Somerset Extra Care Housing Strategic Review

Summary Report
by
Peter Fletcher Associates Ltd

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Research and Consultancy

Somerset Extra Care Housing Strategic Review

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Summary Report

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1. Introduction

PFA was appointed as consultants to this project by Somerset County Council (Somerset Supporting People and Adult Social Care) in March 2008. This brief introduction sets out:

- A summary of the brief for the project
- How the project was carried out
- Accountability arrangements through the project
- The Structure of the Report

1.1 Summary of the brief for the project

Somerset County Council has an established and significant level of provision of extra care housing (23 schemes, 770 units), and extra care housing (ECH) is considered an important resource for both Somerset Supporting People and Adult Social Care. In recent years concerns have come to light regarding quality and consistency in relation to scheme design, service specification and delivery, funding and charging. The brief to the appointed consultants was to assist the commissioners by undertaking a review of current provision, and to make recommendations with regard to future direction and strategy. In meetings with the commissioners, despite some of the specific elements of the brief, stress has been placed on the strategic nature of the review and the need to identify necessary changes that will ensure that the provision of extra care housing services in Somerset remain sustainable and fit for the future.

The brief comprised of 6 elements -

1. **Design** - to evaluate the design of existing ECH schemes compared against current national standards
2. **Needs of current tenants** - to establish if tenants are receiving the appropriate levels of care and support normally expected in ECH schemes
3. **Needs of future tenants** - to establish if the current provision of ECH is appropriate and sufficient to meet the future care and support needs of the communities in Somerset
4. **Satisfaction levels of current tenants** - to identify satisfaction levels of current tenants in relation to the care and support that they receive in their ECH schemes
5. **Value for Money** - to compare the costs of providers for care and support; to review collection methods; to consider future budget allocation

6. **Future development of ECH** – can further sheltered schemes be upgraded to ECH and/or replace any existing ECH provision; can new telecare solutions be developed and how; can greater flexibility be built into the contractual model; can a community model be adopted; more appropriate contracting arrangements?

1.2 How the project was carried out

PFA established a specific team for this project:

- Peter Fletcher (Project Director)
- Simon Sweetinburgh (Project Manager and Lead Consultant for housing design and development matters)
- Heather Eardley (Lead Consultant for care and support, and for older people consultation)
- Louise Craig (Researcher and information/data analyst)
- Avis Duncan (Administrative support/data analyst)

The project team has carried out the work in the following manner by:

- Understanding the local context and how the strategy fits into the wider strategic planning and change agenda in the county (achieved by face to face discussions with commissioners and other key stakeholders)
- Making use of information already available, including reports, documents and contracts
- Talking directly to tenants of ECH schemes through a series of tenant meetings throughout the county, and by hearing from a broader range of ECH tenants via a tenant satisfaction survey
- Talking directly to older people in the community about their experiences, needs and aspirations with particular reference to accommodation, care and support, achieved through a series of public meetings
- Undertaking further quantitative and qualitative research through a series of survey questionnaires and structured interviews geared to the circumstances of different sets of stakeholders
- Actively using examples from other authorities and a growing body of consumer research to provide case studies and benchmarking data

1.3 Accountability arrangements through the project

The project is set within the following accountability framework:

- A tender specification and business case to the consultant from the project commissioners
- A Somerset County Council Project Initiation Document endorsed by the existing ECH housing and care providers in the county
- A Project Plan submitted by the consultant and accepted by the client
- The establishment of a Steering Group Project Board with specific and agreed terms of reference to ensure the project remains on track. This group meets monthly, its membership comprising:

  Chairperson Julia Ingram, SCC ASC
  Viv Streeter, SCC SP
  Christine Hale, SCC SP
  Steve Redman, SCC Contracts Team
  Barbara Mullen (rep for housing providers)
  Joy Kingsbury (rep for housing providers)
  Caroline Bosley (rep for care providers)
  Jill Pearson (rep for care providers)
  Wendy Winter (rep for SP Core Strategy Group)
  Carol Price (rep for SP Core Strategy Group)
  John Moughton, SCC ASC
  Mel Lock, SCC MH and LD
  Laura Ridout, Somerset PCT
  Phil Sealey (Somerset Older Citizens Alliance)

- Key roles and responsibilities to the project as follows:

  Julia Ingram as Joint Project Owner
  Viv Streeter as Joint Project Owner
  Christine Hale as Project Manager for the client
  Simon Sweetinburgh as Project Manager for the consultant

- Key project milestones are:

  Delivery of Draft Report – 21st August 2008
  Delivery of Final Report – October 2008

1.4 The Full Report

The draft Full Report was produced for the purposes of consultation with Project Board Members. It provides an extensive and detailed profile of the position of extra care housing in Somerset backed up by a substantial evidence pack. The report then moved to consideration of future requirements, a vision for extra care housing in Somerset and a set of recommendations. Positive feedback was received to the analysis, conclusions and recommendations of the draft Full Report from Project Board members, enabling

the Steering Group to identify corrections required to produce the Final Full Report, and to determine its requirements for this Summary Report.

1.5 The Summary Report

This Summary Report maintains the thinking of the Full Report in terms of looking ahead and determining future requirements. It provides a profile and assessment of the picture of extra care housing in Somerset now in very much a summary form only. Those wishing to see greater detail about this are referred to the Full Report and its evidence pack.

This Summary Report is structured as follows –

- **Section 1: Introduction**
- **Section 2: National Policy and Regional Strategy Context** – a brief summary of prevailing national policy and regional strategy that places this project in its proper context
- **Section 3: Key Findings** – this section provides a summary profile and an evaluation of the current provision of extra care housing in the county. Key findings are set out; strengths and weaknesses identified; recommendations are provided together with good practise examples from other parts of the country
- **Section 4: Future Requirements –** the drivers for change are considered**.** A future vision for extra care housing provision in the county is set out for 10 years hence, and a set of recommendations are made which would set the county on a path to realise this vision.

2. National Policy context and Regional Strategy context

2.1 Introduction

The purpose of this section is to set this study in its proper context. This is achieved by firstly, identifying and summarising the key policy documents and drivers impacting on the strategic commissioners of housing, care and support for older people, and extra care housing in particular. Secondly, we consider existing strategies of key bodies in the south west region towards the housing, care and support of older people and of extra care housing in particular.

2.2 National Policy context

Department of Health Green Paper – Independence, Well-Being and Choice: Our Vision for the Future of Social Care for Adults in England (March, 2005)

The starting point for the vision "is the principle that everyone in society has a positive contribution to make to that society and that they should have a right to control their own lives. Our vision is that these values will drive the way we provide social care." Key recommendations of the Green Paper included:

- Individual budgets. Care brokers would help people assess their needs, manage their own budget and could act as care navigators
- The development of new responsive models of care including ***extra care housing*** and telecare

Department of Health White Paper - Our Health Our Care Our Say: A New Direction for Community Services (2006)

This set out the Government's vision for more effective health and social care services outside hospital and highlights 4 key points:

- Better prevention services with earlier intervention
- More choice and a louder voice
- Tackle inequalities and improving access to community services
- More support for people with long term needs

The White Paper specifically refers to ***extra care*** schemes as the type of innovative service the government wants to see developed.

A Sure Start to Later Life (2006)

This set out three key principles:

- The government's commitment to progressive, person centred services tailored to meet individual need
- A commitment to social justice which means services that work for all, particularly the most excluded
- A commitment to economically efficient services, through better prevention and joining-up

Putting People First: A Shared Vision and Commitment to the Transformation of Adult Social Care (December, 2007)

This protocol sets out the government's commitment to independent living for all adults, and promotes a new collaborative approach between central and local government, the health and social care professions, providers and the regulator based on a shared set of aims and values. The focus is on personalisation and for statutory agencies to engage with a range of partners in the voluntary and private sectors and to invest in a range of services that promote health and well-being.

Housing Green Paper: Homes for the Future: More Affordable, More Sustainable (July, 2007)

The CLG Green Paper sets out the government vision for everyone to have access to a decent home, at a price they can afford in a place where they want to live. It highlights that "**older people will make up 48% of all new growth in households to 2024, and a substantial majority of new households in many regions will be over 65**". It goes on to make it clear that new housing and infrastructure should reflect this demographic change, and that Regional Spatial Strategies and Local Development Frameworks should consider the housing requirements of older people. It promotes that new housing and its surrounding infrastructure should reflect an ageing population and that there should be more options for older people to downsize. It refers to the importance of Lifetime Homes Standards to ensure that homes properly meet people's needs throughout their lives.

A National Strategy for Housing in an Ageing Society (February, 2008)

In 2008 Lifetime Homes, Lifetime Neighbourhoods: A National Housing Strategy for an ageing society set out the government's vision for meeting the growing demands of an ageing population and ways to meet the changing lifestyle needs and aspirations of current and future generations of older people – these requirements include:

- Better information and advice services
- More investment in new housing
- Building new homes to Lifetime Homes Standards

- The development of individualised budgets
- A new positive vision for specialised housing such as ***extra care housing*** to provide a wider range of both housing, service and tenure choices, beyond residential and nursing home care

Commissioning Framework for Health and Wellbeing

The document published by the Dept of Health in 2007 sets out the requirement for improvements in the way that a range of health and social care services are planned and commissioned

National Dementia Strategy

In 2007 the government launched a one year work programme to deliver the first ever National Dementia Strategy.

Housing Corporation Strategy for Older People's Housing (March, 2008)

This strategy recognises that "***extra care housing*** has emerged as a new and popular model for housing for older people that meets their housing needs, provides support and care and is at its best when it is outward facing and links into the community. The Housing Corporation does not see ***extra care*** as a single model of housing and should be seen and planned for in the context of a spectrum of housing provision, which includes general needs housing, care homes and a range of tenure including home ownership."

Policy development toolkits

CSIP and other agencies have been active in producing toolkits aimed at providing strategic commissioning partners with assistance in the tasks of delivering national policy changes at a local level, for example:

- More Choice Greater Voice – a toolkit for producing a strategy for accommodation with care for older people
- Extra Care Housing Toolkit – designed to assist in the development of extra care housing in the context of the wider accommodation and service needs of older people
- Commissioning for Personalisation – provides a framework to aid local authority commissioners to deliver the personalisation policy agenda at a local level.

Summary

National policy has traditionally focused on the needs of frail older people and the services required to support them and, in health and social care, most resources are

targeted on those with the most severe needs. The focus is changing; national policies now seek to support older people to live life to the full, to remain independent, healthy and active. This represents a shift from dependency and deficit to well being and independence. In this context, ***extra care housing and extra care housing services*** are viewed very much as one of the approaches for the delivery of well being and independence.

2.3 Regional Strategic context

The southwest region already has the highest proportion of older people and the longest life expectancy of any region in England. These proportions are projected to rise even further in the next 20 years, with the number of people over 65 rising by 44% between 2008 and 2025, and the number of people over 85 rising by 57% in the same period.

South West Regional Housing Strategy 2005 – 2016

This Strategy has 3 strategic aims:

- Improving the balance of housing markets
- Achieving good quality homes
- Supporting sustainable communities

The Strategy recognises the ageing demographic profile of the region, and also recognises that to "improve affordability and housing quality will deliver a range of positive health outcomes for older people."

South West Draft Regional Spatial Strategy 2006 – 2026

This draft strategy sets out the proposed direction of development throughout the south west over the 20 year planning period. The draft strategy recognises the ageing demographic profile of the region and, in a letter submitting the document to the Secretary of State for Health, points out:

> "*Planning for future healthcare provision must consider the longer term population and demographic implications of the scale of change the draft RSS is addressing. An extra 750,000 people or more will be resident in the South west over the next 20 years, many of them elderly people with complex healthcare needs. The total population aged 60 and over is projected to increase by more than half a million by 2026 and more than a quarter of a million of this growth will be amongst those aged 75 years and over. Local Authorities should work closely with healthcare providers (Strategic Health Authorities, Primary Care Trusts and NHS Trusts) to ensure that plans for the growth and reorganisation of healthcare within their area and that of adjacent authorities are fully complementary with plans for development and change in the long term. Early dialogue between healthcare providers and Local Authorities in the planning of healthcare is essential."*

NHS South West Strategic Framework

The Framework identifies the main priority of the NHS in the south west as supporting people in living healthier lives. Prevention rather than cure. Whilst the health of people living in the south west is generally amongst the best, there remain major inequalities. In some areas of the south west, the Framework identifies that the NHS will deliver more services from local hospitals, clinics, GP surgeries and other community facilities. Patients and the public will see routine health services taken out of the major hospitals and delivered more locally wherever it is safe and sensible to do so. Instead of patients traveling many miles to a distant hospital for a routine outpatient appointment or a simple x-ray, the NHS will take services to patients.

This will mean that NHS services will be increasingly provided more flexibly at the convenience of the patient rather than the convenience of the NHS. Services will be tailored to individual needs and circumstances, and planned and delivered in partnership with social services.

The Framework identifies a number of priorities:

- Realigning services to shift from a system based on treating illness to one focused on keeping people well and independent
- Supporting individuals to keep well and avoid illness
- Improving the speed and convenience of access to diagnosis and treatment
- Maximising independent living for people with long term health or disability
- Avoiding needless urgent and emergency admissions to hospital
- Ensuring a rapid response in an emergency or where urgent care is required
- Maximising the return to independence after a hospital stay
- Improving the quality of the user experience
- Improving value for money

CSIP Housing LIN (Interim) Report: Assessing Regional Housing Markets and Developing Effective Strategies

With funding from the Housing Corporation, this study aims to:

- Understand more fully the regional market for housing for older people in the South west of England
- Gather best practice examples of housing for older people both nationally and locally
- Provide guidance on how to remodel services to better meet the accommodation needs of older people both now and in the future

The study calls for action in order to prepare for the future in the following areas:

- The sustainability of existing sheltered housing stock
- The need for more new sheltered and extra care housing including housing for sale
- The need for more low level housing support services
- Rural care and support
- The wider health and care economy
- Partnership
- Cultural change and education
- Diversity and innovation

3. Key Findings and Assessment

3.1 Introduction

This section provides a summary profile and assessment of the current position of extra care housing in Somerset. Those seeking greater detail about these matters are referred to the Final Full Report and its accompanying evidence pack. The following issues are considered in turn followed by an overall assessment –

- Demographic Context
- County Strategic Context
- Provision
- Design and Sustainability
- The Service
- Access and Assessment
- Tenant Profile
- Tenant Satisfaction
- Commissioning, Contracting, Fees, Charges, and Partnership Arrangements
- Stakeholder Perspectives and Issues
- Overall Assessment

3.2 Demographic Context

3.2.1 Key Findings - Population Projections

The following table confirms the 2008 Somerset older people's population and sets this against the regional and national population profile for this group:

Fig. 3-1: Population Projections

	Somerset		South West		England	
Age Group	**No.**	**% Total Population**	**No.**	**% Total Population**	**No.**	**% Total Population**
55-64	75,300	14.2	688,900	13.3	6,079,000	11.9
65-74	54,300	10.2	500,100	9.6	4,299,000	8.4
75-84	38,000	7.2	349,700	6.7	2,876,000	5.6
85+	15,500	2.9	144,800	2.8	1,112,000	2.2

(ONS Sub-National Population Projections, 2004-Revised, England data: Government Actuary Department)

This table demonstrates that the south west has a significantly higher proportion of its population as older people in all four of the age bands than the position in the country as a whole. However, Somerset also has a higher proportion of its population as older people in all four of the age bands than the position in the whole of the south west. Older age is a very significant demographic characteristic of the Somerset population profile.

The following table sets out the older people's population projections at 10 year intervals to 2028, confirming that at all age bands over 65, the Somerset population profile will be 'older' than both the regional and national population profiles:

Fig. 3-2: Older People Population Projections

		2008		2018		2028	
	Age Group	**No.**	**% Total Population**	**No.**	**% Total Population**	**No.**	**% Total Population**
Somerset	**55-64**	75,300	14.2	79,300	13.8	90,800	14.7
	65-74	54,300	10.2	76,300	13.3	81,300	13.2
	75-84	38,000	7.2	45,800	8.0	65,200	10.6
	85+	15,500	2.9	20,400	3.6	28,800	4.7
South West	**55-64**	688,900	13.3	722,800	13.0	814,600	13.8
	65-74	500,100	9.6	666,900	12.0	709,000	12.0
	75-84	349,700	6.7	408,800	7.4	557,600	9.4
	85+	144,800	2.8	183,300	3.3	251,400	4.2
England	**55-64**	6,079,000	11.9	6,438,000	12.0	7,200,000	12.8
	65-74	4,299,000	8.4	5,445,000	10.1	5,842,000	10.4
	75-84	2,876,000	5.6	3,298,000	6.1	4,324,000	7.7
	85+	1,112,000	2.2	1,402,000	2.6	1,895,000	3.4

(ONS Sub-National Population Projections 2004-Revised, England data: Government Actuary Department)

This table demonstrates that the older people's population in Somerset is set to grow markedly in the future. In absolute terms, the 65+ population increases markedly in the future, from 107,800 in 2008, to 142,500 in 2018 (32% increase), to 175,300 in 2028 (63% increase). The proportion of over 65s of the Somerset population increases from 20.3% in 2008 to 24.9% in 2018 to 28.5% in 2028.

In comparative terms, Somerset's increasing numbers of over 65s by 32% in 2018 and by 63% in 2028 compares to increases in the south west of 27% and 53%, and 22% and 46% for the country as a whole, for 2018 and 2028.

The increasing proportion of over 65s of the Somerset population – to 24.9% in 2018 and 28.5% in 2028 – compares to 22.7% and 25.6% in the South West, and 18.8% and 21.5% in the country as a whole, for 2018 and 2018.

3.2.2 Illness and Other Health Conditions

For extra care housing, the above population projections need to also be considered alongside projections around illness and other health conditions which might impact upon demand for ECH and related services.

- ***Long term limiting illness -*** The following table sets out the most recent data on long term limiting illness (LTLI) incidence in the county, demonstrating a general correlation between LTLI and older age:

Fig. 3-3: Long Term Limiting Illness

	Total Population	With a Limiting Long-term Illness	Without a Limiting Long-term Illness
Somerset	498,093	90,130 (18.1%)	407,963 (81.9%)
South West	4,928,434	892,034 (18.1%)	4,036,400 (81.9%)
England	49,138,831	8,809,194 (17.9%)	40,329,637 (82.1%)

(ONS, 2001 Census)

The following table sets out the projections around long term limiting illness:

Fig. 3-4: Projections for Long Term Limiting Illness

Total population aged 65 and over with a limiting long-term illness	2008	2010	2015	2020	2025
County	46,620	48,930	56,828	63,825	71,950

(POPPI, from 2001 Census)

- ***Dementia -*** The dementia projections data below has been calculated using the Alzheimer's Society Dementia Prevalence Rates table below:

Fig. 3-5: Dementia

Age (years)	Prevalence
40-65	1 in 1000
65-70	1 in 50
70-80	1 in 20
80+	1 in 5

Fig. 3-6: Dementia Projections

Total population aged 55 likely to experience dementia	2008	2018	2028	% Change 2008-2018	% Change 2008-2028
County	9,392	12,038	16,447	28.2	76.9

(ONS 2004 Revised Sub-National Population Projections, Alzheimer's Society Dementia Prevalence Rates)

This table projects a roughly 30% increase in the incidence of dementia in the county over the next 10 years to 2018.

- ***Learning Disabilities***

Fig. 3-7: Learning disability projections

Total population aged 55 expected to have a learning disability	2008	2010	2015	2020	2025
County	4743	4915	5462	6031	6417

3.2.3 Assessment

This brief run through of relevant demographic projections for Somerset clearly demonstrates both the existing high numbers of older people, and those with chronic illness, dementia, learning disability etc.; and the significant increases in all these areas that the county will experience in the years ahead. These increases are proportionately greater than the South West overall position and much greater than the country as a whole. The extent to which extra care housing is planned or could be planned to provide choice for older people is considered in later sections

3.3 County strategic context

3.3.1 Introduction

This section summarises the strategic development of ECH within Somerset. A number of current and historical relevant strategies are considered, and the strengths and weaknesses of the current strategic framework are set out.

3.3.2 Key Findings - Relevant Strategies and Programmes in place

Somerset Sustainable Community Strategy

This 2008 strategy has been prepared by the local strategic partners in Somerset. Amongst its identified challenges and key priorities are several that are particularly relevant to the subject of this study, including a priority to **"personalise services in ways that enable residents to exercise greater choice and control, living independently for longer."**

Somerset Local Area Agreement

The Somerset Local Area Agreement identifies 13 stretch targets for the Somerset strategic partners to achieve, including the following:

"Prevent dependency, promote social participation and offer greater choice and control to older people."

Somerset County Council Corporate Plan 2007 – 2010

This document has as one of its key aims:

"***To enable vulnerable adults to live as independently as possible – we will support older people, those with a physical or learning disability and/or mental health problems, as well as their carers, either enabling them to live in their own homes wherever possible, or providing appropriate residential and respite care."***

Amongst the plans of the Council are several that are particularly relevant to the focus of this study, including **"obtain corporate support for a broad based Older People's Vision and Strategy."**

Somerset County Council Commissioning Strategy 2002 – Services for Older People

The vision set out by the County Council was quite clear:

- Enabling more older people to remain at home for as long as they can – which is their clearly expressed wish, and
- Where that is no longer possible, to ensure sufficient capacity in good quality residential and nursing home care

The strategy set out 6 specific proposals, including "the expansion and adjustment of extra care housing as an effective replacement for some residential care." Two hundred and thirty four additional extra care units were considered necessary (although the Improvement Plan within the strategy refers to the creation of 500 extra care places). The methodology for calculating either of these numbers is not set out.

It was envisaged that the additional units would be provided through a 5 year programme to convert 24 sheltered schemes into extra care housing, the capital cost of

which would be met "through the existing programme of Credit Approval Transfers from the County Council to District Councils and from contributions from Districts."

The action plan sets out a number of actions to be progressed by a County Working Group plus actions for Areas/Districts.

Joint Somerset County Council and NHS Commissioning Strategy Phase 2: 2006/2008 – Services for Older People

This document builds on the previous 2002 Commissioning Strategy retaining the 2002 overriding aim to enable more older people to remain at home for as long as they wish and where this is not possible to ensure sufficient capacity in good quality residential and nursing home care.

In terms of delivery against this 2002 plan, the 2006 Commissioning Strategy comments:

- 234 additional ECH places have been developed but the majority of the new capacity is located in South Somerset
- Although ECH serves as an alternative to residential care (where it is available), there is still insufficient supply to meet demand

In terms of carry-forward tasks into 2006-2008 the Strategy states the intention to:

"Continue to develop ECH as an alternative to residential care by refining the specification and funding model. Consider new models of provision; e.g. 'virtual' ECH run on a neighbourhood basis coordinated via Community Alarm Services and linked to planned night time care and support."

Somerset Supporting People Strategy 2005-2010: The Big Picture

The document recognises the "increasing numbers of vulnerable older people living in a diverse set of circumstances needing a range of support solutions."

The Strategy goes on to say – ***"Supporting People has a significant role to play through encouraging more Extra Care Housing (ECH) of the frail elderly***, floating support, Home Improvement Agencies (HIA), and maximising use of the existing sheltered stock."

The Strategy also identifies the need to review "the need, use and role of both sheltered and ECH; the opening up of ECH for other client groups such as older people with mental health or younger people with physical disabilities."

Somerset PCT Strategic Framework 2007

In this Strategy, there are no references to extra care housing. The PCT identifies several plans for older people's services in 2007/08 including "to implement the Sustainability Plan to ensure the Active Living Centre model, developed through

Partnerships for Older People's Projects (POPP), is maintained. These centres will provide Somerset Primary Care Trust with an excellent opportunity to promote a positive healthy living message to our ageing population and support older people to take responsibility for their own health."

Active Living in Somerset

This strategic programme is geared to addressing the future health and independence of Somerset's changing population. Fifty Active Living Centres will be developed in Somerset by 2008. Active Living Centres will be drop-in centres where people can take part in a range of activities that help them to stay active and healthy. The centres will be places from where community activities, information, and support services reach out into the community. There appears to be no intention that any of these centres will be based at ECH schemes.

Vision of Sheltered Housing in Somerset Project, 2007

This set out a number of recommendations for the future of sheltered housing in Somerset, including the development of a hub and spoke model of delivery of housing support services in the future, as follows:

"This model is based on local support worker teams located at hub schemes delivering services to 'spoke sheltered schemes' in their locality and to older and vulnerable people in the community. The service delivered to the service users will be assessed according to their individual needs.

It is understood that a programme to implement this model is now under development.

3.3.3 Assessment

There is a clear recognition within the commissioning strategies of Adult Social Care/NHS, and Supporting People that ECH represents an important part of the overall strategy towards greater provision of independence and choice for older people, and particularly to offer an alternative to traditional residential care.

There are, however, a number of weaknesses to the current strategic framework for ECH provision:

- ***Extent of requirement for further provision*** – although there are statements in both the SCC/NHS and SP Strategies to the need for greater provision of ECH in the county neither strategy attempts to quantify the requirement or set out how it is intended that the requirement will be quantified
- ***Vision for ECH*** – in neither strategy are there any statements regarding the vision and purpose of ECH beyond its contribution to providing an alternative to residential care

- ***Definition of ECH*** – in neither strategy is there any statements defining the essential characteristics of ECH, either in terms of the physical characteristics and standards of the accommodation to be provided, or the nature and standards and objectives of the care and support service to be provided (although to an extent the latter are set out in contracts to be considered later in this report)
- ***Potential of ECH*** – there is no cross referencing between the strategies and no linking of strategies to programmes that could involve ECH as a clear focus or setting for delivery, indicating a very limited view of the potential for ECH to contribute to community needs beyond its role as specialist accommodation provision. For example:
    - Whilst the PCT strategy refers to exercise programmes and co-location of health promotion staff, there is no suggestion that ECH schemes could provide an appropriate setting for these
    - The Active Living programme could have been focused on using ECH schemes as ideal locations as Active Living Centres, and an opportunity seems to have been lost here
    - The Vision for Sheltered Housing in Somerset Project report does make reference to ECH schemes being suitable locations for hubs as part of the hub and spoke model to develop housing related support services on a neighbourhood basis
    - The Commissioning Strategy does not make the link as to how the development of ECH can contribute to other plans, such as development of preventative services; expansion of use of assistive technology; developing home care and support services
- ***A clearer strategic framework for the development of ECH –*** *a specific "ECH Strategy"* or *"Older Peoples Accommodation Strategy"* or "*Older People's Health and Well Being Strategy*" – any of these is likely to provide a clearer strategic framework that would deal with the current weaknesses identified above, and relate the development of extra care to wider system development. Alternatively, the scope of a 2008 – 2012 Commissioning Strategy could be broadened to provide the same result
- ***Partnership and buy-in –*** whilst the 2006 Commissioning Framework was a joint product of the County and PCT, the 2002 Commissioning Strategy was County alone. It is recommended that future developments of the Commissioning Strategy are undertaken collaboratively between the County, the 5 Districts, and the PCT. Also, that consultation feedback on the strategy is obtained and commented on from housing, care and support providers, older people, voluntary agencies and carers groups etc.

Fig. 3-8: "More Choice Greater Voice"

Good Practice Example

"More Choice Greater Voice"

CLG, CSIP and the Housing LIN have produced this toolkit for commissioners for producing a strategy for accommodation with care for older people, a whole systems approach to planning and developing accommodation with care.

The summary adds "Those working to develop strategies that co-ordinate the planning of health, housing and social care bodies will find assistance in developing an approach and structuring material. Those within local authority housing or adult social care departments whose requirements may be more focussed on particular services will find materials that will help them set those specific concerns into a wider context."

Fig. 3-9: Wiltshire Older People's Accommodation Strategy

Good Practice Example

"Wiltshire Older People's Accommodation Strategy"

In addition to preparing a future strategy for planning older people's accommodation needs in the future, the authority wanted to possess a model that they could manipulate to undertake scenario planning – in other words, for a given population and accommodation profile and for a given level of investment in a part of the accommodation market, what would the impact on outputs, in terms of accommodation and social care funding requirements.

3.4 Provision

3.4.1 Introduction

This section profiles the current provision of extra care housing in Somerset, considering the overall level of provision, its distribution, situation and location, density, age of provision, tenure, and nature of the providers.

3.4.2 Overall Level/Volume

Somerset has the largest volume of ECH units of accommodation (800) of any county or unitary area in the South West, and the second highest number of units per 1,000 people over 65 (8.3) of any county or unitary area in the South West.

3.4.3 Distribution

There is quite a wide disparity of level of provision between the 5 district areas, with South Somerset district having more than 3 times the level of provision (calculated on the overall numbers of ECH units) as West Somerset district, and both South Somerset

and West Somerset districts having nearly twice the level of provision (calculated on the basis of ECH units per 1,000 over 65's) as Sedgemoor district.

Fig. 3-10: Distribution of ECH units

District	Current ECH provision	Population over 65	ECH units per 1,000 over 65's
Mendip	153	17926	8.5
Sedgemoor	113	20257	5.6
South Somerset	313	29610	10.6
Taunton Deane	124	19626	6.3
West Somerset	97	9261	10.5
Somerset	800	96680	8.3

Considering distribution at the sub district level, it is clear that all major towns in the county bar Glastonbury have ECH provision. This represents very broad coverage although provision as a proportion of the over 65s population of each town does vary. In addition to these major towns, there is also ECH provision in Somerset in a number of smaller towns.

3.4.4 Location and Situation

Almost all social housing providers were extremely positive about the good location and situation of their schemes within the towns. Providers commented on:

- The good relationship that their scheme has to its local community
- Location in safe low crime neighbourhoods
- With good proximity and easy access to local facilities enjoyed by older people – retail, post office; health care; place of worship etc.

3.4.5 Density

Another distinguishing feature of the ECH provision in Somerset is the density of provision, measured by the size of scheme. The 23 social rented ECH schemes provide between them 772 units of accommodation, representing an average scheme size of only 34 units. In current planning terms, such a scheme size would be considered low, with most providers recommending minimum scheme viability levels at around 40 units, in order to reasonably distribute the costs of services charges and staffing provision across the given number of tenants.

The 4 private schemes are small, but significantly all are located adjacent to residential or nursing care homes run by the provider, thereby achieving the necessary economies of scale through an alternative approach.

3.4.6 Tenure

Supply figures in the following table indicate that there is very marked tenure imbalance in ECH provision in Somerset, both in absolute and comparative terms:

Fig. 3-11: Tenure

County	ECH Social Rent	ECH Sale	ECH Social Rent %	ECH Sale %
Cornwall	0	76	0	100
Devon	183	114	62	38
Dorset	111	141	44	56
Gloucestershire	280	140	67	33
Somerset	772	28	97	3
Wiltshire	43	168	20	80

It is unclear why there should be such a low level of private sector ECH activity in Somerset compared with other county areas in the region. Of the 4 private schemes in Somerset, 3 are for leasehold sale, whilst the fourth is let at a market rent level.

Fig. 3-12: The Paddocks, Honiton, Devon

	Good practice example **The Paddocks, Honiton, Devon. Stepping Stones Group**
Tenure	Leasehold
Size	10 x 2 bedroom bungalows completed in 2001. The second phase of a further 12 X 2 bedroom bungalows are now on release
Development	The bungalows are situated within 12 acres of Gittisham Hill House. The properties are in an open setting around two paddocks with views across the grounds
Facilities	2 bedroom properties with bathroom and shower room. Nurse call system linked to Gittisham Hill House
Services	24/7 alarm service and access to services at Gittisham Hill House
Attached Care Home	Gittisham Hill House which is a registered residential home for 30 residents
Location	1.5 miles from Honiton in Devon
Lifestyle	The properties are designed for safety and security and to enable residents to retain their independence. Residents have the use of the grounds and access to the facilities of the care home. Stepping Stones offer a menu of services and tariffs from the basic monthly service charge, meals, domestic assistance, laundry and care services
New residents	The second phase is now on release and prices start at £275,000 for a 125 year lease.

Regional statistics available do not enable a picture to be drawn of the extent of shared ownership ECH activity that has taken place or is taking place in the South West. However, there is anecdotal evidence of a growing volume of this type of provision being developed, providing older people with a further choice other than social rent or sale. For many existing homeowners, outright purchase of an often very 'upmarket' private ECH unit is not an affordable option, yet renting is not their preferred tenure choice either. There is growing evidence that 'downsizing' to an affordable shared ownership ECH unit and releasing some equity for meeting revenue expenditure is an attractive option for some older people.

Fig. 3-13: Hanover Extra Care, Bristol

Good practice example

Hanover Extra Care, Bristol

Hanover retirement development in Portishead, designed specifically with the needs of older people in mind with access to care and support. Completion expected in September 2008. Fifteen of the 68 properties will be for sale on a shared ownership basis. Eight bungalows are available for sale, and the remaining 45 will be available for rent.

Fig. 3-14: Aston House, Pewsey

Good practise example

Aston House, Pewsey

An existing Sarsen sheltered scheme known as Aston House in Pewsey is currently being redeveloped to provide a 24 unit mixed tenure extra care scheme plus 8 cottages. The scheme will open in Jan 2009 and is being jointly capital funded by Sarsen, Kennet District Council and the Housing Corporation. Wiltshire County Council (WCC) will provide social care and SP revenue funding. The concept is an example of a hub and spoke model of provision with the scheme being the hub, but services available on an outreach basis to the older people community in Pewsey including 80 Sarsen bungalows close by. The scheme was conceived as a partnership between Sarsen, Kennet DC, WCC and the Housing Corporation. Key parameters around access criteria; assessment process and other key policies are currently under discussion between Sarsen and WCC.

3.4.7 Age

There appear to have been two distinct 'waves' of activity that have led to the current provision of 772 social rented ECH units in Somerset:

First Wave – newly purpose built ECH schemes all developed between 16 and 32 years ago by local district housing authorities or their housing association partners. These were either capital funded by the local authorities themselves or, in the case of schemes developed by housing associations, by the local district housing authority or by

the Housing Corporation. Although apparently strategically unplanned from a county perspective, the combined provision produced within each district area led to a very significant provision of social rented extra care housing in Somerset 475 by 1992.

Second wave – activity in this period (from 2002) was very strategically driven by Somerset County Council to rapidly increase ECH provision in the county. This was achieved through the voluntary upgrading by social landlords of appropriate sheltered housing schemes with funds made available through Transitional Supporting People Grant. Somerset was very bold in the use of this facility. However, the take-up by social landlords of this opportunity was very patchy, with the result that this upgraded ECH provision was heavily skewed to the South Somerset district.

3.4.8 Profile of Providers

7 social housing providers own or manage the 23 social rented ECH schemes in Somerset, whilst 4 care providers provide the care service within these schemes. In a sector where national providers are relatively dominant, this provider profile in Somerset is quite unusual in that it is dominated by locally based providers on both the housing and care sides. In terms of private provision, the four schemes are all provided by care home operators, 3 of which are local/regional, the other one national.

3.4.9 Assessment of Current Provision

The profile of ECH in Somerset is quite unique owing to the history of its development.

Among the ***strengths*** of this current provision are:

- The scale of provision, both absolutely and comparatively with other authorities
- The scale of provision in the social rented sector particularly the whole pattern of provision indicates some very early and bold strategic work within Somerset, well ahead of most other authorities in seeing the value of ECH as an alternative to residential care
- The distribution of provision across a large and diverse county is particularly impressive, with provision in market towns serving neighbouring villages and rural areas being a particular feature of the ECH landscape in Somerset and one that can be built on
- The fact that almost all existing schemes appear to be well located and well situated in the town
- The history of provision in Somerset provides for a wealth of experience and expertise amongst commissioners and social housing providers in the county that most authorities would envy

The ***weaknesses*** of the current profile of provision are:

- ***Choice*** - A poor range of choices for current older homeowners who may be interested in moving to ECH but for whom renting is not their preferred form of tenure. There are remarkably few ECH units for outright purchase in the county and no shared ownership or shared equity provision at all. Even before consideration of future demographic trends it is clear that there is significant market imbalance in Somerset which should be addressed
- ***Private provision*** - A concentration by commissioners on the social rented market at the expense of the private market. Strategies tend to assume that ECH comes only in the form of social rented provision and consequently there is no evidence of commissioners seeking to manage the overall ECH market in the county, or of active engagement with private sector providers
- ***An ageing stock profile*** - Most authorities have developed their ECH provision much more recently than Somerset has, consequently their stock is more modern. Also, Somerset encouraged the conversion of already ageing sheltered housing schemes into ECH, and this accentuates further the ageing stock profile. Some of the consequences of this will be considered further in the next section
- ***Average scheme size*** - Both commissioners and providers have identified costs and charges as an issue, and it is probable that a relatively small average scheme size is a contributory factor to these difficulties. This aspect will be returned to later in the report
- ***Distribution*** – current distribution is well dispersed across the county but indicates a relative underprovision in some of the larger towns, particularly Taunton. This will be considered further later in the report when we consider the impact of differential population projections across the county
- ***Provider Profile*** – the provider profile is very unusual in its predominance of local providers. The national picture confirms that specialist extra care provision is dominated by specialist providers more so than many other forms of housing. There are, of course, strengths and weaknesses to this pattern, and commissioners will need to consider this aspect if further extra care housing is to be developed.

3.5 Design and Sustainability

3.5.1 Introduction

This section profiles the design and quality of the existing extra care housing and assesses its sustainability in relation to a range of standards and the stated aspirations of older people.

3.5.2 Design Standards

One of the difficulties in assessing ECH design is that, whilst there is a wealth of good practise published by government agencies, providers, architects and others, there is no set of agreed national standards which can be used to provide an objective assessment of the attributes of each scheme.

However, public funding agencies such as the Housing Corporation do set their own benchmarks for minimum standards that they will require in order to consider funding, as have many local authority commissioning partnerships. This has not happened in Somerset.

ECH schemes should be capable of supporting adults with a variety of care needs with a home for the remainder of their life, regardless of changes in their care needs. In order to achieve this, the common threads from all good practise guides are that schemes must strive to meet the following design standards:

- Living spaces (flats, bungalows etc) that are fully self contained, have sufficient space and appropriate facilities such that they are truly barrier free environments
- A communal and external environment that are similarly barrier free in their design
- Adequate communal space and facilities for independent living – laundry, dining, lounges, hairdressing, guest facilities etc
- Adequate communal space and facilities for personal healthcare functions – assisted bathing, GP consultations, district nurse treatments, telehealth etc
- Adequate office and private space for operational and scheme management staff - office, sleepover room, changing and toileting facilities

Fig. 3-15: Bristol City VSH Partnership

Good practice example

Bristol City Very Sheltered Housing Partnership – Joint Briefing Document on Designs for VSH Schemes

A jointly produced design guide between the commissioners and providers and produced by PRP Architects. Although designed for briefing designers for new schemes, this represents an immensely helpful document should Somerset decide to produce its own Design Standards for ECH as later recommended.

Fig. 3-16: CSIP Housing LIN Report

Good practice example

CSIP Housing LIN Report – Remodelling Sheltered Housing and Residential Care Homes to Extra Care Housing – Advice to Housing and Care Providers

This report may be particularly useful to Somerset in the task of agreeing a Somerset Design Standard for ECH. Whilst not ducking the key issues that must be tackled, it takes an immensely practical and pragmatic approach to the problems inherent in remodelling or upgrading sheltered housing to ECH.

3.5.3 Living Spaces

Unit Mix

Fig. 3-17: Unit Mix

Somerset Provision	Bedsit/ studio	1 bed	2 bed	Total
Number of ECH units	23	482	64	731
%	3	88	9	100

Bedsits are not considered appropriate or long term sustainable accommodation for ECH, and most providers find that bedsits are less popular with applicants than one bed flats. However, 3% of Somerset's total ECH provision is bedsits.

Two bedroom accommodation is the recommended provision for new ECH schemes because this is considered a more long term sustainable form of provision. Research with older people confirms their popularity. Older people say that the second bedroom can be more suitable for a partner, for a carer, or for family visitors. However, only 9% of Somerset's total provision is two beds.

Unit Size

Fig. 3-18: Unit Size

Somerset Provision	1 bed	2 bed
Recommended size	51-54m^2	65-68m^2
Average Somerset Provision	43m^2	56m^2
Range of Provision	35.6m^2 – 56m^2	44.2m^2 – 64m^2

There are no mandatory standards for unit size, but the recommended sizes quoted in the table above are taken from two publications from the Housing LIN/Care Services Improvement Partnership – the 'Extra Care Housing Toolkit' and 'Design Principles for Extra Care.' In both cases, the recommendations reflect good practice around barrier free environments. For example, full turning circles for wheelchairs usually result in the need for slightly larger corridors, bathroom, kitchens, and bedrooms. The average size

of Somerset ECH units is around 15% smaller that recommended size for both one bed and two bed units. Some units are more than 30% smaller than the recommended size.

Barrier free units

Fig. 3-19: Barrier Free Units

	Bedsit/ studio	1 bed	2 bed	Other	Total
No of ECH units built or adapted to full wheelchair design	0	24	16	13	53
% of units to wheelchair standard	0	3.3	2.2		7.3

Only 53 units (7.3% of the stock) were built or have subsequently been adapted to full wheelchair standards.

One hundred and eighty one units (25% of all units) have either walk-in bathrooms or bathrooms adapted for people with mobility problems or wheelchair users, whilst only 13 units (2% of all units) have kitchens designed to wheelchair standards.

Fig. 3-20: Units adapted for people with mobility problems

	Number of units	% of units
Units with either walk-in **bathrooms** or bathrooms adapted for people with mobility problems or wheelchair users	181	24.8
Units with **kitchens** that are designed to wheelchair standards	13	1.8

3.5.4 Communal and External Environment

- ***Designing for physical disability - Level wheelchair-user access to the scheme -*** Providers generally consider that their schemes have satisfactory access arrangements into the schemes for wheelchair users
- ***Designing for physical disability - Barrier free wheelchair circulation throughout the scheme -*** Most providers advise that their schemes enable full circulation and barrier free access to all facilities by wheelchair users and are fully DDA compliant. All lifts are to wheelchair standard enabling flats to be accessed by wheelchair users on whatever level. However, providers commented that for some schemes "Some accommodation is not fully accessible to wheelchair users."
- Whether schemes incorporate detailed features that would be part of the specification for new schemes built in 2008 – such as passing points in circulation areas for wheelchairs and scooters; and free swing door closers –

has not been tested, but we would consider these features being in place as unlikely

- ***Designing for dementia -*** It is widely understood that the incidence of dementia is increasing and that 1 in 5 people over 80 are likely to have some form of dementia. So far as we are aware, there are no schemes which have been designed or adapted with the particular needs of people with dementia in mind. Current conclusions from those working in the ECH sector are that there is, as yet, no clear evidence that any specific flat designs or grouping of flats together for people with dementia are necessary or helpful

However, there is a wealth of good practice available about simple design features of the wider scheme that do certainly help with orientation, recognition and familiarity and thereby reduce confusion. Intelligent design of circulation areas: lighting; colour schemes; individualisation of flat entrance areas etc are relatively inexpensive and easy to achieve. However, from our discussions with providers we are not aware of any programme to ensure that the built environment of ECH schemes follows this best practise in designing for dementia.

Fig. 3-21: Designing for Dementia

Good practice example

Designing for Dementia

Whilst we have advised that the general view amongst professionals is that there is no case for design specific dementia living units, the case studies set out in Appendix 3 of the Full Report may be helpful in demonstrating the range of options being explored, particularly with the application of assistive technology.

- ***Designing for people with visual impairments -*** One in six people over 70 suffer from a visual impairment so providing an ECH environment which is suitable for those with a visual impairment is essential. As with designing for people with dementia, there are no particular issues affecting the built form of flats, but the intelligent design of communal areas is critical in establishing a barrier free environment. A wealth of good practise exists in this area including appropriate lighting levels; colour schemes; textiles and fabrics; scored handrails; use of Braille signage. However, from our discussions with providers we are not aware of any programme to ensure that the built environment of ECH schemes follows this best practise in designing for people with visual impairment
- ***Designing for people with hearing impairments -*** The majority of people will experience some degree of hearing impairment as they grow older. Such residents of ECH schemes can be greatly assisted in their enjoyment of the ECH environment by induction loop systems installed in communal areas where residents gather to socialise. We understand that the majority of ECH schemes have a loop system but there is no county wide programme or

standard that requires this. Best practice includes the provision of video entry phone systems in schemes

- ***Designing for learning disability -*** Design for people with learning disabilities will depend on the type and level of learning disability and the presence of other physical or mental disabilities. Best practice identifies signage as particularly important which should be in words and symbols. People with autism and epilepsy should avoid designs with pointed corners and have rounded edges, avoid strip lights and ventilation which gives off a constant hum which can often aggravate these conditions. Security is also an issue and there is scope for a wide use of assistive technology. We are not aware that these design issues have been systematically considered in Somerset ECH
- ***Designing for cultural diversity -*** In order to ensure that providers are offering a barrier free environment they should be prepared to consider whether they can accommodate the design requirement of someone with a particular religious or cultural background. In other areas where we have consulted with ethnic minority groups the plea for more extended family living such as granny flats and additional bedrooms to enable family members to live together and care for elders is seen as important. It has also been requested that people from similar ethnic groups (and people with hearing impairment) could be housed together to aid with communication difficulties and enable better social interaction

3.5.5 Communal Spaces and Facilities for Independent Living

- ***Lounges -*** All providers advise that their schemes have lounges of an adequate size for the needs of residents
- ***Dining Rooms -*** All providers advise that their schemes have dining rooms of an adequate size for the needs of residents.
- ***Laundry -*** Whilst laundries for use by residents and staff are considered a fundamental requirement of ECH schemes, there are some schemes that do not have them:
- ***Hairdressing and beauty therapy -*** Whilst some schemes have visiting hairdressers and other therapists, others have no provision at all.
- ***Guest room facilities -*** Less than half of the ECH schemes have guest room facilities. Some providers used former guest room facilities to provide care staff sleepover facilities as part of the sheltered housing upgrade programme commenced in 2002.
- ***Shop -*** Only a small number of schemes have an on-scheme shop supplying common household items and groceries for residents.
- ***Library -*** Whilst some schemes enjoy visits from mobile libraries, only one scheme has a dedicated scheme library.

- ***IT facilities -*** IT and internet connection facilities are available to residents in the communal areas at a few schemes only.
- ***Residents parking -*** Most providers confirm that their schemes have adequate parking for residents and their guests, although there are some exceptions

3.5.6 Communal Spaces and Facilities for Personal Healthcare

- ***Assisted bathing*** - Whilst assisted bathing facilities are generally considered a fundamental requirement of ECH design, providing a specialist facility not just for residents but also for those in the wider community, there are a few schemes that do not have this provision
- ***Health Treatment Rooms -*** This comprises dedicated space to an acceptable clinical standard for the purposes of community health functions such as GP consultations; district nursing clinics and treatments; chiropody etc. Only a small number of schemes have such dedicated space

3.5.7 Space and Facilities for Staff

- ***Office facilities -*** All schemes have an office space for the scheme manager. Generally, it is considered good practise for the care team to have a separate office on the scheme. However, only some schemes offer a separate office space for the care team, in other cases the office space is shared with the scheme manager
- ***Sleepover facilities -*** Providers confirm that all schemes have adequate sleepover provision for the overnight care and support team
- ***Rest room, changing, kitchen and toileting facilities -*** From provider's replies, it is clear that these facilities do exist, but less clear whether they are separate from or the same space as the sleepover facility

3.5.8 Assessment of Design and Sustainability of Current ECH Provision

From the above, we can say that most of the ECH provision in Somerset:

- Has adequate but not generous communal space and facilities for independent living
- Has adequate but not generous communal space and facilities for personal healthcare delivery
- Has adequate but not generous space and facilities for staff

However, we have some major concerns about the current provision:

- ***Meeting the need*** - Living spaces (flats and bungalows) are generally too small to represent popular provision for the next generation of older people.

The ideal stock ratio may be in the order of 40% x 1 bed flats, 60% x 2 bed flats, whilst current provision in Somerset is 3% x bedsits, 88% x 1 beds and only 9% x 2 beds

- ***Ageing in place*** - Living spaces are generally too small to adequately provide for ageing in place with changing care needs over time that this implies. Only 7% of the stock is designed to wheelchair standard
- ***Barriers to access*** - Schemes generally are not designed to provide a positive living environment for people with a range of disabilities or impairments or conditions and these people are effectively excluded from the schemes. Anecdotal evidence from SCC confirms that potential applicants for a scheme are effectively ineligible to access it because of their disability. Enlarging flats to provide for full wheelchair standard is of course very expensive and sometimes completely impractical. However, design features to enable the environment to be more suitable for people with visual impairment, hearing impairment, and for people with dementia, is usually relatively inexpensive and feasible

It is worth noting that none of the existing scheme designs would now be eligible for capital funding by either the Housing Corporation or Dept of Health.

Perhaps the greatest weakness of the current provision is that there is no Somerset agreement around minimum acceptable design standards for ECH.

3.6 The Service

3.6.1 What services should be provided in Extra Care Housing?

Extra Care Housing accommodation should enable the delivery of health and social care services to service users without the need for them to move out of their own homes. This requires good quality provision of care and housing support services to maximise independence and ensure people receive the levels of care and support they require.

“Housing designed with the needs of frailer older people in mind and with varying levels of care and support available on site.” [1]

“The ethos of extra care is to promote independence, not to foster a culture of dependency”[2].

[1] CSIP- The Housing LIN toolkit ‘More Choice, Greater Voice (Feb 2008)

[2] Extra Care Housing – Development planning, control and management - RTIP Good Practice Note 8 guide (2007)

Housing support aims to enable people to stay in their homes and live as independently as possible. There are some occasions where support will be provided to assist people in moving to alternative accommodation. The range of support services can vary from helping with learning how to cook and budget, identify jobs and training opportunities, claiming benefits, grants etc or access to utility services, support to maintain social life or ensure housing meets access and health and safety needs.

Care is provided via domiciliary care agencies following assessment by a care manager or social worker and a care package put in place. This tends to be tasks such as washing, dressing, and personal care to enable a person to remain as independent as possible. Depending on the ethos, training and experience of the staff the care may or may not be provided with an element of enablement and maximization of the person's independence.

3.6.2 Care & Housing support in Somerset

In Somerset ECH schemes traditionally the support element has been provided by the housing provider through the scheme manager and care (with some elements of cover for support) through a care provider. However, in some schemes the care provider is also the housing provider.

Most of the care providers suggest they have integrated teams of care and support staff or use the same staff with a consequent blurring of roles to provide cover for scheme managers when they are not on duty. This tends to be at evenings, weekends and bank holidays though there is no consistent set of hours when scheme managers are off duty and this varies across the county. From the service users perspective many people have never really understood the difference between the care and support roles and in the tenant's survey we carried out they had difficulty in differentiating between the two.

As the scheme managers do not manage the care & support staff (except in some schemes) it is questionable as to whether a fully integrated model is being provided. This should be a key feature that Extra Care Housing can offer – a flexible and responsive service delivered at a time that residents want and which could change from day to day if residents require this.

In Somerset under the "core contract" housing support cover for scheme managers is jointly commissioned by Adult Social Care and Supporting People. However, the single Somerset "community model" in reality does not exist as there are numerous inconsistencies in service provision from area to area, from scheme to scheme. Here are a few examples –

- Private agreements between the housing providers and care providers for additional cover for scheme managers such as holiday cover if required.
- A floating support service for between 1-3 hours per week in one scheme

- A support worker from 9am – 8pm who works alongside the scheme manager providing support, which is scheme based.
- Housing support cover in another area is provided only when the scheme manager is not on site.
- Other cover which is provided at some schemes is for assistance with tenants' meals or cover for scheme managers lunch breaks. This is not consistent across the county and depends on the particular scheme. The average number of hours provided in a scheme to support meals is 24.23 hours with the maximum at 86 hours and minimum 2.5 hours.
- There appears to be an unclear demarcation between housing and support and some providers more clearly define this than others

" If a community model is to be provided in the future then there must be clarity about criteria, eligibility, task, who is funding and the cost of this service " **(**Source: Care & support provider**)**.

3.6.3 Specification

A service specification exists as part of the overall Somerset contract with a number of appendices but this is a very piecemeal document which appears to have developed at different periods in time. Housing and care providers report that they have found it fairly flexible in application but its vagueness has added to the development of different services in different places with no clear standards or vision of one model.

It also appears that the services specification has been cut back over a period and that valued tenant services such as laundry have been taken out without clear communication or an understanding of why things have changed.

The document exists in separate sections and appendices and providers could not demonstrate that they all have the same document or what they are working to.

3.6.4 Standards

Whilst there are no national standards for ECH the Domiciliary Care Standards set by CSCI are applicable to ECH schemes under the Domiciliary Care Agencies Regulations (DCA) 2002 and National Minimum Standards (NMS).

Each of the four care providers in Somerset works towards these standards as well as having their own quality standards and monitoring processes in place. Unfortunately the tenant feedback was not so positive about care provided in the schemes – negative feedback was received about lack of time, training, experience, age or occasional language difficulties.

3.6.5 Relationships

Care providers report a good relationship with commissioners with regular communication and review meetings. However, they suggested that a lack of clarity about what is being delivered (para 3.6.2 above) has impacted on the relationship between them and the housing providers. This appeared less of a problem where the housing care and support provider is one and the same - here managers are provided with housing enabling and care staff to support them e.g. can organise a diabetes healthy eating group.

3.6.6 Staffing

It is apparently very easy to recruit care and housing support staff to work in ECH schemes as opposed to in the community especially without the need for transport and with all service users in one place this makes working conditions much easier.

However, historical legacies e.g. successive TUPE transfers of staff, together with the separate contracting of care and support mean that it has been difficult to move to integrated care and support teams.

Schemes can be run very differently even with the same care and housing providers and much appears to be about the scheme managers' professional background, leadership, understanding and approachability.

Training is not seen as a problem so much as releasing staff to do this.

3.6.7 Choice - times/staff/task

"If service users are not happy with the carer this can be addressed". Yet many times tenants said they were unhappy with carers and this was not addressed. Timings of visits is a big issue as it is difficult when everyone wants the same time for key tasks such as getting up, going to bed, baths etc.

3.6.8 Continuity and quality of care

This was not seen as an issue by the care providers who mainly have a dedicated team rather than individuals working to tenants - if there is an issue with a particular tenant then a different carer would be allocated. This may or may not become easier with individual budgets as service users could purchase their own care but whether they could specify a carer is debatable and this could then cause an issue with lots of carers coming into scheme which some scheme managers find difficult.

3.6.9 Constraints

Health and safety was sited frequently by tenants as an issue in preventing staff from being able to do things they needed them to do such as changing light bulbs, curtains etc. One provider seems to take a more pragmatic approach to this and does carry out these tasks as part of housing support.

Lone working is also an issue especially at night and could be more difficult with the community hub model, though not insurmountable.

3.6.10 Quality assurance systems

All care providers have their own quality assurance systems in place and work to the CSCI requirements but often there are different requirements and expectations by ECH and a common set of standards which are externally monitored may be required to ensure a more consistent service.

3.6.11 Contract monitoring/flexibility of contract

As previously stated the contract is very vague and flexible and so enables a very inconsistent approach to care and support. Housing providers and care providers need to have a copy and be very clear about roles responsibilities, accountabilities and task breakdown etc.

“We were very clear about our boundaries but housing providers weren’t playing their part. Doesn’t go into enough depth, very ambiguous – deliberate?”

“All sorts of things being charged for that shouldn’t be – e.g. use of rooms – housing providers wanted another contract between care providers and housing providers – care providers would like to do just what’s in contract – e.g. bank holiday cover not in contract that care providers should cover – has caused issues”

3.6.12 Out of hours

In all schemes out of hours provision is available via a sleep-in member of staff jointly funded out of the Supporting People budget and Adult Social Care. All sleep-in staff receive an allowance and are then paid overtime if they are called out but they often have to work in the daytime the following day. Each resident has access to an alarm which either goes to the call centre or direct to the sleep in member of staff.

The dependency survey and feedback from care & support providers suggested that there is not a lot of current demand for waking night staff. However, by not having a 24 hour waking night facility this limits the people who are offered places to those with a lower dependency and may mean that ECH is not a viable alternative to residential care.

3.6.13 Assistive technology (including alarms and telecare)

“On 21 July 2008, Social Care Minister Ivan Lewis announced a further 25 new extra care sites. These sites will make use of telecare, telehealth and other assistive technologies to support people to remain independent in their own homes.” (CSIP telecare newsletter August 2008).

Assistive technology has a key role to play in the development of extra care sites and Somerset has yet to maximise this opportunity. Telecare systems can include personal alarms; environmental sensors to detect smoke, water flooding, unlit gas and

temperature or movement sensors that detect if fridge doors are opened, a bed is occupied or if a person has fallen and cannot get up. Systems that are more sophisticated monitor many aspects of the home environment and communicate interactively with the person. For example, some detectors are able to sense when the resident has gone to bed and remind them that a window has been left open. Used appropriately these systems promote independent living and peace of mind and, if well targeted, can prevent problems such as falls and unwanted moves to residential care. In particular, these systems can help enable people with dementia, as part of a tailored, personalised care package to remain in their own home for longer.

Although there is currently no Somerset Assistive technology strategy there is much work in progress in this area and an action plan as part of the preventative technology grant. This does not, however, contain any reference to extra care schemes.

Every ECH scheme has an alarm system fitted but not all tenants are using this service. Those tenants who use it value this service and consider it should be a requirement that all tenants wear pendants at all times.

During the day if an alarm cord is activated then the scheme manager or support staff on duty will respond to the call. At night, on-call numbers are provided by all housing providers and a variety of arrangements are in place. Some housing providers have their own call centres, others use the Piper system with a central call centre and others go direct to the sleep in staff.

There is considerable scope to develop the use of assistive technology across all ECH in Somerset. This is also an area where it would be invaluable to engage tenants and enable their participation in any working groups or think tanks.

A telecare project officer has just been appointed by Somerset CC and it is suggested that this person takes a close look at the ECH schemes and ensures up to date use of technology in each scheme. A telecare assessment tool would also be a valuable process to carry out with each tenant in order to identify individual needs.

Fig. 3-22: Opening Doors for Older People Project

Good practice example

Opening Doors for Older People Project (ODOP)

West Lothian Councils elderly services have become synonymous with rolling out innovative telecare. The ODOP project is a large scale example of Telecare supporting relatively frail older people. There are two strands to the project:

- Development of four new purpose built extra care schemes to replace residential care homes
- Introduction of "SMART" home technology in residents existing homes

The Council believes the extra care scheme with assistive technology has:

- Significantly reduced length of stay in care homes
- Prevented a number of hospital admissions
- Significantly contributed to a reduction in delayed discharges

The above services, along with other changes in service delivery across the whole system, have resulted in opportunity cost saving of £841,000

(Audit Commission, 2004 'Assistive Technology')

3.6.14 Meals

Meals are extremely important to tenants and this topic was raised at every tenants meeting. Tenants did not like the fact that they had no access to fresh meals, especially vegetables. Meals are usually frozen and reheated, which tenants see as processed meals of poor quality which they have to eat on a daily basis.

The ideal is of course fresh cook on site. Where this is not possible or viable, then fresh cook off site and delivered is the next preferred option. Frozen regenerated meals are not popular with tenants.

However, providing a cost effective meals solution is a big challenge for housing providers, and most do their best to find solutions that work for them, and the contract provides this flexibility for the provider rather than specifying the solution most favoured by tenants. On the other hand, there is no evidence of any attempts at collaborative working amongst providers around meals provision, and attempting to find a better solution for tenants that would not be possible for one provider alone. As an example, in Bristol, several providers have 'bought in' to the fresh meals service provided and delivered by another provider, providing greater volumes for the meals provider and a tailored cost effective service to the other providers and to the tenants.

3.6.15 Health & well being

The Housing LIN report "Commissioning Housing Support for Health and Wellbeing" (July 2008), identifies the crucial role housing and support can play in the health and well being of local populations.

Evidence from our review in Somerset suggest that there is scope to widen the involvement of the PCT in providing services for ECH schemes and ensuring a more joined up approach to service provision in this area. The current distribution of district nurse input into schemes is very variable

ECH schemes have a lot to offer the health service in terms of preventing unnecessary admissions to hospital, falls prevention, management of long term conditions etc. Closer working with the ambulance trust and out of hours GPs, especially if 24 hour cover were more readily available, would also bring considerable benefits not only to ECH but could also impact upon numbers of emergency admissions to hospital and better preventive care.

Other aspects such as continuing health care, greater input by district nurses and community mental health teams could also play a role in supporting people in the community longer. Use of schemes as a hub for health promotion and prevention venues is also a possibility with the possibility of linking with the Active Living Centres.

3.6.16 Assessment

Strengths

- The level of provision is commendable (one of the highest numbers of ECH schemes in the Country) with a wide range of schemes across Somerset
- Housing and care & support providers are working together to offer care and support in a variety of different ways with limited resources
- An action plan is in place for assistive technology with some creative ideas about use of the preventative technology grant
- There are specifications in place which give details of the service requirements

Weaknesses

- The services provided to the ECH schemes have been developed in a piecemeal fashion with no clear vision or expectations about consistent standards or one model which every tenant can expect to receive
- The care and support roles are blurred which may not be a bad thing as tenants themselves cannot see a difference, however the care role and the subsequent training required for this should ensure that the enabling element (so key in the support role) is also maximised and fundamental to the care role. No tenant should be receiving care that does not ensure maximum levels

of independence, dignity and choice and that should always be focused on the tenant being in control and doing as much as possible for themselves

- The management arrangement is causing tension and confusion and clear standards and specifications, which all parties are aware of and work to, can only be for the better
- A strategic and consistent approach to the provision of assistive technology within ECH schemes could have a significant impact on the lives of tenants such as reducing the need for hospital admission and giving increased independence. For the provider this approach has the potential to need less staffing with consequent cost savings
- With closer involvement and more input from the PCT it may be possible to redefine the roles of care and support into a more integrated post with better outcomes for the tenant and better use of funding pooled together from different funding streams
- Meal provision is unsatisfactory and the need for more freshly prepared, nutritious food to be prepared on site is important to tenants
- Standards need to be set for care and support tasks and for a consistent approach to the scheme manager role, the hours available and the way cover is arranged

3. 7 Access and assessment

3.7.1 Eligibility criteria

Most ECH or very sheltered schemes have a set of eligibility criteria and access arrangements agreed jointly by housing providers and adult social care teams.

As part of the specification appendices to the Somerset ECH contract there is a 6 point document entitled “Criteria for Admission to ECH”. The criteria for admission is fairly wide ranging and does allow for a mix of abilities within the ECH schemes which is suggested as advisable by the CSIP Housing LIN guidance.

3.7.2 Assessment process

The Single assessment process is used by health and social care staff across Somerset and this fulfils the Community Care assessment referred to as part of the eligibility criteria. The SAP overview assessment tool used by Somerset is a home-grown tool devised by Somerset CC and Somerset PCT. There is the potential to develop this assessment tool further to ensure a more thorough assessment of housing needs with such questions as type of accommodation, tenure, smoke alarm, access, keeping warm, state of repair, safety ,other, key holders and whether the person lives alone. These could also be included at contact assessment stage to identify any housing

issues early on, and could be started at housing, health and social care to avoid duplication.

Each of the district councils has a separate assessment tool as do the housing providers with very similar questions being asked on this entire assessment tool. To ensure a consistent approach and avoid duplication it is suggested that by amending the SAP tool the other assessment tools and processes could be deleted.

With the introduction of personalisation there will be the opportunity to simplify assessment processes further particularly with the introduction of assessment and resource allocation (RAS) tools. When Somerset is designing such tools it will still be important to ensure that the housing element of the assessment is taken into account at an early stage.

3.7.3 The allocation process

There is not a consistent allocation process or a panel for selection of new tenants. Each district area has a different process in place but usually includes a community care assessment by the care manager or social worker, assessment visits by the housing provider and a discussion or panel meeting between housing providers and adult social care team managers.

None of the care and support providers are involved in this process and this should be reviewed. Care is often being provided already to a person living in the community prior to application for the ECH scheme, or a heavy package of care and support is requested at very short notice, which if the care providers had been involved at the decision process they could have been better prepared, or contributed to ideas and discussion about the care and support plan.

Some wheelchair users have not been able to gain a place due to difficulties with access to, or size of schemes, or because funding is so limited that additional hours required for assistance for people with high care needs (for involvement in activities, pushing in wheelchairs etc) means that there are no staff available to do this. One housing provider said they were anxious to retain the balance between low dependency and high care needs, not because of wanting to have a balanced community, but because they say funding is so tight that they are not able to cater for wheelchair users.

Fig. 3-23: Bristol VSH Scheme

Good practice example – Bristol very sheltered housing scheme

The Bristol VSH scheme has just changed its criteria for admission so that a greater proportion of its tenants come from high dependency needs. All applications now come through adult social care teams and must be FACs eligible with 40% being high dependency, 40% medium dependency and 20% low dependency based on number of hours in a care package as follows:

- High - In need of over 10 hours per week
- Medium - In need of more than 5 and up to 10 hours per week
- Low - In need of 5 hours care per week or less or meeting alternative criteria

Work is currently underway with providers to agree new contract hours on the basis of achieving 40% high needs, 40% medium and 20% low but there will clearly need to be some increase over the current contract hours.

New pathways and flow charts have been produced to ensure awareness about the new referral route.
(Source: Bristol VSH update April 2008)

Allocation panels

In Somerset we have not been able to obtain any data on the total number of applications or the number of people declined or on waiting lists for the Somerset ECH schemes, as this information is not kept centrally. Each housing provider runs an allocation process and keeps a small waiting list, but there is no central data which we would recommend is established with a common policy about a panel process and who should be part of this.

3.7.4 Assessment

Strengths

- Somerset has an eligibility criteria in place for ECH
- There is a form of panel process for allocation at each scheme which involves adult social care and housing provider
- Applicants are considered from a range of ages and abilities so the provision is not just restricted to older people
- Somerset has the single assessment process in place with the opportunity to share information across agencies without duplicating assessments

Weaknesses

- The assessment and allocations process in Somerset appears to be fragmented, inconsistent and unclear which was also commented upon by some tenants
- There is a lack of detailed housing and support questions in the Somerset single assessment process assessment tools
- There are duplicate assessment processes in place for the district councils
- There is no consistent panel process across the county, and care and support providers are not involved in the allocation process
- Somerset ECH schemes have a relatively low proportion of high dependency applicants (29% compared with 40% in Bristol), which may be due to building design or staffing levels. Wheelchair users and other people with high dependency needs are therefore being denied access to ECH schemes

3.8 Tenant profile

A tenant profile for each ECH scheme in Somerset has been complied from data provided from the dependency survey. (see Evidence Pack 4 in Full Report).

3.8.1 Age Profile

73.3% of tenants are over 75 and 39.8% of these are over 85 which suggests a very similar age profile to that of residential care homes for older people

Tenants' reasons for moving to ECH schemes were often cited as a result of hospital admission or inability to care for themselves at home or inability to cope with looking after larger property.

The numbers of people under 65 years and under 50 are much lower (10.3%). These tenants have different needs such as learning disability or mental illness.

Mix of ages

From the tenants satisfaction survey and tenants meetings there have been responses from younger people with physical disabilities, learning disabilities and mental illness. All have high levels of satisfaction in the schemes and did not think there was a problem with mixing the age groups. The older people also like the mix of age group and would like more contact with younger people. Some thought there may be issues with noise, music etc. but this does not appear to have presented any problems where there is a mix of ages in a scheme

There could be challenges with mixing age groups but with the necessary building design features in place, and the introduction of personalisation, each tenant will have their own individual support plan, so aspects such as activities, social stimulation etc.

would be addressed individually. The new philosophy in learning disability for example is for people to use community facilities such as local adult education colleges rather than have group activities in a day centre with a peer group. Similarly older people's aspirations and needs are changing, and not everyone wants to take part in bingo or basket making

3.8.2 Gender Profile

The majority of tenants are females (70.21%). This is not surprising considering that more females than males live to over 75 although many of the male tenants interviewed said they benefited from the fact that they had been used to being looked after by their wives/partners and needed more help with tasks such as cooking, washing etc. though this requirement is likely to change in future generations

16% of tenants are couples in Somerset which is likely to be higher than couples in residential care, due to the high cost and lack of funding unless both need that level of care, both partners will not be in a home. This suggests that it easier or more preferable for couples to live in ECH than a residential care home

3.8.3 Ethnicity profile

The majority of tenants are White British (98.4%) which mirrors the low levels of people from ethnic minorities in the population of Somerset

Despite contacting the Race Equality Council and making efforts to consult with the BME community, there were no groups established to consult with about provision of services

In other authorities feedback suggests that people from different ethnic communities like to be housed together where language and cultural differences are made easier, and where there are similar people in close proximity for mutual friendship and support.

3.8.4 Dependency levels

As part of this review we measured dependency levels of each tenant based on the dependency survey. (See Evidence Pack 4 - Dependency survey in Full Report for full results). These findings could also be compared to the Bristol Very Sheltered Schemes dependency levels which have recently been reviewed at 40% high dependency, 40% medium dependency and 20% low dependency.

Apart from the maximum dependency category there appears to be a fairly even spread across low, medium and high categories (ranging from 21.9% - 25.9%) with 18.9% independent (this figure seems quite high for an ECH scheme, and begs the question as to whether these people should be here). This was borne out by remarks from tenants themselves who thought that they did not need ECH but were there due to an historical situation of having been in sheltered housing when the categories changed and the schemes were developed into ECH.

3.8.5 Behaviour causing concern

3 schemes identified that they have a number of tenants with behaviour causing concern. This may warrant further investigation as to why these schemes are experiencing higher levels of behaviour causing concern, and this may give an indication of where greater staff resources, staff training and assistive technology may best be focused

3.8.6 Depression or mental health related behaviour causing concern.

There are a large number of tenants with depression or mental health related behaviour in several of the schemes. Again this could provide some indication of where training and assistive technology should be concentrated on mental health issues, especially dementia

3.8.7 Alcohol related behaviour causing concern

There are only 4 tenants with alcohol related problems causing concern. This is an area which may cause increasing demand in the future based on feedback from health care professional on other areas of the country (e.g. Wiltshire)

3.8.8 High service levels

It is interesting to note that, with few exceptions, high service levels at schemes does not correspond with other data on behaviour causing concern

However, there is a correlation between with the 10 schemes with the highest service levels and the 10 schemes with the highest dependency levels

It is interesting to note the wide variations in District nursing input into schemes- this ranges from 80% (16) of tenants in the highest input scheme right down to 12% (3) of tenants in the lowest input scheme

3.8.9 Support plans

There are 77.7% of tenants with a support plan in place which begs the question as to why the rest have not? This is information provided by housing providers – the care and support providers do not have access to the support plans but also have care plans in place for tenants – this raises the question as to whether there is a need to combine these two types of plan into a joint agency document which the tenant holds and directs? With the introduction of personalisation and self directed support, support plans will play a key part, and this may be a training need for care and support staff into how to adopt a different approach here.

3.8.10 Services not needed that are provided and needed but not provided.

Despite the fact that many of the 23 schemes were converted from sheltered housing schemes, and still contain a number of low dependency tenants, the percentage of services not needed that are provided appears very low at 5%. This could be that whenever services are provided there is always a need for them, or that only a low level

of services are provided which meet the needs of the more independent tenants. There are quite a high number of tenants (36%) who said there were services not provided that are needed.

The following are comments made by the scheme managers on the dependency survey returns about the type of services not provided that need to be:

- Escorts for GP/hospital appointments/shopping
- Night care to change pads - (3)[3]
- Collecting emergency prescriptions. Shopping service. Hospital Transport (2)
- Younger disabled people for care and bathing and wheelchair user with very high care packages
- Consistency of care packages i.e. same time each day and same carer where possible
- Fast response when needed for aggressive disorientated residents. Professional assistance is essential when dealing with this type of behaviour
- Hospital transport. Living in a rural area, it is very difficult, stressful and expensive for older people to find their way to hospital, especially now hospital transport seems to be being taken away
- It can be hard or impossible to get additional support services to residents within ECH
- Some people with mobility and other problems are unable to use their door entry systems properly
- Day centres and social activities especially for younger physically disabled people
- More staff support to enable inclusion of vulnerable residents in social activities and social interaction between tenants

3.8.11 Assessment

Strengths

- Somerset is catering for a mixed group of tenants (age and type of disabilities) with the potential to increase this mix
- Somerset has a reasonably high level of high dependency tenants and maximum dependency in its ECH at 25.9% +9% respectively making a total of 34.9% (–cf. Bristol at 40% high dependency)
- There are few services provided that are not needed

[3] Number in brackets indicates no. of people making the same comment

Weaknesses

- Not all tenants have support plans in place
- There are a number of services which are not provided but needed
- There are a number of schemes which are experiencing behaviour from tenants which is causing problems and this needs further investigation
- There appears to be insufficient time allocated for support tasks to increase activity levels and social interaction
- There are 18.9% of tenants who have been identified as independent and therefore less high dependency people who are able to access an ECH place in Somerset

3.9 Tenant satisfaction

Tenants were a very important part of this review, and were asked a range of questions such as why they came to live in an ECH scheme, what were their expectations before after moving in, their experiences of care and support, housing providers and what they would like in an ideal world. They were also asked what advice they would give to other people thinking of moving into a scheme.

3.9.1 Reasons for moving to ECH

Some people had not moved specifically to ECH, but had been reclassified from a sheltered housing scheme before it converted. In almost all cases more help and support was the reason for the move, along with other reasons such as:

- Health problems
- Accommodation difficulties
- Desire to be nearer family
- More help with care and support

Most people (69% of respondents) lived either in a house or bungalow prior to moving to ECH and were finding it difficult to manage their accommodation as discussed earlier. 68% of respondents lived in privately owned accommodation, and 32% of respondents lived in rented accommodation. They all had moved to rented ECH as there is little provision for privately owned ECH in Somerset (something that was frequently mentioned by tenants and members of the public during the consultation meetings).

79% of tenants said it was their decision to move to an ECH scheme with 18% of people saying it was someone else's choice. During the tenants meetings this was discussed and tenants had often moved directly to an ECH scheme from hospital due to ill health and GP, hospital staff or family had encouraged them to move to a safer environment

A fairly equal proportion of tenants had also considered sheltered housing, staying put with adaptations, or moving into a care home. Some of the tenants had moved to sheltered housing and then it was converted to ECH and they either did not consider that they needed this, or indeed that they were living in ECH. Others had opted for ECH as it offered more support and a safer environment

3.9.2 Tenants expectations

People chose ECH mainly due to being unable to care for themselves because of health problems or hospital admission. The results from the questionnaire and tenants meetings varied in this question. In the questionnaire survey most people's expectations have been met in respect of standard of accommodation, privacy and retention of independence, but in the tenants meetings there was a higher degree of dissatisfaction with the level of care support, quality standards and staff availability.

62% of respondents said expectations had totally been met and 33% partially, whilst 5% had not had their expectations met. More people expressed dissatisfaction in the tenants meetings and said they would have liked more information about what ECH is.

What did you expect of ECH and staff?

- Letters to be posted, shopping, phone-calls to be made if feeling too poorly to cope
- Calling doctor, organising, fetching, emergency prescription, assistance in emergency
- No corruption, it was better run by the council
- A shower appropriate to the needs of a wheelchair user
- Good home
- More outings and entertainment on the premises
- The security to know that when I need more help in the future it will be there for me
- Expect prescriptions to be taken in - was not sure what to expect
- For a short time, perhaps washing up. However there does appear to be a change recently when I requested someone to phone my GP. I felt exhausted and she did phone
- Very nice staff
- More than 1 night staff on at a time
- To have all the help that is available
- More than 2 staff on the complex
- I have a tailored care package

- Unhappy about what 24 hour care really means
- Cleaning flat
- Punctuality (due to staff shortage)

3.9.3 Independence & well being

Most tenants thought that staff always or sometimes enabled them to so things for themselves. It is perhaps surprising that “always” is not higher, with the same proportion saying sometimes

55% thought the atmosphere at their scheme was positive and 34% sometimes positive, with only 7% saying there was a negative atmosphere

15% of respondents said their physical health had improved since they moved to the scheme, with 41% staying the same and 40% saying it had got worse

The numbers of people feeling worse seems quite high at 40%, and the impact of ECH does not seem to have made such a positive impact on physical and mental health as one might have hoped. This may be due to the age or physical condition of the tenants involved, but it would be worth looking at this aspect in more detail, as with more staff support, activities or trained staff to deal with specific issues, the levels of satisfaction in this area may increase. If more work was carried out in the schemes in terms of health promotion, which we have suggested elsewhere in the report, this could have an impact upon on these figures in the future?

37% of respondents said they felt more independent since moving to the scheme, and 48% said they felt the same. 11% of people thought their independence had got worse

3.9.4 Involvement in decision making and choice

Tenants were also asked about their personal freedom with things like having a bath when you want to; going to bed or general privacy and these figures were high at 93.2%. 68 tenants who responded said they had privacy, 78.1% (57) could have a bath or shower when they wanted, and 89% (65) could go to bed when they wanted to.

40% of respondents said they felt better in themselves since moving to the scheme with 37% the same and 19% feeling worse

51% respondents said they felt part of the wider community with only 13% of respondents saying they felt isolated and cut off

66% of respondents did not think they were involved in decisions about other people coming into the scheme, and this was borne out about decisions generally taken by housing and care and support providers during the feedback at the tenants meetings. Many people said they did not think that the care and support or housing providers listened to them, or took their views into account, when making changes to the services. Many people said they like the opportunity to attend tenants meetings which were borne

out by the high numbers of tenants who attended, but even when providers had held such meetings they said they had seen no results of these views being acted upon.

3.9.5 Access

77% said it was either easy or quite easy to get around the buildings and garden, with 18% saying it was difficult or quite difficult. Ideally ECH schemes should be providing accommodation and services to enable people to get out and about, regardless of their ability or frailty, so in this respect the figure of 18% is quite high

58% of respondents said it is easy or quite easy to get out and about, but 35% said it is difficult or quite difficult. Again, this suggests that more should be done to enable tenants to get out and about more if the ethos of ECH to support independence and involvement in the community is taken seriously. The fact that there is limited staffing for the enabling tasks and activities is substantiated here, and in the suggestions for improvement by tenants where activities and help with getting out features strongly

3.9.6 What do you like about ECH?

Tenants were asked both in the questionnaire and in the meetings what they liked about ECH, and the following answers were given:

- Location – near to where had lived before or near shops and GP
- Liked a flat of own and to be able to take own furniture
- Central heating
- Garden
- Care on site
- Lift
- Dining room
- Meals on site
- Social activities

3.9.7 Positives/areas for improvement

Positives	Areas for improvement
Buildings Some buildings seen as excellent with refurbishments such as new radiators, double glazing, insulation and new kitchens sited "Very happy with what I have and	Concern that some schemes were Sheltered housing sites and not designed for ECH – mixture of abilities, lack of access for wheelchairs and feeling that "I shouldn't be here"

Positives	Areas for improvement
how looked after" Quiet friendly neighbours Space and communal areas Location	Insufficient washing machines in some sites (having to wait two days and can only get in at 7pm) – reliant on carers so times clash Lifts out of order – lack of staff to help people with mobility /or to get scooter etc (several schemes) Loop systems frequently not working or not available
Garden is nice but...	Like pulling teeth to get staff to put out tables and chairs. Gardens often not used or tenants unable to get to them
Choice of Menu Some local shops that deliver	Poor food/ or lack of fresh food- reliance on frozen prepared meals or processed food Lack of cook
Some people think quality of care is very good - particularly if local staff who they have known in the past and have built good relationships with. Some schemes have carers which work specifically in their scheme Other people like to have a change of carers in case you don't get on with one Some carers very helpful and can't	Lack of staff time or insufficient staff (scheme managers and carers) Poor quality carers, lack of training, age, language problems. Would prefer specific carers for a scheme rather than going off into community with very little time (not all schemes) Lack of waking night staff (common theme) – one person told to wear pads at night as no waking night staff to take to toilet) "Often feel put down by staff which is bad for your confidence" Constraints of health and safety –

Positives	Areas for improvement
do enough (though still H&S constraints)	prevent staff doing many things such as picking up off floor if fallen, cleaning windows, skirting boards, putting up curtains, sticking on a plaster
Activities Some schemes have outings arranged by other schemes or tenants or ex staff – Some schemes tenants have organised activities(but have had poor response) Good service from some local churches who come into schemes	Lack of activities and trips out (common theme in most schemes)
Definition of ECH /expectations ECH good idea but needs to be properly staffed 24 hours	ECH not clearly defined and constantly changing Hasn't been changed from SH to 24hr care. Poor access and buildings not designed for ECH
Dignity and respect Feel privacy is respected by scheme managers – "nothing goes further". Appreciate the gardening	Scheme managers changing/rotating – prevents ability to build trust and a good relationship
Cost Scooter room – get plugged in but no extra charge. Everything in rent except electricity	Cost of services too expensive- think twice before having a bath – can cost £16 for a bath. £1 per pad at night instead of being taken to the toilet.

3.9.9 Assessment

Strengths

- The views of about 250 tenants from ECH schemes in Somerset have been obtained during the course of this review and highlight a very vocal group of people who have clear and strong views about their current service and suggestions for improvement
- Tenants feelings of independence have improved or stayed the same since moving to ECH
- Tenants are on the whole very pleased with their accommodation and location of schemes close to community facilities
- Tenants expectations of ECH in the main have been met since moving in
- On the whole tenants think that staff enable them either most or some of the time to do things for themselves.
- Tenants consider that their dignity and privacy are respected
- Alarm systems within ECH are well used and valued by tenants

Weaknesses

- 18% of tenants did not think they had a choice or were involved in decisions about moving into ECH
- Tenants do not appear to be well communicated with about decisions made which impact upon them e.g. – standards for ECH , expectations of what should be expected from ECH and costs
- Some tenants whose schemes were converted to ECH do not consider they need this facility
- There are a small proportion of tenants who do not think staff enable them to do things for themselves
- Tenants do not feel their views are listened to or acted upon, or that they are involved in decision- making
- Tenants consider that care and support staff need better training
- Meals are a big issue for tenants, and need to be of a better quality and freshly prepared with use of fresh vegetables and unprocessed food
- Tenants would like more information about assistive technology
- Loop systems in communal lounges are frequently not working or not used and staff should be aware of their importance, and ensure they are in use

3.10 Commissioning, Contracting, Fees, Charges, and Partnership Arrangements

3.10.1 Commissioning

We have previously referred to the 2 waves of extra care housing development in Somerset. The first wave of schemes was commissioned and developed by district housing authorities or their housing association partners, and was funded by either the district authority or the Housing Corporation.

The second wave of schemes was commissioned by SCC Adult Social Care and Supporting People as upgraded sheltered housing schemes. Despite the volume of ECH provision in the county, SCC have never commissioned a new build extra care housing scheme.

SCC SP and ASC have, however, specifically commissioned the extra care service to be delivered at these schemes, and this took place most recently in 2006. This appears to have been undertaken in a fairly narrow process that did not engage effectively with the housing providers of schemes

Although we understand that the care providers also provide domiciliary care services in the areas where they now provide services into the ECH schemes, the opportunity has not as yet been taken to evolve commissioning arrangements so that people requiring care in the vicinity of an ECH scheme can also receive care from the care team based at the scheme. This is a development of the hub-and-spoke model that we shall return to later in the report.

3.10.2 Contracting

We understand that contracting arrangements at ECH schemes are divided into 3 contract types:

- The Supporting People contract between SCC and the housing provider. This identifies the housing support service that is provided between the core hours of the day, 8.30am – 4.30pm
- The social care contract between SCC and the care provider. This sets out the personal care tasks to be undertaken for the benefit of care user residents at the scheme
- A contract between the joint commissioners – SCC SP and ASC teams – and the care provider for the provision of an ‘out of hours’ care and support service at the scheme, which includes the sleeping nights service

Whilst this set up in Somerset is unusual, it is also the case that there are very few norms emerging in the contracting of extra care services, and each local authority is developing its own model. Commenting on the Somerset model -

- ***Division of housing, care and support services*** - In principle, and given the diversity of providers and their different skills and experience, the approach

taken in Somerset is a perfectly reasonable one, and one that can work as well as any other. However, there are issues around how the model is taken forward in contracting terms.

- ***Separation and drafting of contracts –*** Somerset commissioners have taken sole responsibility for the drafting and construction of the contract documents. Providers have pointed out to us specific concerns about the contracts and how they are not seamless when put together.

  An alternative approach to implementing the Somerset model, but one which might resolve some of the issues that housing and care providers have with the contracts is to:

  - Involve the providers in the drafting of the contract, in particular the care and support service matters
  - Jointly construct with providers a single contract that covers all functions rather than dividing up the functions into separate contracts. The single contract will be signed up to by all relevant parties. Elsewhere, we have come across a single contract for one ECH scheme requiring the signature of no less than 3 separate providers and 2 separate commissioners, yet the contract provided for all matters

  Such an approach provides for more effective partnership arrangements and should illuminate many of the interface issues requiring further discussion, and which can then be resolved at the drafting stage

- ***Aims and objectives –*** the individual contracts express the intent behind the different services commissioned, but because they are separate documents, in no place do you find a single document, signed up to by all, that starts by setting out the agreed ethos of extra care housing, what the aims and objectives are, and what the provision is intended to achieve for the commissioners and for the residents. This 'Partnership Agreement' could represent the preamble or first section of a new single contract

3.10.3 Fees

Fees are payable by SCC in accordance with the 3 different contracts. Whilst fee levels are always an issue between providers and commissioners, specific concerns have been raised with us by commissioners and providers over the following matters:

- Comparisons with sheltered housing over housing support fee levels – as we understand the position, housing support payments to providers are more generous at sheltered schemes than they are at ECH schemes. We would have expected the reverse to be true as, in an ECH environment, for every communal activity organised, residents can be expected to require more support in travelling between home and the venue for the activity, and require more support to fully participate in the activity, than residents at a sheltered scheme

- We understand that the out of hours contract is funded 50% by ASC and 50% by SP. From the evidence we have seen, the bulk of the services likely to be provided out of hours are of a personal care nature. There is a case for the county to review this funding split, but possibly the proposed removal of the SP ringfence within local authorities will make this review unnecessary

3.10.4 Charges

Various anomalies have been presented to us by commissioners and providers relating to anomalies between schemes in relation to charges levied to residents for rent, service charge, supporting people, care cost contributions, ancilliary charges such as meals, as well as differential charges to self funders and tenants not requiring an extra care service. In the time available, we have only been able to consider this at a fairly superficial level.

However, we would comment that there appears to be no countywide agreed charging policy framework for extra care housing despite the 2002 County Commissioning Strategy identifying the clear need for this. In other areas that we are aware of, providers and commissioners have agreed a charging framework within which rents, service charges and other charges may be levied within a range, or up to an agreed maximum. In Somerset, commissioners have encouraged issues to be resolved at a local district level, and this has probably had the effect of increasing anomalies when looked at from a county perspective, rather than diminishing them.

Rent

Fig. 3-24: Rent levels

	Bedsit	1 bed	2 bed
Range of net rents charged (Somerset)	£46.92 - £56.66	£52.99 - £73.80	£70.05 - £78.46
Range of net rents charged (Bristol)	N/A	£63.68 - £78.00	£68.36 - £82.00
Average (Somerset)	£51.00	£64.46	£72.99
Average (Bristol)	N/A	£69.33	£76.97

These average rent levels are consistent with rent levels we are aware of in other parts of the South West. It should be noted that registered social landlords have to account to their regulator in respect of rent levels and that, at a local level, RSLs are working to a programme of rent convergence over a number of years. Local authority landlords are accountable to the District Auditor for their rent levels but are subject to different rent accounting arrangements than RSLs. For example, local authority landlords will typically have lower rent levels (and local authority schemes are at the lower end of the these Somerset ranges quoted above) but are more likely to be providing housing requiring considerable upgrading to achieve Decent Homes standards.

Charges also need to be assessed not just between authorities, but in comparison to what the tenant is receiving for their money. In this context, it is quite clear that extra care tenants in Bristol are enjoying a significantly higher quality of accommodation than extra care tenants in Somerset.

Service Charges

Fig. 3-25: Service charge levels

	Bedsit	1 bed	2 bed
Range of service charges (Somerset)	£14.08 - £38.73	£9.63 - £47.50	£9.63 - £47.50
Range of service charges (Bristol)	N/A	£22.86 - £44.72	£22.86 - £44.72
Average (Somerset)	£27.85	£28.54	£22.93
Average (Bristol)	N/A	£36.32	£36.32

There is a significant range in service charges levied by Somerset landlords, and this should be explored further. However, the averages are generally lower than service charge levels we are aware of in other areas. As with net rent above, housing associations and local authorities are subject to different accounting rules for service charges which will have an impact on which costs may be charged through this route rather than through net rent, and on the depreciation and sinking charge calculation methods that must be employed.

As with rent levels, comparison of service charge levels must consider the extent and quality of housing related services received by tenants, and this will differ from scheme to scheme. The wide range of Somerset service charge levels would indicate the value of developing a charging policy in the county, the need for which was recognised back in 2002.

Housing support charges

Fig. 3-26: Housing support charge levels

Range of Housing Support charges to tenants	£ 16.87 - £55.42
Average	£30.67

It is unclear why these charges should vary quite so much, and this should be explored further within the context of a countywide charging policy.

Meal charges

Meals arrangements and costs vary quite sharply between schemes. For instance, charges are not optional for one provider, tenants are charged whether they take the meals or not. More common is for residents to pay as they go. In some areas, meals appear to be subsidised by the local ASC team.

Charges to self funders

We are advised that charges to self funders vary between areas and that this is as a consequence of different interpretation of guidance and rules by housing benefit departments in different districts. This indicates a need for ASC to consult with district HB offices with a view to agreeing consistent countywide interpretations of relevant rules and guidance.

Charges to former sheltered tenants

We understand that original tenants of sheltered schemes since upgraded to extra care are responsible for full extra care charges even if they have no need for extra care services. We do not know what sort of terms were agreed with tenants when proposals for upgrading sheltered schemes were put forward to tenants for consultation, but subject to that, it does seem iniquitous that such tenants are responsible for full extra care charges, and this is a further area which would benefit from a policy review instigated by ASC.

3.10.5 Partnership Arrangements

Whilst it is very clear to us that commissioners and providers do work together as partners, there is little infrastructure that binds all parties together for common purpose. In the absence of this, the reality is that providers and contracts managers have resolved their matters. Such local arrangements have proved essential for providers to be able to present and discuss operational difficulties, and has no doubt resolved many issues at that local level. However, this is likely to have increased anomalies in service provision across the county when considered at a county level.

We were surprised to find 2 specific gaps in the infrastructure that we would consider essential for the maintenance of a thriving commissioner/provider partnership working towards the same goals:

- A partnership document that sets out in one place the shared aims and frameworks that partners have agreed to that will enable the extra care service to develop – such a partnership document would include sections on:
  - Vision, purpose and guiding principles of the extra care housing programme
  - Commissioning and contracting arrangements
  - Eligibility, allocations and nominations arrangements
  - Charging framework
  - Service specifications
  - Protocols and liaison arrangements
- An established countywide forum where commissioners and providers meet regularly. A place where operational policy issues can be discussed and resolved within the framework of an established partnership between commissioners and providers

Fig. 3-24: Bristol VSH Partnership Agreement

Good practice example

Bristol VSH Partnership Agreement

A single document agreed and entered into between Bristol City Council (Housing and Adult Social Care) and all its extra care housing partners. This provides a positive enabling framework document within which providers have the confidence to develop their schemes and services, and represents a clear reference tool for operational managers, contract managers and others where policy matters are questioned.

3.10.6 Assessment

There are many positives about the commissioning, contracting, charging and partnership arrangements in Somerset, including:

- Commissioning arrangements have secured a small number of established, locally based and responsive care providers for the ECH schemes
- The contracting principles used by Somerset for the ECH schemes, whilst rather unusual, are perfectly reasonable and workable
- The fact that contracts were not readily available to us may be of concern but, positively, it is also a reflection of the fact that providers say they rarely need to refer to them. This is usually the sign of a good contract!
- Whilst charges for rent and services do vary quite widely, averages are in line with our experience elsewhere
- From our discussions with a range of stakeholders, it is clear that partners do work well together, and are committed to developing the ECH concept in Somerset

There are also, of course, areas for development and we have identified these as:

- **Commissioning as partners** – to date commissioning has not been undertaken in such a way as to enhance the partnership ethos between commissioners and providers, and has actually gone some way to undermine trust between parties. This is an avoidable problem
- **Commissioning scope** – to date this has been framed narrowly around the traditional notion of care and support services only, with the result that these services do not deliver a broader and seamless extra care service – for example, use of telecare; health prevention work etc.
- **Contracts availability** – it should be possible to produce actual signed contract documents far more easily than has been the case on this occasion
- **Contracts approach** – concern that the 3-separate contract approach is unlikely to ever deliver a seamless service, and that there may be a better

approach to contracting which does not undermine the principles that Somerset are keen to secure

- **Charging** – there has been no attempt to manage or control the charging process through the development of a charging policy or framework, with the result that charges currently vary more than might be expected and a range of anomalies now exist across the county
- **Value for money for tenants** – when quality of extra care accommodation provision is considered between Somerset and Bristol, this must raise the question of whether Somerset tenants are obtaining as good value for money from their rent payments as corresponding tenants in Bristol
- **Partnership Agreement** – partners operate without a Partnership Agreement which would bring a common sense of purpose to all
- **Common countywide approach** – partners have operated without an established countywide forum where operational policy matters, contractual difficulties or strategic issues could be discussed and resolved. This has led to the development of ad hoc and local arrangements, increasing the range of service anomalies when considered from a county perspective

3.11 Stakeholder perspectives and issues

3.11.1 Introduction

As part of the consultation and engagement process for this report stakeholder feedback was gathered from the following sources:

- Five public meetings were held between May and July 08 – one in each District area
- Attendance at a carers meeting in Taunton in July 08
- A stakeholder event was held in July 08

For extensive details about these meetings please see Full Report.

3.11.2 Public Meetings

The majority of people consulted (70%) were living in houses or bungalows, and were owner occupiers who were interested in how to access ECH if owner occupiers, and what developments which were in place for private schemes could be purchased

What help may be needed if you intend to remain in your own home:

The main reasons people thought they would need to move were due to concern about maintaining property and garden.

The majority of respondents would move to either sheltered or ECH in these situations - others would move to a bungalow or flat. None would move to a bedsit (NB- a high proportion of ECH at the moment are bedsits). The majority of people did not think there is enough choice and support for older people to remain living independently in their own homes.

Many people did not know about ECH or assistive technology and wanted more information.

- 71% were not aware of telecare
- 58% not heard of ECH
- 50% had not heard of home improvement agencies
- 42% had not heard of handy person schemes
- 22% had not heard of adaptations and equipment

Would you choose ECH in the future?

There was a mixed response about whether people would choose ECH in the future. Although it was seen as preferable to residential care, people were still keen to remain in their own homes and cost was often cited a as a key factor:

Suggestions for improvements about extra care housing in Somerset

- More publicity is needed to let the over 60s know what is there for the future and the cost implications of this
- More information needs to be available to the general public
- Insufficient knowledge to make any constructive operations or comments
- All staff to be trained on a level basis
- Level of care to be reviewed regularly
- To have enough staff trained in EC to enable more elderly people to remain in their own home and environment

3.11.3 Carers' feedback

Carers pay a large role in supporting older and disabled people in the community. In Somerset there are approximately 50,304 unpaid carers across the county and their views were very important in understanding the current and future requirements for services. The following comments were given by carers at the meeting:

- Please provide more extra care Housing in Taunton
- Respite needed as part of this scheme. Respite so variable – depends on assessment, social worker/where you are
- Transport to care homes difficult

- My concern is that all the resources will be put into extra care schemes and there will not be nursing/EMI places for those who need 24hr care
- How reliable will the care be especially for those using the facilities in their own home?
- Who pays for it? How does one get to know about it. How unfit/disabled does one have to be to stand a chance of entering?
- Should advise the professionals to promote this service when available so everyone has this option to consider
- Staffing problems in residential homes – not properly staffed, language problems with foreign staff although very nice
- Why aren't more social workers aware of all this?
- Staffing levels of high dependency unit and large turnover of managers
- Very poor standards. Concern about wages for care staff
- Bus once or twice to pick up carers to take to various care homes
- Concern about how to get the right staff in ECH schemes. Scheme X not like the DVD!! Like a glorified care home
- If a disabled person needs nursing care what would happen to the carer in ECH accommodation?

3.11.4 Stakeholder event

Approximately 40 people attended from a wide range of backgrounds and organisations. This included representatives from Somerset PCT, Somerset Partnership Trust, Older people's Alliance, Housing, care and support staff from each of the Somerset providers, Supporting People, adult social care team staff, ECH review project board members and the ASC and SP strategic commissioning leads.

As well as key issues and challenges attendees were asked to list what the key elements of ECH should be, what standards should be in place, what changes need to be made, and how working together could be improved. Attendees were asked what about the issues, challenges and suggestions for the future model of ECH in Somerset .

Key issues and challenges:

- Skill levels for dealing with people with different and complex needs
- Management of people with different needs – MH, dementia, LD Bespoke training programme for people working in ECH
- Hot meal logistics
- Dispersed bungalow schemes - access to main building in bad weather – covered canopies..? Drop kerbs problem

- Value for money – people who fund themselves (self-funders) are currently paying different rates across the county which is perceived as unfair and inconsistent
- Issue of many people were sheltered scheme residents without care needs but paying anyway

Standards & specification

- Tenants not always clear what they can expect
- Performance indicator set required across the county
- Scheme as a flagship in the community/community resource model
- Care spec – doesn't include escort services; hospital appts. etc.
- Need for waking night cover?
- Integrate with new "end of life" strategy
- Inclusive schemes not specialist schemes?
- TDBC ERO model re sleep-ins

Referral process

- Balanced community approach or always accept people with greatest care needs?

- Inconsistent referral process across the county

Information and profile raising

- Increase awareness of what ECH is with other professionals
- Information directory

3.11.5 Assessment from all stakeholder feedback

Strengths

- Good range of ECH across Somerset
- All stakeholder consulted with thought ECH was a very good idea and that there should be more of it
- The idea of virtual ECH was well received
- Members of the public identified their future needs as being about housing – i.e. ability to manage house, garden, and personal care – all of which is being provided by Somerset ECH schemes

Weaknesses

- Few people have heard of ECH or know what it is
- Confusion about name and message it is giving (i.e. extra care = more care than residential care!)
- More people were interested in owner occupier schemes which Somerset does not have
- Concern about standards and monitoring of quality, staff levels and training
- Need for clear specifications and eligibility criteria

3.12 Overall Assessment

3.12.1 Introduction

In this section we draw together the evidence from the previous 10 sections, and attempt to provide an overall assessment of extra care housing in Somerset now.

3.12.2 Strengths

There is a huge amount for Somerset to be justifiably proud of, and particularly its early appreciation of the limitations of residential care and the potential for extra care housing to provide a realistic and superior alternative for older people, and their pioneering efforts to deliver this. Examples of this early appreciation include:

- A legacy of over 600 extra care housing units provided by district housing authorities and their housing association partners between 16 and 32 years ago
- A commissioning strategy as far back as 2002 that recognised the significance of extra care housing and the need for further provision
- The creative use of public capital availability to provide additional extra care housing
- The early appreciation of the potential for sheltered housing to be upgraded to extra care housing
- The vision and risk taking by both commissioners and providers to develop a significant programme of extra care housing at a time when most authorities and providers had not grasped the potential significance of this new supported accommodation model

However, as is the case with all pioneering ventures, followers learn from what has gone before, improving and refining the models and approaches trailblazed by the pioneers. As the ideal models develop and improve pioneers then have to look back at

their own products and consider critically whether they remain sustainable and fit for the future.

This is the position Somerset now finds itself in, and looking critically about what has been achieved in the past, it is clear that the county has a number of new challenges to address.

3.12.3 Areas for Improvement

Quality of provision

It needs to be borne in mind that existing provision is as a result of:

- Decisions taken between 20 and 35 years ago about appropriate design for extra care housing
- Decisions taken 6 years ago about minimum requirements for upgrading existing sheltered schemes to extra care

As a consequence of the above, the quality of existing accommodation is now generally considered not to be to an acceptable standard and, therefore, its prospects for long term sustainability are poor. The quality is considered below acceptable standards because:

- Of the existence of bedsits and low number of 2 bed flats
- Of the size of individual units
- Of the low number of units that are barrier free, and suitable for people with a range of disabilities

The accommodation is considered to have poor prospects for long term sustainability because:

- Will enough people want to live there? It does not meet the quality expectations of older people, thus raising questions around popularity of this provision compared to other options
- Will enough people be able to live there? It does not meet the requirements of people with a range of disabilities, thus being unsuitable for a significant number of people who might otherwise be interested in this form of supported accommodation

Range of provision

Whilst the overall level of existing provision is good as is its distribution around the county, there are other aspects of the range of provision which need to be addressed:

- There is an extremely low level of private sector extra care housing provision in the county, providing a poor choice for most older people in the county who are traditional home owners

- There is no equity share extra care housing provision in the county at all, when there is evidence elsewhere that this can be a popular form of provision for the "asset rich cash poor" older home owner
- There is relative under-provision of extra care in the bigger towns particularly Taunton
- Whilst accommodation cannot always be new, the accommodation profile in Somerset is exclusively older property, much of it over 20 years old, with no new social rented extra care housing built in the last 20 years
- There is a limited range of social rented extra care housing providers, the vast majority being local providers of a range of social housing types. Only 1 provider is exclusively concerned with housing for older people

Quality of partnerships

Whilst Somerset enjoys a range of strong partnerships and has a good reputation for partnership working, we consider more work is needed in the area of extra care housing:

- Between commissioners, housing providers and care providers. The evidence indicates that commissioning and contracting arrangements have undermined partnership working, and the lack of progress in agreeing common policies and standards has prevented more positive partnership working from developing as providers and commissioners take different positions. There is no countywide forum where consistent approaches to operational policy matters can be raised and discussed
- Between the county, the PCT and voluntary sector agencies. The development of the Active Living Centres has largely ignored the potential contribution of extra care housing schemes, as has the planning and delivery of health promotion programmes by the PCT

Quality of service

The feedback from tenants about the quality of service was not as clear cut and overwhelmingly positive as we would have expected. On digging further, we consider that whilst tenants are questioning the quality of service received, this is not necessarily a function of the quality of service provided by the providers. Instead, the issues appear to be more about:

- The specifications for care and support and how these have been cut back by commissioners – e.g. laundry service for tenants
- The specification for out of hours care which does not provide for a round-the-clock personal care service that some tenants need
- The separate contracts for the 3 services that result in some schemes being inadequately covered at certain times of the day, or on certain days in the calendar – e.g. staff holidays, bank holidays etc.

- The fee levels for housing support which prevent the scheme managers from organising the range of activities that we would have expected to see at the schemes

Policies and standards

Whilst the 2002 and 2006 Commissioning Strategies both recognised the need for the development of common policies and standards, there has been very little progress in delivering these. Areas that cause the most concern are:

- Lack of agreed standards of design for extra care housing. This includes not just key building and cost decisions around, for example, sizes of units of accommodation; but also issues with far less building and cost implications such as appropriate signage, lighting, loop systems and decoration/colour schemes for those people with a range of disabilities or impairments
- Lack of policies or framework around charging
- Inadequate policies around access and assessment arrangements
- Lack of agreed protocols between housing and care providers for delivery of services at the schemes

Strategic management and intervention

Whilst the Commissioning Strategies are good so far as they go, their scope is more limited than we would have expected, for example:

- There is no consideration that extra care housing might or should exist beyond the social rented sector and, hence, no evidence that the county has attempted to manage or intervene in the wider private extra care housing market
- There is no consideration that extra care housing may have a role to play in the delivery of other objectives beyond providing a replacement for extra care; nor that the delivery of other programmes e.g. health preventative work etc. through extra care housing schemes is essential for the effective functioning of the extra care housing service
- The 2006 strategy does not comment on the range of actions for extra care from the 2002 strategy beyond confirming the delivery of additional units. The 2002 strategy indicates that much of the work was to be undertaken by “areas/districts” but the evidence suggests that little was achieved of the 2002 actions beyond the upgrading of sheltered housing schemes. This raises a question about the effective management of the delivery phase of the commissioning strategy

Performance and quality management

So far as we are aware the county has not identified a range of performance indicators in order to monitor the effective performance of extra care housing schemes, nor does the county routinely monitor a number of functions of extra care housing in order to determine whether policy review or operational intervention is required. Whilst we know that the contracts teams undertake regular reviews to monitor quality of housing support and care services, we would also expect that the county would additionally be monitoring the following areas as a minimum:

- Who is accessing the schemes – maintaining an entry profile of dependency levels, age, sex, race, current location etc
- Who is considered inappropriate to be offered accommodation, and why – results of panel decisions
- Who is offered accommodation and refusing it, and why
- Rate of turnover at the schemes
- Speed of letting
- Tenant profile at each scheme

Tenant involvement

- We were surprised by the tenant response around lack of involvement in decision making on matters that affected them. This is an area we did not have the opportunity to explore further, but suggest that the commissioning partners do undertake further work in this area. Given that work needs to be done on agreeing a range of common policies and standards, this represents a great opportunity to involve and consult with tenants about service matters that directly affect them

3.12.4 Recommendations

It is, of course, possible to present a range of recommendations here, arising from these observations around areas for improvement. However, without considering the future and, in particular, the drivers for change which will shape the future, such recommendations may subsequently be found to be inappropriate. Therefore, the next section considers the drivers for change in the future, and overall recommendations appear at the end of this report.

4. Future Requirements

4.1 Drivers For Change

4.1.1 Introduction

In this section, we consider some of the issues that will force change in extra care housing in Somerset, focusing on the impact of future demographic changes and the impact of the implementation of key national policy imperatives.

4.1.2 Demographic Drivers

Population Projections and ECH Supply – Somerset County level

Population projections have already been considered in Section 3 of this report, with a fuller breakdown available in appendix 1 of the Full Report. In this section we focus on what these projections might mean for the requirement for extra care housing in Somerset.

The extra care housing market is still too young to be able to reliably identify any reliable demand indicators. We also know that there is a very low level of public awareness about extra care housing (ECH). However, what we do know is:

- Public reaction to the concept of ECH is always very positive, particularly as an alternative to residential care
- There is need and demand for the current level of provision of socially rented ECH in Somerset
- There are some people who would benefit from ECH but cannot be offered ECH in Somerset because the accommodation is not designed to their needs
- There is no supply of shared ownership ECH, and where this has been tested in other areas, it has proved to be popular
- There is an extremely low level of private ECH provision in the county which indicates some latent demand
- In addition to growing numbers of older people over the next 20 years, there are also escalating increases in the incidence of dementia, long term limiting illness, and learning disability in the older age ranges

In reality, the actual amount of ECH that will be needed is a function of the impact of other programmes as well as demographic trends:

- How successful ASC is in diverting people away from residential care and into ECH

- How successful ASC is in keeping people at home through its preventative services programmes
- How successful the future strategy for sheltered housing turns out to be in supporting people in their own homes through the hub and spoke floating support model
- The extent to which the private sector provides choices and increased provision for older people through new higher quality private sheltered housing, extra care housing, and residential care

Nevertheless, and for the purposes of this exercise, we do need to make some conclusions and working assumptions about the future ECH requirement in Somerset, even with the development of other programmes enabling more older people to stay in their own homes. These are:

- The requirement rate for additional socially rented ECH should exceed the rate of increase of older people over 65 by a small amount only – say 10%
- Supply of shared ownership ECH accommodation is required, steadily rising to a level of 10% of all ECH provision in 10 years time
- Increased supply of private ECH accommodation is required, steadily rising to a level of 40% of all ECH provision in 10 years time

The following table projects the ECH supply requirement, based on the above assumptions:

Fig. 4-1: ECH supply requirement

Year	Population Over 65	Rate of Increase	Required level of ECH stock	Social Rented	Shared Ownership	Private
2008	107800	-	800 - Actual	772	0	28
2018	142500	32.19%	2103	1045	209	836
2028	175300	23.02%	2620	1310	262	1048

Population Projections and ECH Supply – District level

The following table sets out the ECH supply requirement for the individual districts, in order to project an equitable distribution of supply according to population, also correcting any current imbalances in supply. The table makes the ***same key assumptions*** as were made for the county as a whole. In this table, the ECH stock level is inclusive of all tenures:

Fig. 4-2: ECH supply requirement by district

District	2008		2018		2028	
	Over 65 pop'n	Current ECH stock level	Over 65 pop'n %	Projected ECH stock requirement	Over 65 pop'n %	Projected ECH stock requirement
Mendip	20,000	153	18.75	394	18.77	492
Sedgemoor	22,700	113	21.31	448	21.39	560
South Somerset	33,200	313	30.82	648	30.77	806
Taunton Deane	21,800	124	19.96	420	20.05	525
West Somerset	10,100	97	9.17	193	9.02	236
Somerset	107,800	800	100	2103	100	2620

Population Projections and ECH Supply – Sub district level

At a sub district level, this report has indicated that the major towns, particularly Taunton, appeared to have a current undersupply, and that the over 85s are predominantly concentrated in urban rather than rural areas. We would recommend that any increases in supply of accommodation take these findings into account whilst trying to preserve the excellent coverage that currently exists across the county and districts.

4.1.3 Policy Drivers

A. Personalisation agenda

A key part of current government policy is about promoting personalisation on a number of fronts – this is evidenced by the following key documents:

- Putting people first: a shared vision and commitment to the transformation of adult social care (2007)
- "Our health, our care, our say" – White Paper 2006 and statements in the 2007 budget report and Comprehensive Spending Review announcement
- Opportunity Age: Meeting the Challenges of Ageing in the 21st Century (HM Govt 2005)
- Our NHS/Our Future-Next stage review (Darzi) - June 2008

We consider that the personalisation agenda will have the following impacts on extra care housing:

- ***Information*** - people with care or support needs should have better access to all public services, should be better informed about the services and support available to them and should be better empowered to make decisions about

their own lives. People will therefore need to know about the range of options available for accommodation and support including the role of Extra Care Housing - what it is, what people can expect from it, what are the quality standards and clarity and transparency about costs

- ***Commissioning*** - The way commissioning is carried out will need to change with the new commissioning role about supporting individuals to do things for themselves, not doing 'to' or 'for' people. By 2011 Somerset County Council will need to have a commissioning strategy in place for health and wellbeing that maximises choice and control and ensures investment in prevention, early intervention/re-ablement and intensive care and support for those with high-level complex needs

  Somerset must also respond to the demographic challenges presented by an ageing society and the rising expectations of those who depend on social care for their quality of life and capacity to have full and purposeful lives. It will be important that the demographic data available in this report is put to good use in the commissioning strategy to enable better planning and delivering of an ECH service fit for the future.

  The CSIP Commission for Health and Social Care suggests that joint commissioning of housing support services across health and social care will be increasingly important to ensure the Local Area Agreements and other targets are met as well as ensuring a whole system approach to prevention.

  Practice Based commissioning[4] also provides another opportunity for linking housing support and health services and raising awareness to GPs and other health professionals about the presence and potential of Extra Care Housing.

- ***Brokerage –*** Brokerage will be a key in the delivery of services when individual budgets are in place. The support and enabling function of Extra Care Housing will need to be improved in the context of the county council approach to service brokerage and direct access to services. Somerset County Council's new commissioning role will need to incentivise and stimulate quality provision whilst at the same time supporting innovation particularly from the third sector.

  "People will be supported to understand the money and community resources that are available to them and will be encouraged to use these imaginatively to meet their needs" [1]

[4] Practice based commissioning – Budget setting refinements and clarification of health funding flexibilities , incentive schemes and governance

B. Health and well being

Extra Care Housing can play a major role in the area of keeping people fit and well and preventing people from needing statutory services such as admissions to hospital or residential care. Whilst people will be entitled to personal budgets for publicly funded adult social care, there will need to be new methods of commissioning care for ECH schemes and developing access arrangements for individual older people, to take account of these changes. The Local Area Agreements rely on strong partnerships between agencies and Extra Care Housing could play a key role here in the local community. Somerset is very well placed to use the ECH schemes for this as there are so many of them and they are well placed in most Somerset towns.

Somerset will need to strengthen the relationship between health, social care and wider community services in the Third Sector which will be integral to the creation of a personalised care system, e.g. an opportunity for closer working between the Active Living Centres and the ECH schemes. The development of Extra Care Housing would benefit from these new partnership arrangements, especially for people with long-term conditions, with the addition of NHS resources and preventative services into the schemes.

Other initiatives such as falls reduction, health promotion, facilitating hospital discharge, reduction in emergency admissions, and improved care for mental health could all be incorporated into the ECH housing developments. There is also the possibility of closer working with the ambulance trust e.g. pop in visits during the night in down time whilst waiting for emergency calls.

C. Dementia

One of the great challenges for housing with care will be the growth of the number of people with dementia who will have increasingly complex housing and care needs. Somerset's ECH will also need to adapt to meet this challenge. The new National Dementia Strategy which is currently out for consultation will be a key policy driver for this aspect of the service. Along with this will also be the need to develop assistive technology.

D. Assistive technology and telecare

The Department of Health – Extra Care Housing Bidding Guidance 2008 suggests that telecare and other technology within ECH should be maximised to maintain health and well-being as well as to support virtual communities in the local area to reduce isolation and respond to identified emergency situations. The Independence, Wellbeing and Choice 2005 document outlines the fact that telecare has huge potential to support individuals living at home, assist carers and transform the way services are offered.

The Government has set a target and list of expected telecare outcomes to be achieved with the preventative technology grant. Somerset has an action plan in place for this but this has no reference to ECH. With the new developments in technology the possibility of people using assistive technology, telecare and telehealth care to remain living in their own home is increasing. By ensuring that Extra Care housing is fitted with the most up to date technology to meet the needs of its occupants, this provides even greater opportunities to enable people to remain independent.

As outlined in Section 3 Somerset ECH schemes have only made limited use of assistive technology at present, mainly through community alarms. Many authorities now have an assistive technology strategy in place and Somerset needs to ensure that one is developed and that ECH is included as part of this.

Fig. 4-3*:* Northamptonshire "Safe at Home"

Good practice example:

Northamptonshire 'Safe at Home'

The project involved the Lifeline 4000+ from Tunstall, an easy to use home hub supporting a comprehensive range of telecare services.

The Lifeline 4000+ connects with up to 35 smart sensors detecting intruders, inactivity, carbon monoxide, smoke, floods and falls and other potential risks to support independent living and provide reassurance and additional support to carers.

According to a research study, the scheme has brought the local agencies in Northamptonshire equivalent savings of over £1.5 million over the 21 months during which the research took place.

Total project costs over the 21 month period were £286,853.46. The report highlights how by integrating assistive technology solutions into existing care provision, four times as many individuals were able to remain living independently in their own homes over the research fieldwork period.

E. People with learning disabilities

There is greater potential to provide more ECH for people with learning disability .The "Valuing People Now" consultation paper contains a section on housing and the need to accommodate people with learning difficulties in ordinary housing rather than institutional settings.

F. People with mental health needs

All the most recent policies for mental health emphasise the importance of ensuring that this group of people have access to mainstream services and ordinary housing, and ECH could be part of this. Somerset is already housing some people with mental health needs very successfully in its schemes and with higher support levels and assistive technology there is scope to further develop this aspect.

G. People who misuse drugs and alcohol

Housing and support can play a positive role in bringing stability to drug and alcohol users. Somerset ECH have not currently any tenants who misuse drugs, but do have a few with alcohol problems. New strategies need to include how to meet the challenge of inclusion of this group of people, whilst at the same time recognising that a large proportion of tenants will be older people due to the demographic trend.

H. Building of lifetime homes

The planning and building of lifetime homes must also be taken into account by Somerset for new build, and when renovations are undertaken. Design features that enable people to remain in their homes when they become frail or physically disabled, and better opportunities for people with learning disabilities and mental health difficulties to access alternative forms of housing such as ECH.

I. Staying put

Most people say that they want to remain in their own home, even in preference to ECH, so the idea of a virtual ECH scheme where the benefits of extra care housing with care and housing support on site could be transferred to people in their own homes seems very attractive. The use of a hub for meals, activities, health promotion etc and with more housing support and care staff visiting people in their own homes and adopting a much more enabling approach could offer great potential for a new type of ECH service in the future.

J. Extra Care Housing funding

Funding has been made available by the Dept of Health to develop Extra Care Housing in England in areas where need has been demonstrated (as reflected in local needs assessment, commissioning priorities and other relevant strategies, particularly local Supporting People strategies, Local Delivery Plans and regional housing strategies). It also needs to show a range of benefits for older people, people with disabilities or long term conditions that cover:

- Impact on health and well being

- Promotion of dignity, choice and control, and offers personalised and focused services
- The prevention of unnecessary hospital or residential care admissions or reduce delayed discharge
- Preventative services and well-being strategies which increase independence and delay the need for high-dependency solutions
- Demonstration of an inclusive approach
- Effective local commissioning arrangements between the NHS, Partnership arrangements with local housing authorities, Supporting People teams, Adult social care services, care providers, Housing Associations, private sector and other developers

4.2 Vision for Extra Care Housing in Somerset

4.2.1 Introduction

In this section, we set out 2 alternative visions for ECH in Somerset, together with the likely consequences of these visions. The 2 alternative visions are:

1. ***MINOR*** – ECH plays a significant but minor role in our overall strategy towards older people, by offering an alternative to residential care. We have delivered the ECH we need at minimal public cost. It exists, it seems to work okay. We can leave it alone for the next 10 years

2. ***MAJOR*** – ECH is fundamental to our overall strategy towards older people, much more than just an alternative to residential care, it is a key resource in our objectives to improve the health and wellbeing of older people and to offer personalised care and support. Nurturing and developing extra care housing and the services that go with it, in partnership with the PCT, voluntary agencies, providers and older people, is a key strategic imperative for the next 10 years

4.1.2 ECH as a MINOR role – What ECH will look like in 2018

Provision

The level of ECH provision has increased a little. Social rented provision has remained the same, as no schemes have been commissioned, and providers have received no encouragement from commissioners to develop further. No shared ownership provision has been developed and private sector provision has increased slightly by healthcare agencies and without contact with the county. Most of the new provision has been sold to older people moving to the county rather than existing Somerset residents.

Fig. 4-4: Tenure

Year	Social Rented	Shared Ownership	Private	Total
2008	772	0	28	800
2018	772	0	96	868

Stock distribution obviously remains the same as before as does the profile of the providers. Stock has aged 10 years, and so the average age of an extra care housing unit in Somerset is 17 years old.

Design and Sustainability

The profile of the stock by size has not changed and there has been no remodelling work by providers to alter scheme mix. Somerset's social rented ECH stock still comprises 3% bedsits and only 9% 2 beds.

Providers are finding it increasingly difficult to let the bedsits and smaller 1 bed flats, and commissioners have had to agree to relax their care package requirements for accessing the scheme in order that these units can be let.

Social care teams are complaining to commissioners that the number of people requiring extra care that they cannot place there because of inappropriate accommodation, or because applicants are turning down the flats has increased. Commissioners are experiencing greater pressure on their residential care budgets than they had anticipated.

Providers are providing disabled adaptations where Disabled Facilities Grants are available, but otherwise schemes are not upgraded beyond their normal asset management cycle for replacement of components.

Services

The service model has not developed beyond its state 10 years previously. In particular, ideas around virtual extra care in the community built around a hub and spoke model have not been progressed.

Tenants complain at lack of activities on their schemes and a slow erosion and deterioration of services – frozen meals being a particular and regular gripe. Housing providers complain of a lack of housing support funding to develop activities for this frail client group, and care providers complain that they are not getting paid to support clients or cover for the scheme manager.

Some providers are considering declassifying their schemes from the ECH programme as they consider they would achieve greater scheme viability as a traditional sheltered scheme.

Commissioning, contracting, charging

Providers continue to make local agreements with local contract management teams, increasing the anomalies of services and fees across the county. Tenants complain of differential charges as they always have done.

Policies and standards

Some attempts have been made to develop countywide policies and standards but they have not been concluded owing to competing priorities.

Overall

The extra care housing service is dying on its feet. Without any significant investment since schemes were originally built 20+ years ago, provision is not fit for purpose and is unsustainable. The quality gap between Somerset and its neighbours who are building new high quality schemes is ever widening. Applicants are increasingly seeing no benefit in moving from their home to what increasingly appears poorer quality accommodation. ECH has become the sheltered housing of 20 years ago.

4.1.3 ECH as a MAJOR role – What ECH will look like in 2018

Provision

Overall provision has increased more or less in line with the projections set out in section 4.1 – i.e. 2103 units of which 1045 are social rented units, 209 are shared ownership and 836 are privately owned units.

Design and Sustainability

Almost all the private and shared ownership provision is newly built to a modern high standard with a mix of 1 and 2 bed units. The make up of the increased social rented provision has changed dramatically. There are now no bedsit units and 2 bed units comprise 25% of the stock. All schemes provide for people with varying needs in an appropriate way and there are now no scheme refusals on grounds of unsuitability. A new build programme has boosted the social rented provision providing flagship design and facilities, setting the standard for others. ECH is popular and the provision is of good quality and sustainable into the future.

The service

The service model has changed dramatically, aided by advances in telecare and the positive involvement of the PCT and other healthcare services. The extra care service is geared to the care needs of the individual and not confined to ECH schemes. Any person in Somerset is eligible to receive an extra care service wherever they live, provided that their home is suitable, or can be adapted to make it suitable for their needs. Specifically, this means that:

- People living in their own homes in the community may receive an extra care service provided their home is suitable/meets the defined standard

- People living in sheltered schemes may receive an extra care service provided their home and the scheme environment is suitable/meets the defined standard
- People living in accommodation units within existing extra care housing schemes may be unable to receive an extra care service in their home if the unit or the scheme environment is not suitable/does not meet the defined standard

Once eligible to receive the extra care service this comprises entitlement to a direct payment in order to pay for the following services:

- Personal care
- Housing support and other household tasks
- Hot meals
- Health promotion advice and information (free of charge = NHS service)
- Telecare and telehealth monitoring
- Out of hours support from rapid response team
- Community nursing services (free of charge = NHS service)
- Access to social activities at the local active living centre or extra care housing scheme

Commissioning, contracting, fees and charges

Extra care service providers are commissioned on a zone/catchment area basis, each zone containing an extra care housing scheme or other suitable base from which area based services are organised. Some providers opted to provide all the services commissioned in their zone, others just some of the services. However, in each zone there is just one overarching contract to which all service providers for that area have signed up.

Policies and Standards

The county has an up to date bank of operational policies and standards which are kept under regular review by a standing group of commissioner and provider and service user and other stakeholder representatives. These policies and standards include:

- Minimum accommodation unit standards for eligibility to receive extra care services into
- Minimum scheme environment standards for supported accommodation schemes to be eligible to receive extra care services
- Access, eligibility and assessment policy
- Charging policy framework
- Extra care service specification

- Protocols between providers delivering part elements only of the extra care service

Partnership working

The county has developed a new range of strong partnerships that have enabled the service to develop in the way that it has, including:

- With the PCT and health care providers, in order to provide the healthcare care components of the extra care service – community nursing services; telehealth; rapid response, health promotion information and advice
- With providers, service users and their representatives – a countywide forum that considers and resolves operational policy questions, and seeks to ensure common approaches to policy matters and equitable service delivery across the county. Public awareness of extra care services has increased significantly.
- With private sector providers of extra care housing, a new forum that meets twice a year with representation from the residential care operators as well

Strategic management

A new countywide Health and Wellbeing Strategy for Older People is in place, developed in partnership with commissioning agencies; providers, voluntary agencies and older people. This places the development of extra care services at the very heart of the strategy, and connects extra care to key health, care and housing support objectives of individual commissioning and stakeholder organisations.

A multi agency strategic group has overseen the implementation of the 2008 Commissioning Strategy for Older People update which placed the development of the new extra care service model as the key priority in the county. Central to this update were 2 key strategic developments:

- Transformation and expansion of the existing extra care housing into a quality range of provision, providing an attractive option for older people in a variety of different circumstances and with different needs
- Transformation of the extra care service model from a narrow care and support model centred on extra care housing schemes, to a health, care and support model centred on the needs of the individual anywhere in the county

Performance Management

The county has agreed with its stakeholders the relevant performance indicators that it measures, monitors, and publicly reports on to assess the effectiveness of its extra care service.

Service user involvement

Service users and their representatives play an active part in the monitoring and development of the extra care service. They have been involved in the development of policies and standards, and continue to help develop the future of the service.

4.3 Recommendations

The recommendations below are intended to provide the commissioners with the key elements of a route map which will enable the County to move from its current position (as set out in section 3) to the future vision of 10 years hence, (exemplified by the ECH as a **MAJOR** role as set out in section 4)

Strategy

Recommendation 1:

That Somerset commissioners develop a Commissioning Strategy for Older People Update or an Older People's Health and Well Being Strategy in order to place ECH within an appropriate strategic framework. This strategy would be developed in partnership with stakeholders, providers, voluntary agencies and older people, and would set out the following 3 key imperatives:

- That extra care is at the very heart of future strategy towards older people
- The intention to transform the county's unsustainable existing provision of extra care housing into an expanded and modernised range of attractive and appropriate accommodation over a period of 10 years
- The intention to transform the county's existing and narrow care and support extra care service model into a holistic and seamless health, care and support extra care service model centred on the needs of the individual wherever they live in the county

Strategic management and intervention

Recommendation 2:

In order to rebalance the current tenure provision in the county, commissioners should develop an approach to market management that goes beyond the social housing sector and embraces the private sector as well. Such an approach could include research into the private ECH market in the south west; involvement in planning policy development and land availability studies being undertaken by Somerset planning authorities; discussions with existing residential care providers in the county, and market engagement with the private sector through established procurement mechanisms.

Recommendation 3:

In order to stimulate affordable home ownership options for older people, commissioners should develop their own understanding of the shared ownership market and the contribution it can make to providing choice for older people. Engagement with providers who have undertaken this should be considered as well as establishing the appetite of existing housing providers in Somerset to develop this tenure.

Policies and standards

Recommendation 4:

The commissioners and providers should work together to produce a set of agreed Somerset Design Standards for ECH. These standards should cover the 5 key areas or common threads:

- Living spaces that are fully self contained, have sufficient space and appropriate facilities such that they are truly barrier free environments
- A communal and external environment that are similarly barrier free in their design
- Adequate communal space and facilities for independent living – laundry, dining, lounges, hairdressing, guest facilities etc.
- Adequate communal space and facilities for personal healthcare functions – assisted bathing, GP consultations, district nurse treatments, telehealth etc.
- Adequate office and private space for operational and scheme management staff – office, sleepover room, changing and toileting facilities

Investment programme / sustainability

Recommendation 5:

The commissioners and providers should work together to produce a 10 year investment programme that will bring all schemes up to the new Somerset Design Standards for ECH. This will include not just matters with significant building work and cost consequences, but other matters equally significant in their benefit to tenants but far less costly – issues such as lighting, signage, loop systems, colour and decoration etc.

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Commissioning

Recommendation 6

That future commissioning is undertaken in an inclusive, open and transparent way, involving consultation with and, where appropriate, involvement of existing providers and residents or service users, at the different stages of the commissioning process.

Contracts

Recommendation 7

That consideration is given to the advantages of constructing a single contract between all commissioners and all providers at an ECH scheme, with the objective of better fostering mutual understanding between partners about the services required and how they can best be delivered as a seamless service, ensuring that the contract is drafted in consultation with interested parties

Fee levels

Recommendation 8

If we have understood the position correctly, there may be a case for reviewing the housing support fee levels to providers at the ECH schemes to ensure that activities they are contracted to provide can be organised safely and efficiently with sufficient support staff available to support residents in participation

Partnership Agreement / Framework

Recommendation 9

That the current commissioners and provider partners together construct and develop a model Partnership Agreement that all parties can sign up to, which will assist all partners by providing a framework within which more operational policy decisions can be taken. Such a Partnership Agreement should, at a minimum, incorporate sections on the following matters:

- Vision, purpose and guiding principles of the extra care housing programme
- Commissioning and contracting arrangements
- Eligibility, allocations and nominations arrangements
- Charging framework
- Service specifications
- Protocols and liaison arrangements

Countywide consistency

Recommendation 10

That the commissioners and providers construct for themselves a countywide forum at which operational policy, contractual queries and strategic matters may be discussed and considered. Partners should agree their own terms of reference and modus operandi for this forum.

Provision / Development Strategy

Services / Training

Recommendation 12

Resolve these current operational policy matters in order to deliver improved services:

- Investigate further those tenants exhibiting problem behaviour to identify reasons and causes and implement solutions
- Ensure all tenants have support plans in place
- Staffing levels in each scheme should be reviewed to ensure they meet the

needs of tenants

- Laundry facilities should be reviewed in each scheme to ensure they meet the needs of each tenant
- Night cover should be reviewed in each scheme to ensure individual needs are being met
- More housing support should be available for tasks currently not carried out by care staff
- All staff should be made aware of the importance of loop systems which should all be in good working order and used more frequently as a matter of course
- More activities need to be organised for tenants recognising that with higher dependency tenants activities are more difficult for them to organise themselves (though tenants must be involved in the planning and decision making about the type of activities arranged)
- That the training requirement for ECH care and support staff and scheme managers is reviewed and a new training plan put in place which includes the aspects listed and ensures a joint approach to training. It is also recommended that care management staff should be given awareness raising training about ECH and what is involved - this could also be extended to health staff including hospital staff and GPs who often have a large influence on the type of accommodation people move to after admission to hospital or in times of crisis

Service Transformation

Recommendation 13

The service commissioners and providers to develop a 10 year (5 year?) service transformation plan in order to design and achieve the holistic seamless extra care service to people in Somerset, as set out in section 4.2.

Contracts and policies

Recommendation 14

Resolve these current contract and policy matters in order to improve partnership working:

- Reconsider balance of care and support hours
- That Schedule A of the contract is reworked to include a vision statement that is bolder and clearer about what is and is not
- That there should be a list of core care tasks as well as the core housing support tasks of which both care and housing providers are aware
- That the provision of meals schedule should be updated based on comments in the meals section of this report
- Providers to meet and share problems over meals provision with a view to exploring the possibility of a viable 7 day fresh cooked meals service to operate across the county
- That a common set of local standards for care providers into ECH is drawn up and monitored by the commissioners as part of the contract
- That a consistent panel process is set up across the county to ensure fair and equitable access to ECH with clear eligibility criteria, an agreed quota of dependency levels and representatives from adult social care, housing providers and care and support provider as part of the allocation decision making process.
- That more high dependency applicants are accepted for ECH schemes
- That Somerset single assessment process contract and overview assessment is reviewed to include relevant questions on housing and support.
- Protocols to then be put in place so that the single assessment process tools can be used across housing, health and social care to remove the need for duplicate assessments by the district council and housing providers.

Telecare

Recommendation 15

That the telecare project officer ensures ECH is targeted as a key area for telecare developments – at present this is not mentioned in any of the documents. An audit of each scheme about existing and potential use of telecare would be a useful exercise

together with an assessment of the high dependency (or all tenants) in ECH schemes for assistive technology requirements.

Tenant information and involvement

Recommendation 16

- Any future changes need to be well communicated in advance to tenants
- Tenants should be more frequently consulted with and participate in decision making which affects them by care and support providers, housing providers and commissioners
- Tenants should have better information about all aspects of ECH including assistive technology

Performance management

Recommendation 17

Develop a set of performance indicators for extra care housing and measure and monitor performance against these.

This should include a central record of panel decisions to assist with strategic planning and decision making.

Appendix 1 - Somerset ECH review - Glossary

ACS- Adult community services (a department of Somerset County council dealing with people over 18 and community services such as libraries and adult education)

Allocation panel – a group of Somerset managers who meet to decide who can receive services when services have to be rationed

ASC team - group of adult social care staff who work in a team

Assessment – gathering of information to make a judgement about need

Assistive technology - the use of technology to support people to live independently

Barrier free units – accommodation that is easily accessible for use with wheelchair or other equipment.

Benchmarking - Process that helps practitioners to take a structured approach to share, compare, identify and develop the best practice**.**

Brokerage - a professional or organisation who acts on behalf of the service user to control and spend money allocated in an individual budget if they so wish as part of personalisation (see personalisation).

Care provider – organisation providing care to the tenants
Units- a block of flats, bed-sits or bungalows grouped together

Care package - Following an assessment, a care package is agreed to enable a patient to receive care appropriate to their needs. Where necessary this covers both NHS and social care.

Contracting out - organisation(s) purchasing services from the private sector, charities or other bodies, rather than providing the services themselves.

Commissioning- The process local authorities and primary care trusts (PCTs) undertake to make sure that services funded by them meet the needs of the service user.

CSCI (Commission for Social Care Inspection)-The single, independent inspectorate for social care services in England.

Cultural diversity- ensuring a range of different ethnic and cultural aspects are included.

DDA - Disability Discrimination Act

Domiciliary care agency – agency that provides home care that helps people cope with disability or illness, and allows them to maintain independence.

District auditor - District Audit has merged with the Audit Commission's Inspection Service Audit and is the primary auditor of local public services. Auditors are appointed to provide assurance and promote value for taxpayers' money across local government, health, housing, community safety, fire and rescue and other public services..

ECH – Extra Care Housing – Covers a range of types of supported housing which provide a 'caring environment' for older people. It is often specially designed self contained housing and may have a range of communal facilities sometimes available to older people in the local community as well as the scheme. There are dedicated care teams and personal care is provided either by the housing provider or on a contract with another agency or social services. Also known as 'extra-care' it offers care services for older people to provide a 'home for life'.

Eligibility criteria - a list of requirements which identify whether a person is eligible for specified services

Housing LIN – Housing local Involvement Network- set up by Care Service Improvement Partnership to enable networking between staff from different agencies to improve standards and working arrangement

Housing support charges - charges made for support to enable people to remain independent such as help with collecting pensions, planning meals, assistance with benefit claims etc.

LD - learning disability

Lifetime homes - a home designed to accommodate people's changing needs throughout their life.

Local area agreements (LAAs) - Three year agreement that sets out the priorities for a local area in certain policy fields as agreed between government, local authority and other partners.

PCT- Primary Care Trust – NHS bodies with responsibility for delivering health care services and health improvements to their local areas.

Partnership Arrangements - formal or informal arrangements between organisations such as NHS and local authorities who agree to work together to improve services.

Personalisation – a new Government initiative to ensure that every person who receives support, whether provided by statutory services or funded by themselves, will be empowered to shape their own lives and the services they receive in all care settings.

Policy Drivers - important policy documents that influence what needs to be done.

Practice Based commissioning – where budgets are given to GP practices or groups of practices to spend money on services required

Project initiation document – a detailed project plan involving all aspects of a project set up

Project Board – Group of people appointed to manage /oversee a project and to whom the project managers or team are accountable to.

Providers - organisations that have been contracted to provide a service

RSL - Registered Social Landlord (RSL).Term introduced by the 1996 Housing Act applying to housing associations registered with the Housing Corporation. RSLs have access to Social Housing Grant public funding for the capital costs of providing housing.

RAS – Resource allocation system – a way of deciding how much money or resources will be allocated to a particular person

SAP - Single Assessment process- one assessment process across health and social care required to be implemented by NHS and social care organisations to assess health and social care needs once without the need for duplication.

SAP tool - Single assessment process form with a range of questions to enable a decision to be made about a persons needs and used by a range of agencies to avoid the some questions being prepared or duplicated by different agencies

SCC - Somerset County Council

Service user - Anyone who uses, requests, applies for or benefits from health or local authority services.

Scheme manager – the manager of an extra care housing scheme, usually available on site.

Service charges – charges made for services provided in an extra care schemes such as cleaning of communal areas, gardening etc

Service specification – a set of requirements that a service should meet

Sleep in staff – staff that sleeps in the extra care scheme overnight and are available on call.

Sheltered housing - covers a wide range of supported housing, generally provided in specially designed self-contained flats or bungalows. Schemes may have communal facilities such as a common room, laundry and guestroom and the provision of warden services. Wardens do not provide personal care but offer low level support including emergency support often through a linked alarm system. They also help older people to obtain the care and support they need, manage the scheme and organise activities.

Social housing provider - an organisation that provides homes for letting or low cost ownership and associated services for people whose personal circumstances make it difficult for them to meet their housing needs in the open market**.**

SMART technology - the use of technology either in design or equipment to support people to live independently

Stakeholders - a wide range of people or organisations that all share an interest in its work, including service users, public, NHS, local authorities and social care providers, charities, and the voluntary and community sector.

Strategy - a high level plan based on evidence and informed thinking over a period of time.

Staying Put - term used to describe services that help people with repairs, improvements and adaptations but can also refer to people choosing to remain in their own homes.

SP- Supporting People - Grant programme that provides local housing related support to services to help vulnerable people live independently at home.

Support plan – a plan to identify the support or services a person chooses usually drawn up with the person themselves.

Telecare - A combination of equipment and monitoring that helps individuals to remain independent at home- (see also Assistive technology)

Tenants – someone who lives in a property belonging to and landlord and holds a tenancy lease or licence

Third Sector - voluntary and independent sector

TUPE - Transfer of Undertakings (Protection of Employment) Regulations 2006 – this is European legislation which protects staff when their employer changes as a result of a transfer of ownership or contract arrangements.

Quantitative research – research involving the collection of large amounts of statistical data

Qualitative research - evidence gathered which involves people's thoughts, feelings and opinions rather than large amounts of statistics.

Voluntary and community sector - Groups set up for public or community benefit such as registered charities, and non charitable non profit organisations and associations

VSH - very sheltered housing schemes (another name for Extra Care Housing) Covers a range of types of supported housing which provide a 'caring environment' .It is often specially designed self contained housing and may have a range of communal facilities sometimes available to people in the local community as well as the scheme. There are dedicated care teams and personal care is provided either by the housing provider or on a contract with another agency or social services. Also known as 'extra-care' it offers care services for older people to provide a 'home for life'.

Vulnerable adults - People with disabilities or mental conditions who are unable to take care of themselves, or protect themselves against harm or exploitation from others