the senior care assistants. An alternative approach suggested by one major provider of Extra Care is to appoint a shift leader when the scheme manager (in integrated model) or care team leader is not on site. He/she would have an enhanced rate of pay for that particular shift. Night staff should have access to off site management back up.

5.3.8 Independence Promotion

Ideally, sufficient time needs to be available to allow staff to assist service users to undertake tasks themselves, rather than doing it for them which is often quicker.

***Note:** Whilst the authors consider the above features to represent optimal care provision, they are matters of judgement. The list is not intended to be exhaustive or prescriptive and it is up to project partners, and the commissioners in the final analysis, to decide.*

5.4 LEVEL OF SERVICE PROVISION

5.4.1 Number of Hours

This is potentially the trickiest aspect when commissioning care for a new scheme because partners do not know at this stage exactly who the residents will be and the composite of their care needs.

It can be tackled in a number of ways, but certain principles should apply whatever method is used:

- Once the scheme is up and running, the service should not drop below the agreed minimum levels which might include, for example:
 - Number of staff on site at any one time during the day

- Number of staff on site at any one time at night if different from above
 - Number of hours not tied in to individual care packages
 - Expectations regarding management presence on site
- There should be agreed arrangements for varying the overall service level in response to changes in the overall need profile of the residents.

Standard Figure Approach – Several years ago, some providers worked on the basis that a scheme of average size and eligibility will require a standard figure, say 400 contact hours for a 40 unit scheme, the distribution of which could then be determined by the care provider on the basis of minimum requirements and care package patterns. This approach has been replaced for the most part by one which is based more on anticipated need levels of the target resident group.

Staffing Ratio approach – In some care villages where staffing is characterised by multi-skilled staff undertaking a range of activities, staffing is based less on a calculation of anticipated hours of care, and more on staffing ratios needed, determined by the size of the village and projected resident profile within pre-determined bands.

Minimum cover plus estimation of additional hours needed - the estimation could be based on

- An estimate of the composite of care plans derived from eligibility criteria, or
- A likely schedule of cover.

Example calculation

The following gives an example of a calculation of care hours needed in a 40 unit scheme based on the “thirds principle” – i.e. a projected dependency level of a third low (less than 5 hours care), a third medium (5 – 10 hours), and a third high (more than ten hours) – and no special features. The approach assumes:

- a minimum block contract topped up by additional blocks of 50 and/ or spot purchased hours
- 2 staff on site during day time hours
- 1 staff member on at night
- Care team leader/unallocated time additional

Minimum block contract:

Day time cover – 2 members of staff x 14 hours x 7 days per week = 196 hours

Night cover – 10 hours x 7 days per week = 70 hours

Handover time – 1 hour x 7 days per week = 7 hours

Care Team leader/floating time = 37 hours

Total – **310** hours inclusive of care team leader hours

If the scheme is likely to take a couple of months to fill, commissioners may wish to consider phasing in the block. If so the care team leader’s hours could form part of the minimum 2 person cover = **273** hours initially (for first month or two).

Total amount of care needed:

Based on a 40 unit scheme, two approaches could be taken to estimating the amount of care needed –

- a) A guestimate of day time hours per week needed, based on the “thirds principle”, or
- b) The likely schedule of cover based on experience

a) A guestimate of day time hours per week needed, based on the “thirds principle”:

No: Residents	Hours of Care per week each	Total hours per week
13	3	39
13	7.5	97.5
7	13	91
5	15	75
2	20	40
Total for all 40 residents		342.5 hours per week

Total basic day time hours = 342.5 + 70 night hours = **412.50** hours per week (or 449.50 if you add on the care team leader’s hours. See the sub-section on “Costing the Service” below)

b) Likely schedule of cover:

Times of the Day	Length of session in terms of hours	Number of staff on duty	Number of staff hours per session per day
7.30 – 10 a.m.	2.5	5	12.5
10a.m.– 12 noon	2	2	4
12 noon – 2 p.m.	2	4	8
2 p.m. – 6 p.m.	4	2	8
6 p.m. – 10 p.m.	4	4	16
Handover time			1
Total Staff Hours per Day			49.5 hours per day

Total 49.5 hrs per day = 346.5 per week + 70 night hours = **416.5** hours per week (or 453.5 if you include the care team leader’s hours)

On that basis, 400 contact hours per week seems a reasonable working target, though:

- a) it is unclear how quickly that level of input would be needed.
- b) the need might be higher once the scheme is full and over a period of years is likely to increase from its starting point
- c) it would be preferable not to have a ceiling

Top up of minimum block contract:

This means looking at approximately 100 hours on top of the minimum block contract of 310 hours

Housing 21’s preferred approach is for the block contract to comprise the total of the minimum eligibility requirement (e.g. 4 hours per resident per week) plus the night time cover, plus the Care Team Leader post, and for the remainder of the care to be spot-purchased on top of that. Important in this approach is allowing the care provider flexibility to determine – with the residents – how each care package is to be delivered to maximise efficient use of time.

5.4.2 Costing the Service

The most usual way to purchase domiciliary care is by the number of contact hours. This means that the costs of the Care Team Leader post and other non-contact activities and costs are loaded into the hourly rate for the commissioned contact hours. These would include management and administrative tasks including supervision, liaison and rotas as well as meeting and handover time, training etc. They would also include a percentage to cover annual leave and sick pay entitlements. Equally night time costs will be calculated at the relevant unit cost and then included in the total costs to come up with a single hourly rate which is charged for all the contact hours commissioned.

The care does not have to be commissioned in this way. The Care Team Leader hours can be added to the total and a different hourly rate attributed for them. Or, as happens in at least one authority, Social Services contributes an agreed proportion of the cost of a given post, e.g. scheme manager. Similarly, whilst night-time cover is usually part of the total contact hours with the same hourly rate as described above, if only sleeping cover is provided, it can be itemised and costed separately.

Note: *If going out to tender for the care, it is essential for the commissioner to specify how the care provision proposal should be costed so that like can be compared with like when comparing submissions. Commissioners must be clear, for example, whether the 400 hours do or do not include the night cover and care team leader, and whether each of these different components should be costed separately or built into a single hourly rate. If the traditional approach of a unit cost per contact hour is adopted, it is advisable to ask for a breakdown of the component parts.*

Some providers offer an open book accounting approach in which the cost of every component of the service is itemised and transparent. This enables commissioners and providers to negotiate components which might be boosted or omitted. At the end of the financial year, any surplus is re-distributed on a pre-determined basis. A relationship of trust and a partnership style of working is fundamental to this approach.

It is very helpful for providers to be granted some start up costs in recognition of the preparation needed to set up a care team in an Extra Care scheme (see section on “Information to Care Providers” p20) and to fulfil registration requirements.

5.4.3 Timing of Provision

Assuming that it is anticipated that for a period of time the block will stabilise at around 400 hours a week, should that be the level of the block contract from the outset?

It is probably safest to commit to the minimum block initially aiming to have an additional 50 hours in a month or so later and the full 400 a month after that.

The project group should make a judgement on this, depending on how quickly allocations are being made to the scheme. In some areas, all units have been allocated prior to opening whereas in others, for various reasons, it may take a several months. In some areas, a Voids Indemnity Agreement is reached with social services to cover the cost of rent and service charge if units remain unfilled after an agreed period of time.

It is good practice to have the basic team in place and able to meet as a group from the date of scheme completion, even though residents may not move in for a week or two. Although a scheme may not fill immediately, having the core team there from the outset enables effective team building and an opportunity to get accustomed to the environment before having to deliver the service.

It also means that staff can provide additional support to new residents moving in. They quite often need fairly intensive support and care whilst settling in, before their care needs stabilise, often at a lower level.

Other pre-requisites to registration as a domiciliary care provider also necessitate the core provision being in place before starting to deliver the service.

5.4.4 Distribution of Hours

This is best left to care providers to determine. However, there is usually a need for a concentration of staff in the mornings to help residents to get up and dressed. Additional input may be needed at lunch time, depending on what the meal arrangements are at a given scheme. Afternoons are usually the time least in demand for delivering care plans. Thus, so long as the care team leader or scheme manager (in an integrated model) is available, one care assistant might suffice depending on the scope of the care assistant's role. Tea time and preparation for going to bed in the evenings usually form additional peaks.

Unfortunately, the times when a concentration of staff is needed do not always coincide neatly with availability of staff or acceptable shift patterns and therefore compromises may be required, for example having staff on duty for longer in the morning than the composite of care plans necessitate. However, care in Extra Care Housing does lend itself to greater flexibility in service delivery because all the service users are within one building.

Employing care staff on a guaranteed minimum contract of 18 hours or so, with the likelihood of additional hours enables much greater flexibility to deploy staff at times when they are needed than a single full-timer.

5.4.5 Shift Patterns

- These do not differ significantly from those in the wider community.
- Part-time staff often assists in boosting provision at peak times.
- It is best to avoid split shifts

- In six to ten hour shifts an unpaid break of half an hour must be taken for lunch
- Two short breaks of 15 minutes each are allowed mid-morning and afternoon
- Night shifts commonly run from 10 to 7 but are sometimes extended and/or started half an hour later to boost morning provision
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HOW MUCH CARE – KEY POINTS

- Whilst a range of factors will influence the level of care provision, the best schemes are those where the decision is driven by the interests of the residents and not budgets
- Above an agreed basic minimum, it is important to be able to vary the level of care up and down as the combined needs of residents change
- However costed, the need for an element of non-contact hours on the scheme should be catered for
- A dedicated team promotes service cohesion and teamwork
- Waking night staff allows for those needing planned care at night to move to, and remain in, an Extra Care Housing scheme
- It is difficult to predict exactly how much care will be needed, but block contracts should be calculated on an estimate based on minimum cover requirements and anticipated care package levels.
- Transparency in care costing is valuable to both commissioners and providers

6. REFERENCES

1. Department of Health, Domiciliary Care National Minimum Standards, Care Standards Act 2000
2. ODPM, What is Supporting People?
3. Department of Health, London & South East Capacity Development Programme, Collection of Papers on Domiciliary Care by Lucianne Sawyer, Autumn 2004
4. Department of Health Housing LIN Factsheet 9: An Introduction into Workforce Issues in Extra Care Housing
5. Department of Health, Supported Housing and Care Homes, Guidance on Regulation, August 2002

Other useful material

1. Department of Health Housing LIN, Extra Care Housing for Older People: an introduction for commissioners, 2004
2. Department of Health Housing LIN, Developing & Implementing Local Extra Care Housing Strategies, 2004
3. Department of Health Housing LIN Factsheet 14: Supporting People with Dementia in Extra Care Housing

7. CASE EXAMPLES

SOMERVILLE – ST MONICA’S TRUST

RETIREMENT VILLAGE – INTEGRATED HOUSING AND CARE MANAGEMENT

<p>Name and brief introduction to the Scheme</p>	<p>Somerville Very Sheltered Housing scheme in Westbury Fields Retirement Village, Bristol.</p> <p>The scheme was developed in partnership with Bristol City Council who have a dedicated extra care development officer leading a programme that will eventually provide 600 extra care dwellings.</p> <p>St Monica Trust is a charity founded more than 80 years ago by the Wills tobacco family. The Trust has started an ambitious programme of new development for older people in Bristol. One of their first new projects is the Westbury Fields retirement village.</p> <p>The community has three distinct elements, laid out around a central cricket field with a pavilion and public house:</p> <ul style="list-style-type: none"> • A 60 place care home which incorporates 15 intermediate/ short term care places where people stay for up to 6 weeks and a 15 bed specialist residential dementia care wing • 105 sheltered flats for sale • 51 flats in a Very Sheltered Housing scheme • 10 of the flats in the Village can be purchased on shared ownership terms. <p>Some services such as portering, security, grounds and building maintenance are organised to serve the village as a whole but for simplicity our example concentrates on the very sheltered housing facility. This is called Somerville.</p>
<p>Number of Units and tenure</p>	<p>51 units – mixed tenure</p>
<p>Housing Provider</p>	<p>St Monica Trust</p>
<p>Care Provider</p>	<p>St Monica Trust</p>
<p>Care Commissioner</p>	<p>Social Services</p>
<p>Thumbnail sketch of model it's illustrating</p>	<p>St Monica is both the care provider and landlord and provides an example of an integrated care and housing service. The Operations Manager, based in the Extra Care Housing building, has responsibility for all aspects of day to day</p>

	<p>management and maintenance of the buildings as well as care and support services. Located off site are central services common to St Monica Trust wider activities such as finance and marketing.</p> <p>Care and housing-related support are delivered by the same staff group</p>
Fundamentals of eligibility criteria and any target groups	<p>Somerville is targeted at two groups:</p> <ul style="list-style-type: none"> • Half the residents are people who would have been placed in residential care (25 people) • Half the residents are people who were seeking sheltered housing. The criteria include being on the local authorities housing register (26 people). <p>Social Services provide a normal social care assessment for the “residential care” applicants. The Trust also assess them using the “easycare” assessment model. St Monica carry out assessments for the “sheltered housing” also using the same assessment format.</p> <p>Four levels of care are provided from a basic of less than 1.5 hours of direct support up to intensive 24 hour care. All residents have on-call help and waking night cover.</p>
Care charges paid to?	St Monica’s
Care staff structure - posts and number in team	<p>9.5 care staff plus one full time Care and Support Manager and two part time service support seniors.</p> <p>The manager is additional to the contracted hours while the seniors are part of it.</p>
Minimum cover requirements	<p>Minimum of 1 care staff but with one “special resident” to whom we offer 24/7 care that means that there are always 2 carers on site.</p> <p>Manager is on call 24/7 as is the Operations Manager.</p> <p>Porters are also available to assist they are on duty 24/7. At night just one is on. They are trained in lifting and handling and assist the carers if needed.</p>
Care hours and distribution of hours during the day	Social Services contract a block of 306 hours of care a week and SP fund 206 hours per week
Night time cover	47 hours

Shift patterns	6am-2pm and 2-10 pm
Any responsibilities apart from those relating to care?	Providing housing related support. Single comprehensive team.
Additional Features	<p>Spread over 3 floors the building is configured in a Y shape. Going through the entrance two enclosed wide streets make a big impact. Along the streets are bowling, boules and other games, a café, tables and chairs on the “streets” creating a Mediterranean atmosphere.</p> <p>The scheme has a wide array of additional amenities now characteristic of villages including:</p> <ul style="list-style-type: none"> • restaurant • several lounges and activities and meeting rooms • IT suite • Gym and pool • Treatment rooms <p>(More detail is contained in Case Study No 5 – Village People: A Mixed Tenure Retirement Community).</p>

HARP HOUSE – HANOVER HOUSING ASSOCIATION

SEPARATE HOUSING AND CARE MANAGEMENT WITH INDEPENDENT CARE PROVIDER

Name of Scheme	Harp House, Barking
Number of Units and tenure	36 units for rent
Housing Provider	Hanover Housing Association
Care Provider	TLC Care Services – An independent home care provider in London which specialises in services for people with dementia
Care Commissioner	LBBB Social Services Department
Thumbnail sketch of model it's illustrating	<p>Separate housing and care management and service delivery.</p> <p>Full time Estate Manager employed by HHA.</p> <p>Care staff employed by TLC.</p>
Fundamentals of eligibility criteria and any target groups	One-third low (0-5 hours), one-third medium (5-10) and one-third high (10 hours plus a week)
Care charges paid to?	LBBB
Care staff structure - posts and number in team	<p>Care Team leader – 35 hours per week. No planned care input</p> <p>2 Care co-ordinators – senior care assistants. Both part-time, working 27 hours per week each, of which 7 office hours each and 20 hands on care.</p> <p>One manager present during day time hours</p> <p>Approx 12 members of team, some part-time in addition to seniors and CTL.</p> <p>All staff have 20 hours guaranteed but are invited to do more. Staff benefit from custom and practice protection but enables greater flexibility for rotas</p>
Minimum cover requirements	2 on at all times

<p>Care hours and distribution of hours during the day</p>	<p>385 hours per week block contracted. Block has recently been increased to reflect increases in care plans.</p> <p>Also 35 hours for the CTL post plus 14 hours office for care co-ordinators.</p> <p>Only contact hours specifically commissioned and counted in block hours. The cost of non-contact hours is incorporated into unit cost for contact hours.</p> <p>7 – 7.30 a.m. = 2 people (the two night workers) 7.30 – 9.30 a.m. = 4 people 9.30 – 1a.m. = 3 people 1 – 10 p.m. = 2 people</p>
<p>Night time cover</p>	<p>140 hours – 1 waking 1 sleeping 10 p.m. – 7.00a.m.</p> <p>The sleeping person works a half-hour shift from 10 – 10.30 p.m. as a waking worker, and also from 7 – 7.30 a.m.</p>
<p>Handover time</p>	<p>15 minutes overlap at 4.30 p.m. and at 7.30am. One person.</p>
<p>Flexible care</p>	<p>Up to 4 hours per week per care service user agreed on temporary basis to reflect changing care needs.</p>
<p>Any responsibilities apart from those relating to care?</p>	<p>Have recently got agreement to provide 16 hours support to 2 people from SP on Saturdays and Sundays</p>
<p>Carers special grant</p>	<p>Small grant to support families / carers</p> <p>Has been used for carer relief for husband; lives in HH with his disabled wife.</p> <p>Plans to run quarterly family support sessions</p>
<p>Additional scheme features</p>	<p>Harp House in Barking was developed in partnership with the London Borough of Barking and Dagenham.</p> <p>It is an example of core and cluster housing with the core being Extra Care housing and the cluster being sheltered bungalows in the grounds of the scheme. Sheltered tenants make use of the facilities in the core.</p> <p>It is fortunate to have a range of additional facilities, thanks to capital made available by the local authority.</p> <p>The cybercafé is open three days week serving light meals and snacks. It is run by the Osborne Partnership who train people with disabilities for employment, and is used by people from the local community as well as scheme residents</p>

	<p>and day centre users. The plan is to extend opening to five days a week.</p> <p>The Osborne Partnership is also preparing to run computer training sessions in the café for scheme residents and adults with learning disabilities.</p> <p>A series of “Fit for Life” sessions are provided in the gym by the LBBD Leisure and Environmental services for residents and others. The local PCT runs Pulmonary rehabilitation sessions a couple of days a week.</p> <p>The bowling green provides additional recreational opportunities in the summer months.</p> <p>An Age Concern day centre for people in the surrounding area meets at the scheme five days a week, and the cook provides meals in the restaurant for residents as well as people attending day care.</p> <p>In addition, one day a week the library is used to provide day care for people from ethnic minority groups, also run by Age Concern.</p>
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OAK HOUSE – HOUSING 21

INTEGRATED HOUSING AND CARE MANAGEMENT

Name of Scheme	Oak House, Stutton, Suffolk
Number of Units and tenure	38 flats of which 8 two bedroomed flats. Assured Tenancies
Housing Provider	Housing 21
Care Provider	Social Services in-house home care service employ staff who are seconded to Housing 21. Work to H21 policies and procedures and Suffolk Social Services employment terms and conditions
Care Commissioner	Suffolk County Council
Thumbnail sketch of model it's illustrating	Integrated management model. Housing 21 employs Scheme manager who manages all services on site. All staff apart from care staff are employed by H21 including P/T admin assistant, cleaners, P/T activities co-ordinator and P/T handyman. Care and housing-related support delivered by same staff group. Is a day centre on site and H21 also employ a day centre co-ordinator and day care staff. Pod design of which one pod is designated specifically for people with dementia.
Fundamentals of eligibility criteria and any target groups	All applicants should need a minimum of four hours personal care. Should have a housing need, be over retirement age. People with dementia targeted for dementia unit.
Care charges paid to?	Paid to Social Services in accordance with Suffolk County Council's domiciliary care charging policy. Following "Fairer Charging" financial assessment, Social Services bill residents on the basis of the actual amount of care delivered.
Care staff structure - posts and number in team	Full-time Scheme Manager Seniors – 4 day time and 1 x 20 hour post vacant and two night time Support Assistants – 4 night-time and 12 daytime (mostly on part-time contracts)

Minimum cover requirements	Always a senior member of staff on duty both day and night. Never less than three care/support staff on duty at any one time during the day. This is operationally determined rather than being a requirement of the Commissioner.
Care hours and distribution of hours during the day	Block = 144 senior hours per week of which 72 are contact hours 319 care/support hours from support assistants Additional input currently 70 hours = 533 care and support contact hours of which approximately 90 hours are funded by Supporting People
Night time cover	2 waking members of staff (1 senior and 1 support assistant) 73 senior hours (additional to allow for handover time) and 63 support worker hours per week
Shift patterns	<u>Mornings:</u> 7 – 10.30 one support assistant 7 – 1.30/2 four support assistants 7 – 3 one senior = 5 assistants plus senior at peak morning period <u>Afternoons:</u> 2 – 10 two support assistants 4 – 9.30 one support assistant 2 – 10 one senior = 3 assistants plus senior at peak teatime period
Any responsibilities apart from those relating to care?	Yes, housing-related support. Seniors also deal with urgent building and housing management tasks when Scheme Manager off site.
Additional Interesting features	Dementia unit and day centre. Hoping to offer cooked midday meal soon.

PINEAPPLE PLACE – HANOVER HOUSING ASSOCIATION

SEPARATE HOUSING AND CARE MANAGEMENT WITH INDEPENDENT CARE PROVIDER ALSO DELIVERING SOME HOUSING-RELATED SUPPORT

Name of Scheme	Pineapple Place, Birmingham
Number of Units and tenure	34 flats of which 31 one bedroom two person flats and 3 two bedroom two person flats. All for rent
Housing Provider	Hanover Housing Association
Care Provider	Care UK, a large independent care provider
Care Commissioner	Birmingham City Council Social Care and Health Directorate (SC&H)
Thumbnail sketch of model it's illustrating	Housing management and some of the support provided by Hanover's Estate Manager. Additional housing-related support and care provided by Care UK's on-site dedicated team, with joint funding coming from Birmingham City Council and Birmingham Supporting People Authority.
Fundamentals of eligibility criteria and any target groups	Aim for a mixed community High – 25% Medium – 45% Low* – 30% * This category to include low care needs or housing-related support needs only.
Care charges paid to?	Birmingham City Council
Care staff structure - posts and number in team	Care Team leader works 9 – 5 weekdays co-ordinating the service, responding to emergencies and covering when people are absent. CTL's post is added to hours and paid for in addition rather than being added to the unit cost of the contact time. 9 care and support workers

Minimum cover requirements	At least one care and support worker on site at all times – made up of sleeping night worker, care team leader post and care support worker time.
Care hours and distribution of hours during the day	250 care hours per week, 76.75 support hours, plus 37 hours combined care and support team leader time - (care 21 hours and support 16 hours). Block purchased. Provision for up to 50 hours spot purchasing on top to be used to ensure an enabling style of service delivery → additional blocks of 50 if needed.
Night time cover	Combined care and support sleeping night cover of 1 person 10 p.m. – 7.15a.m = 64.75 hours per week including handover time
Shift patterns	3 on between 7 a.m. and 2.30 3 on between 2.30 and 10.p.m. Care team leader 9-5 weekdays Additional staff as needed
Any responsibilities apart from those relating to care?	Yes – housing-related support
Additional scheme features	Midday meal cooked on the premises provided 7 days a week and served in restaurant

EXTRA CARE CHARITABLE TRUST

CARE VILLAGE - A TYPICAL OUTLINE

Name of Scheme	ECCT Retirement Village
Number of Units and tenure	200 – flats and bungalows Mixed tenure Prefer a split of 50% leaseholders and 50% rented
Housing Provider	Usually a registered housing association which issues the leases and tenancies and is responsible for maintenance. The ECCT manager is responsible for all services on site
Care Provider	ECCT
Care Commissioner	Social Services block contracts the care for an agreed number of people in each of the bands. If Social Services are not involved, the individual him/herself will in effect commissioned the service.
Thumbnail sketch of model it's illustrating	A large retirement village in which all services are managed and delivered by ECCT staff although the funding comes from a range of sources. This model probably represents the least delineation of roles and services operationally, and the greatest flexibility to provide a responsive service.
Fundamentals of eligibility criteria and any target groups	Commonly six dependency bands from 5 to 0. Top three are nursing home equivalent, residential home equivalent and sub-residential. Lower three are primarily sheltered housing with those in Band 0 requiring no care provision.
Care charges paid to?	Care charge is determined by band. Where Social Services have commissioned the care the charge following a Fairer charging financial assessment is payable to SSD though may be collected by the Trust. Where SSD not involved, separate support agreement between resident and ECCT covers care, support and other services and charge is payable to the Trust.
Care staff structure - posts and number in team	Information not available. However, staff deliver care and housing-related support combined. No distinction is made in terms of service delivery although funding comes from SSD and SP.

Minimum cover requirements	Because of size, will be several people on site round the clock, usually including a qualified nurse.
Care hours and distribution of hours during the day	ECCT doesn't tend to quantify care delivery rigidly in terms of hours. They will have a specific number of multi-skilled care/support/housing staff on site as required and work to an outcome based care and support plan drawn up with the resident by SSD or themselves.
Night time cover	Care available around the clock
Any responsibilities apart from those relating to care?	Yes, support generally including those accepted by SP as housing-related support and also some housing management functions
Additional Interesting features	Whole ethos is very strongly to rehabilitate and maximise independent functioning. Wide range of facilities that would be more difficult to provide in smaller Extra Care schemes – e.g. bar, fully equipped gym, on site activities organisers, health staff including physios and qualified nursing staff.

THE PADDOCKS – GITTISHAM CARE LTD

PRIVATE EXTRA CARE FOR SALE

Name of Scheme	The Paddocks, Honniton, Devon
Number of Units and tenure	10 with a further 12 under construction Owner occupied under 125 year lease
Housing Provider	The Stepping Stone Group Ltd. Close Care Homes Ltd was the developer but Gittisham Care Ltd now owns the freehold and holds the lease.
Care Provider	The Stepping Stone Group Ltd/Gittisham Care Ltd
Care Commissioner	Individual lessees
Thumbnail sketch of model it's illustrating	<p>The bungalows are built adjacent to a care home and within the same freeholding.</p> <p>Incorporated in the service charge is the cost of care being available in an emergency, summoned via a linked alarm. Emergency care is available 24/7</p> <p>Personal care is tailored to meet individual needs and is available 24/7. Care packages are agreed on an individual basis according to need, incorporated in a care plan signed by the provider and lessee and charged for separately.</p> <p>The care home is a registered with CSCI. Additional staff are employed for the purpose of providing emergency and planned care from the adjacent care home</p> <p>Discussions are taking place between CSCI and The Stepping Stone Group over whether the single registration can be extended to supply the outreach domiciliary care service to the lessees</p>
Fundamentals of eligibility criteria and any target groups	Over 60s with a care need
Care charges paid to?	Gittisham Care
Additional Interesting features	Insurance, window cleaning, use of minibus, payment to sinking fund and maintenance of all external parts are covered by a monthly service charge

	Meals, domestic help, laundry service, dry cleaning, handyman service, escorts, chiropody, physiotherapy, occupational therapy, reflexology and aromatherapy are all available for purchase as and when required.
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DENHAM GARDEN VILLAGE – ANCHOR TRUST

MIXED TENURE VILLAGE

Name of Scheme	Denham Garden Village
Number of Units and tenure	182 leasehold houses and flats for outright sale 140 tenancies inherited from Licensed Victuallers
Housing Provider	Anchor Trust
Care Provider	Anchor Trust registered as domiciliary care providers with CSCI
Care Commissioner	Individual residents except where care spot purchased for individual residents by Social Services.
Thumbnail sketch of model it's illustrating	Local authority has not been involved in the development of this scheme, but has agreed to spot purchase care from the on-site provider for those assessed by SSD as needing care. Access to emergency care included in service charge but care packages assessed and charged on an individual basis. Denham offers a menu of services from which residents can select.
Fundamentals of eligibility criteria and any target groups	People of retirement age who have the resource to purchase the properties, since the village has had no subsidy. A proportion of the lettings come through the Licensed Victuallers Association for retired publicans, caterers etc.
Care charges paid to?	Anchor Trust unless commissioned by SSD, in which case charge to SSD. Domestic help and support as well as care are charged per hour
Care staff structure - posts and number in team	Currently only 5 care and support staff on site as sales have only just started. Staff members have a 20 hour guaranteed contract plus agreement to work additional hours as required.
Any responsibilities apart from those relating to care?	Housing-related support
Additional Interesting features	Handy-person service available at an hourly rate. The village has a pub on site open to the wider public, a GP practice which also serves the wider community and a range of leisure facilities including a gym and swimming pool.

HOLLINS HALL – RAVENS AUDLEY COURT

PRIVATE EXTRA CARE FOR SALE – SINGLE PROVIDER, SEPARATE HOUSING AND CARE MANAGEMENT

Name of Scheme	Hollins Hall, Lund Lane, Killinghall Harrogate HG3 2HP
Number of Units and tenure	71 apartments and cottages Leasehold with variety of financial arrangements
Housing Provider	Raven Audley Court
Care Provider	Audley Court Estates – registered with CSCI as domiciliary care provider.
Care Commissioner	Usually individual lessees. Care is provided to lessees under a separate contract from the lease. Individual lessee free to purchase care from another provider. Occasional spot purchases by social services.
Thumbnail sketch of model it's illustrating	Development has a General Manager responsible primarily for housing and facilities management. A separate Head of Care” manages the care, support and housekeeping services. Head of care is accountable both to the General Manager and The Operations Director /Registered Provider Domiciliary Care
Fundamentals of eligibility criteria and any target groups	55yrs plus, with exception made for younger adults with disabilities
Care charges paid to?	Audley Court Estates, except where commissioned by SSD when charge paid to Social Services.
Care staff structure - posts and number in team	Head of Care oversees the care and house keeping team.
Minimum cover requirements	At night - awake duties 1 Care Co-ordinator and 1 night Porter During the day - There are two Care co-ordinators in the mornings and 1 in the afternoon In addition to the General Manager.

Any responsibilities apart from those relating to care?	Yes. Housing-related support and housekeeping tasks such as cleaning, shopping, laundry, delivery of meals etc
Additional Interesting features	<p>Two units being used for “transitional care” from North Yorkshire County Council</p> <p>Meals available on a pay as you go basis.</p> <p>Fitness Suite including Exercise Pool</p> <p>Mini Bus available</p> <p>Exercise Classes on a weekly basis</p> <p>Hairdressing Salon and Physiotherapy /Consulting Rooms</p>