Care and Support Strategy within Extra Care Housing 2018-2025

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Executive summary

This strategy examines the care and support delivered in extra care housing. Extra care housing is one of a number of housing options. The key features of extra care housing are independent community living, security of tenure and personalised care, should it be needed. Extra care housing should be about *living at home, not in a home.*

Population projections for Bolton show a steady growth in the older population including those with disabilities. Extra care housing is a valuable resource to address both the housing and care needs of older people. It provides an alternative to residential care for many older people and supports independent living for longer. Therefore, this strategy aims to ensure that the care and support delivered in Bolton's extra care housing schemes integrates the latest developments in the field and focuses on meeting the outcomes of tenants with care and support needs.

Bolton's vision for extra care housing contained in this paper has been co-designed with tenants, social workers and their managers, landlords and those currently delivering care and support. It incorporates best practice from successful schemes across the country such as the use of technology to assist tenants and commercial and co-location opportunities such as restaurants and pharmacies within the schemes.

During the development of this strategy, it was found that Bolton's current extra care housing schemes have overly favoured people with care needs. Moroever, care was rarely delivered in a personalised manner. This strategy focuses on:

- ✓ Changing the way care and support needs are delivered;
- ✓ Changing the staffing structure; and
- ✓ Changing the referral process into extra care housing.

The delivery of care has been revised to reflect the nationwide trend towards outcome based objectives for care. The emphasis on outcomes allows for flexibility and personalised care. To accommodate outcome based care, a new staffing structure is proposed.

The referral process should be revised to allow the schemes to be occupied by tenants with no current care needs as well as those with higher level needs. A balance of care needs is seen as a significant factor in promoting vibrant community living in successful schemes.

Finally, an eight step model to implement the change strategy is proposed to ensure that the strategy is embedded amongst all stakeholders.

Acknowledgements

We are indebted to the tenants of the current extra care housing schemes for their views on how the schemes were working and how they could be improved. Both tenants and staff gave us a valuable insight about the actual workings of the schemes rather than the versions contained in paper files. We would also like to thank the social workers and their managers for meeting with us. Their often contradictory views were essential in formulating this strategy. We are grateful that we eventually reached a consensus on the purpose of these schemes.

We are most grateful to Joanna Jackson, Operations Manager at Bolton Cares for sharing her vast experience in this field. Without her understanding and critical comments, this strategy would have been very difficult to complete. It is a good example of how Bolton Council cooperates with its partners and service users in an endeavour to improve the lives of our older residents.

Bob Charles

1 Aims of this strategy

- To examine the developing consensus on successful extra care housing schemes
- To take a strategic overview of the current Bolton extra care housing schemes.
- To examine the demand to meet the aspirations of people who might want to live in an extra care housing scheme.
- To consult with stakeholders about their vision of an extra care housing scheme.
- To analyse and estimate future demand.
- To advance commissioning considerations of extra care housing schemes based on a model that has been co-designed with stakeholders.

2 Bolton's vision for extra care housing

2.1 The agenda for extra care housing has been driven by the personalisation agenda[1] and a government policy of supporting people to stay in their own home, in their community[2]. Personalisation is designed to deliver choice and control of services to people in a way that they want.
Extra care housing is a specific resource amongst a collection of housing alternatives ranging from independent living in your own home to moving into a care or nursing home[3]. Some researchers think that extra care housing will eventually replace residential care homes[4]. However, it is likely that specialised care homes and nursing homes will always be required for those with higher level needs.
Appropriateness of extra care housing depends on the combined housing, care and service model available rather than the care component in isolation. It is distinct from residential care because occupants have tenure rights. Consequently, extra care housing should not be seen as an alternative to residential care but rather, as an constituent in a continuum of alternative housing and care provision. Research suggests that given the right management, extra care housing schemes are suitable for nearly everyone except[5],

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[1] Hunter, S., & Ritchie, P., (Eds.) (2007) *Co-Production and Personalisation in Social Care Changing relationships in the provision of social care* Jessica Kingsley: London
[2] HM Government (2010) *The Coalition: Our programme for Government.* Cabinet Office, London.
[3] Cm 6499 (2005) Independence*, Well-Being and Choice. Our Vision for the Future of Social Care for Adults in England.* The Stationary Office: London
[4] Housing Learning and Improvement Network (2003) E*xtra care Strategic Developments in North Yorkshire.* Case study No 1. Housing Learning & Improvement Network, Health and Social care Change Team, DOH, London.
[5] Callaghan, L. (2008) *Social well-being in extra care housing.* PSSRU

- People whose behaviours challenge services either as a result of cognitive difficulties or through substance misuse and
- People who cannot orientate around the scheme or its immediate environment.

2.2 There is no single definition of extra care housing but it is generally understood that the purpose of extra care housing is to meet the housing, care and support needs of older people, while helping them to maintain independence in their own private accommodation[6]. It is primarily a housing option, not a care option. It is a lifestyle choice for people who want to remain as independent as possible, for as long as possible. The distinguishing feature of extra care housing from other housing alternatives is its emphasis on helping to preserve and/or build capacity in individuals to achieve independence and well-being. Consequently, extra care housing can play a key role in delivering both preventative and re-ablement services and by providing suitable environments with practical (physical and emotional) support. The combination of an independent living ethos, flexibility, responsiveness, security and safety in these schemes will give tenants an improved quality of life, higher quality of care and more effective care, which is the true hallmark of personalisation.

2.3 Success of extra care schemes is measured by less people going into care homes and an increased level of well-being amongst tenants of extra care housing schemes.

2.4 The most successful schemes have a balance of tenants with either no care needs or varying levels of care needs. These schemes have an independent living ethos together with a sense of community that slows those predicted to have care needs from developing them and those who already have care needs, from seeing them escalate to the same degree had they been living in the community. An important feature of these schemes is that the younger fitter tenants tend to influence the not so well to a greater degree of well-being than if the latter had been living on their own. It is a relationship of mutual benefit as the more fit get satisfaction from participating in community life and helping others whilst the less fit are helped to achieve higher levels of independence. These schemes take a collegiate approach between landlords, care providers and referrers to attain a balance that promotes vibrant community living. Therefore, Bolton's vision of the features of a successful extra care housing schemes will include[7]:

[6] Darton, R., Baumer, T., Callaghan, L., et al, (2012) The characteristics of residents in extra care housing and care homes in England. *Health and Social Care in the Community* 20(1), 87-96.
[7] Riseborough, M., Fletcher, P., Gillie, D. (2015) *Extra care housing what is it*. Housing LIN Factsheet 1.

- Safe and secure independent living – having a front door- *living at home not in a home*;
- There is separation between the supply of landlord services and the care provision;
- Primarily for older people although younger people with disabilities may be suitable, depending on the balance of tenants in the scheme and their lifestyle expectations;
- 24/7 on-site physical emergency response;
- Emotional support for tenants on a 24/7 basis;
- A balance of tenants with varying care needs (low, medium, high – measured in hours of eligible care needs) to ensure vibrant community living including a thriving tenants association;
- Self-contained apartments, which can be modified to address differing care needs;
- Communal services/facilities including a reception;
- Planned care interventions, which can be flexibly delivered in a culturally sensitive manner, by a consistent staff team, within a familiar locality;
- Responsive to the changing needs of tenants;
- Ethos of independence and reablement;
- Working in partnership with friends, relatives and professional health and care staff to ensure care needs are met;
- Security of tenure and a mixture of rented and equity holdings;
- Use of technology enabled care; and
- Resources which encourage wider community engagement.

3 Strategic overview of the current Bolton schemes

Location and care needs

3.1 There are currently ten schemes managed by three landlords. Four are run by Bolton at Home (BAH); five are run by Anchor and one by Places for People. Bolton Cares delivers the on-site care service for all ten schemes. Figure 1 shows the location of the ten extra care housing schemes in Bolton. With the exception of Manor Gardens all of the schemes are located within the most deprived areas of Bolton.

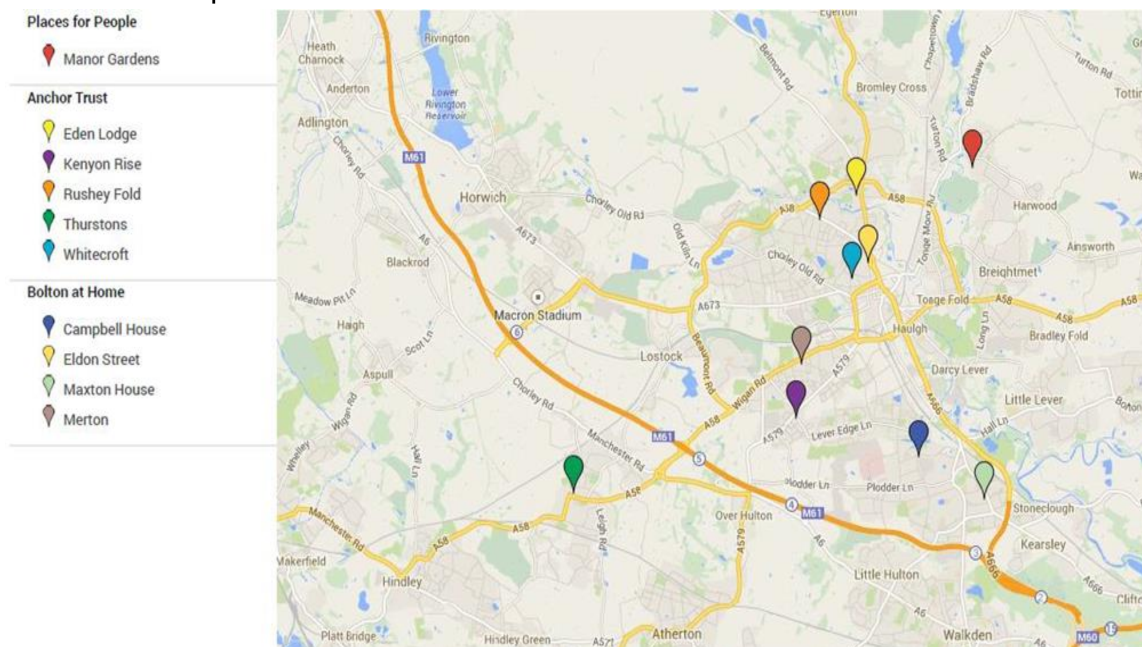

Figure 1: Locations of the extra care housing schemes

Table 1: Overview of the Bolton extra care housing schemes

Care Provider	Landlord	Scheme name	Number of Units	Numbers with eligible care needs	Percentage care needs/units	Location by Ward
Bolton Cares	Bolton At Home	Campbell House	24	23	**95.8**	Farnworth
Bolton Cares	Bolton At Home	Eldon Street	31	26	**83.9**	Tonge with the Haulgh
Bolton Cares	Bolton At Home	Maxton	38	27	**71**	Farnworth
Bolton Cares	Bolton At Home	Merton	32	26	**81.3**	Rumworth
Bolton Cares	Anchor	Eden Lodge	29	18	**62.1**	Astley Bridge
Bolton Cares	Anchor	Kenyon Rise	38	26	**68.4**	Hulton
Bolton Cares	Anchor	Thurstons	30	22	**73.3**	Westhoughton
Bolton Cares	Anchor	Rushey Fold	29	21	**72.4**	Crompton
Bolton Cares	Anchor	Whitecroft	38	25	**65.8**	Halliwell
Bolton Cares	Places for People	Manor Gardens	36	19	**52.8**	Bradshaw

3.2 The emboldened figures in red in table 1 show that all of the schemes have a high percentage of tenants with care needs although it does not give an indication of the levels of need. With the exception of Manor Gardens, all of the schemes have been converted from sheltered accommodation[8].

3.3 Clearly, the current Bolton schemes do not demonstrate the essential features of successful extra care housing schemes because they have not achieved the mix of tenants to promote community living. Having more people with care needs tends to promote a culture similar to a care home setting than an extra care housing scheme. Plainly, the current Bolton schemes are a care choice for tenants rather than a housing and lifestyle choice. As such, these schemes miss one of the key success factors of extra care housing schemes, having a balance of care needs.

3.4 Analysis is difficult where tenants have multiple disabilities. In these cases, the following investigation is based upon the most serious disability as assessed by a medical diagnosis. An examination of the assessed eligible care needs by age shows that there is correlation between age and disability in three main categories:

- Tenants with a physical impairment: 48% were in the over 75 age bracket whilst 49% were over 60.
- Tenants with a sensory impairment: 70% were over 75 whilst 28% were over 60.
- Tenants with dementia: 71% were over 75 whilst 29% were over 60.

The population of tenants with these disabilities far outweigh tenants with other disabilities.

What we currently deliver

3.5 Payments for extra care housing are divided into accommodation charges and care fees. Tenants pay for the accommodation costs, which include a service charge for telecare and other services.

3.6 In 2016-2017, 116,000 eligible care hours were delivered (2,224 hours per week). For 2017-2018, it is estimated that this will rise by 15% to 133,568 hours (2,562 hours per week).

3.7 In addition to the above costs, there is a payment to each of the landlords for office space.

[8] Accommodation for elderly or disabled people consisting of private independent units with some shared facilities and a warden.

3.8 The BAH schemes have a Careline system for addressing night time concerns. The other six schemes which do not have Careline services, Bolton Council pay a fee for emergency physical response between 11pm and 7am for sleep-in staff at four of the properties together with one waking night staff who works across two schemes: sleep-in in one scheme and on-call for another scheme.

3.9 Bolton Council's care provider, Bolton Cares provides a core service as well as a care and support service for those with eligible needs. The core service provides:

- Temporary care and emergency response between 7am and 11pm or 7:30am to 10pm (BAH schemes) for all tenants regardless of whether they have assessed eligible care needs or not;
- An emergency response service outside of these hours delivered either by Careline or care staff;
- Partnership working with the landlord to ensure the wellbeing of all tenants and to facilitate activities to reduce social isolation;
- Provision of information and help to access health and social care services for all tenants;

3.10 The service charge paid to the landlord is for:

- A housing staff member on site - Monday to Friday
- Daily proof of life checks – Monday to Friday
- Weekly visits to tenants to assist with benefits and debts
- Facilitating social activities
- Provision of a repairs

4 Challenges identified with the way care is delivered

Reviewer's impressions

4.1 With the exception of Manor Gardens, all of the schemes had transitioned from supported housing into extra care housing schemes. Many of the staff and working practices have been retained during this transition. There was evidence of staff retaining some of the practices associated with supported living arrangements. This gave rise to expectations amongst tenants to behave in ways that were reminiscent of institutional living. Effectively, these behaviours resulted in disabling tenants, building dependency and taking away independence. Successful extra care housing schemes promote liberation from routine interventions and freedom to choose how to live.It is important to note that the prevailing culture is a result of design and evolution to its current state, rather than the fault of providers.

Delivery of care and support

4.2 The consequence of the different shift patterns is (a) tenants who need help going to bed are required to retire either before 10pm (BAH schemes) or before 11pm at the other schemes. Moreover, tenants with eligible care needs that require night time interventions cannot be catered for in any of the ten schemes.

4.3 The principal model used in social care is an assessment followed by a care plan. The care plan denotes tasks required together with the time it takes to complete these tasks. This system can be inflexible and lead to institutionalised methods of delivering care, such as predictable meal times and personal care delivered to suit staff working preferences rather than tenant choice.

4.4 **Referrals**

The current referral process is designed to give Bolton Council 100% nomination rights for the first 10 days after a vacancy is identified. After this, nomination reverts to the landlord. Due to demand for accommodation from social care, prospective tenants have care needs because social care only delas with those with eligible care needs. In all of the ten schemes, there is an overrepresentation of care needs generally and in some schemes, an over representation of the same types of disability (e.g. physical or sensory impairment or dementia). There is no control of the balance of care needs amongst tenants to ensure a vibrant community ethos. Consequently, the schemes take on the look of an institution rather than an extra care housing community. The current referral process does not contribute to preventing or delaying care needs. Successful schemes design their referral process to achive a balance of care needs amongst tenants with the purpose of promoting community living within an ethos of independence and reablement[9].

[9] Darton, R., Baumer, T., Callaghan, L., et al, (2012) The characteristics of residents in extra care housing and care homes in England. *Health and Social Care in the Community* 20(1), 87-96.

5 Estimating future demand

5.1 The overall population of Bolton is expected to rise from 284,167 in 2017 to 293,887 in 2025[10]. Because extra care housing is primarily for older people, table 2 presents the population projection age for the period 2017-2025. Tables 3 and 4 examine population growth by disability in 2017 and 2025[11].

Table 2: population projection by age

Bolton Population Projections 2017-2024 by Age									
	2017	2018	2019	2020	2021	2022	2023	2024	2025
55+	81,452	82,758	84,259	85,798	87,295	88,788	90,228	91,634	92,991
55-64	32,424	32,976	33,716	34,553	35,338	35,903	36,394	36,793	37,118
65-74	28,049	28,120	28,171	28,237	28,281	27,750	27,517	27,565	27,805
75-84	15,307	15,911	16,545	16,989	17,461	18,740	19,623	20,229	20,753
85+	5,672	5,752	5,827	6,020	6,215	6,395	6,693	7,046	7,316
Total	162,904	165,517	168,518	172,097	174,590	177,576	180,455	183,267	185,983

Table 3: Population growth by disability 2017

Bolton 2017				
Condition	All	50+	60+	75+
Physical Impairment	48,308	23,264	24,934	11,329
Sensory Impairment	19,892	9,103	12,787	7,552
Dementia	2,842	2,023	2,557	1,259
Severe Mental Health	5,683	2,023	639	1,259
Mild/Moderate Mental Health	25,575	8,092	2,557	839
Learning Disabilities	5,683	1,011		
Long Standing Illness	65,359	29,333	21,738	5,245
Other	31,258	14,161	10,869	3,357
None	144,925	40,459	15,984	3,147
Total	349,525	129,469	92,065	33,987
Percentage of total population		37%	26.3%	9.7%

[10] Office for National Statistics, Mid-Year Estimates 2016. Crown Copyright. Data is rounded to the nearest hundred.

[11] Office for National Statistics, 2014-based Subnational Population Projections. Data is rounded to the nearest hundred.

Table 4: Population growth by disability 2025

Bolton 2025				
Condition	**All**	**50+**	**60+**	**75+**
Physical Impairment	49,961	25,522	28,798	15,157
Sensory Impairment	20,572	9,987	14,768	10,105
Dementia	2,939	2,219	2,954	1,684
Severe Mental Health	5,878	2,219	738	1,684
Mild/Moderate Mental Health	26,450	8,877	2,954	1,123
Learning Disabilities	5,878	1,110		
Long Standing Illness	67,594	32,180	25,106	7,017
Other	32,328	15,535	12,553	4,491
None	149,883	44,386	18,460	4,210
Total	361,483	142,035	106,331	45,471
Percentage of total population		39.3%	29.4%	12.6%

5.2 Those with physical impairments show a rise of 2,258 for the 50+ and rise of around 3,800 for the 60+ and 75+ groups.

5.3 Those with sensory impairments show a steady rise in all the age groups, particularly those in the 75+ group.

5.4 Those with long standing illnesses rise for the over 50s and then falls for the over 65s and drops sharply for those over 75. Similarly, non-defined illnesses (classified as other) peaks for the over 55s at 1,374 but dips for the older age groups. The meanings of long standing and non-defined illnesses lack precision to plan a strategy around extra care housing for this group. They may be better suited in other forms of housing provision.

5.5 Although the numbers are small overall, as expected, the numbers of those with dementia rise with age.

5.6 In the mild/moderate mental health group, the projected rise is small but the numbers (over 8000) are significant for the over 50s but declines markedly for the over 60s and the over 75s.

5.7 Whilst it is expected that mortality will increase with age, there is a marked decline in population of those aged over 75 (Table 2) As a percentage of the total population of those with care needs, the over 75s population decreases significantly than those in the over 55 and over 65 age bracket (Tables 3 and 4). Therefore, it is proposed that this strategy should prioritise those in the 65-75 age bracket for extra care housing. Currently, the average age of entering residential accommodation in Bolton is round 83[12].

[12] 2016-2017 in Bolton – Liquid Logic information system.

Life expectancy in a residential accommodation is relatively short[13]. Therefore, extra care housing if provided sufficiently early can make a valuable contribution to keeping people within the community and reducing levels of admission into residential care.

Local needs

Numbers

5.8 The Housing Needs Survey 2016 suggests that 64.2% of older households (30,816) want to stay in their own homes with support. Estimates suggest that 25.6% (12,288) would consider moving to sheltered accommodation and 17.6% (8,448) would consider extra care housing schemes. Currently, there are 320 places within the ten Bolton extra care housing schemes.Without additional schemes, there is a likelihood that domiciliary care numbers will increase.

5.9 Currently, 67% of people in Bolton who use domiciliary care are over 75 and 84% are over 60[14]. It is likely that if there is insufficient accommodation for those that want to move, there will be a noticeable increase in domiciliary care, which given the current resources may become unsustainable.

5.10 The clear and recognisable answer is for additional purpose-built extra care housing schemes.

Location

5.11 One of the aims of an extra care housing scheme is to allow the tenant to maintain relationships with family, friends and the local community[15]. Consequently, locations of these schemes will need to take account of the current concentrations of older people with care needs – see table 3 above and Figure 3 below.

5.12 The highest levels of care needs are located within areas of most deprivation. Therefore, purpose built schemes could be be located near the town centre, Tonge, Breightmet, Deane, Derby, Daubhill and Great Lever. Additionally, more affluent areas where extra care schemes could be located are, Heaton, Lostock, Smithhills, Horwich, Blackrod, Westhoughton, Chew Moor and Over Hulton.

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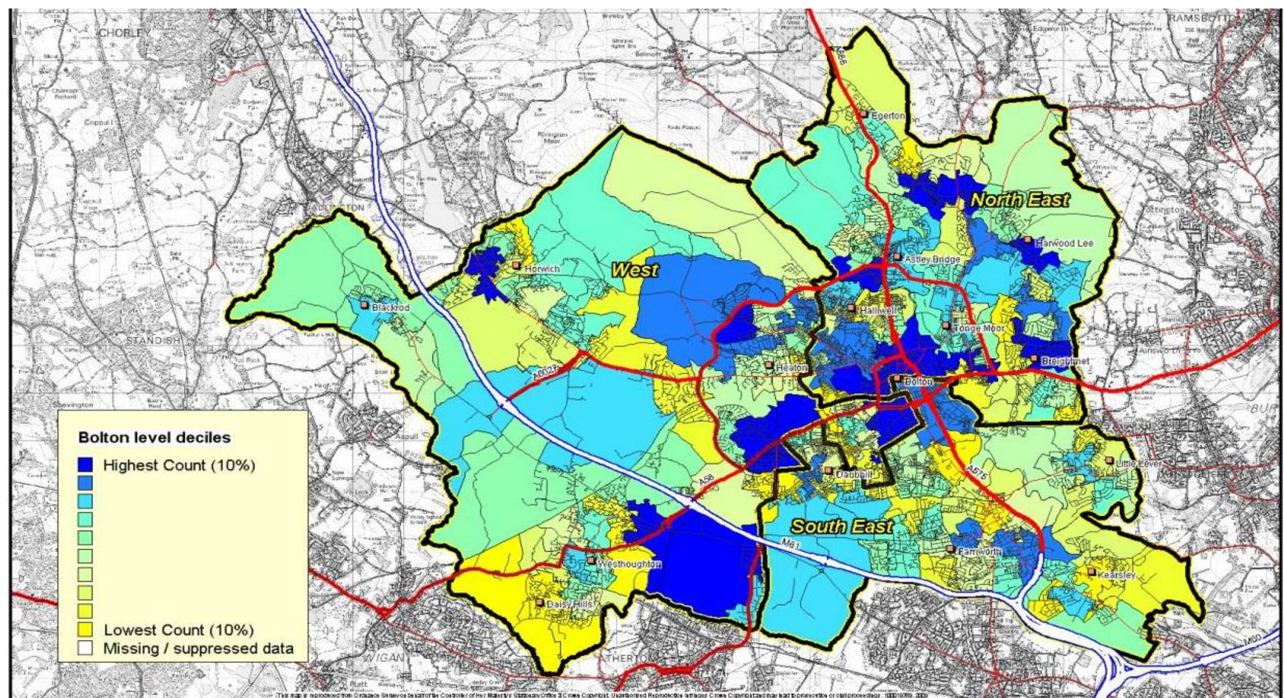
[13] Forder, J and Fernandez, J-L (2011) *Length of stay in care homes*, Report commissioned by BUPA Care Services, PSSRU Discussion Paper 2769, Canterbury: PSSRU

[14] Bolton Home Care Data 2011

[15] Healthy Ageing Evidence Review *Age UK* 2014 ; European Scaling Up Strategy, *European Commission*, 2015

Figure 3: Concentrations of the over 65s with care need in Bolton.



5.13 Further analysis shows there are particular pockets of the population located in more affluent areas such as Bradshaw, Bromley Cross, Heaton, Horwich (north east) and Farnworth, where the numbers of people living with dementia is predicted to grow.

5.14 The sheer weight of evidence suggests that to cope with the expected population growth in older people, Bolton council will need to build new extra care housing schemes or adapt and convert exisiting suitable properties at the earliest opportunity. The 2016 Household Survey estimates that 8,448 older households would consider extra care housing.

5.15 A review of the evidence from successful schemes advises that a new scheme should be approximately 60 units. Larger schemes can contribute to staff being unresponsive because they cannot cover the whole building. Smaller schemes do not have the economies of scale to be financially viable and may not allow the right balance of tenants with varying care needs to promote community living. Putting this into context, in excess of 100 schemes of 60 units would be required to satisfy current demand.

5.16 For prospective tenants, the factors affecting the actual demand for extra care housing for those with a social care need are[16]:

- Relative wealth of the population;
- The way in which the needs of people with lower care needs are met including the use of assisted technology;

[16] Bolton, J., (2016) Predicting and managing demand in social care. *Institute of Public Care.*

- The approaches taken towards greater independence for those with long-term conditions;
- The way in which people with long-term conditions are helped to self-manage their conditions including dementia care;
- The availability and the nature of supported housing services; and
- The availability of the type (bungalow, flat), quality (purpose built or care home architecture/furniture) and location (deprived or affluent area).

6 Consultation with stakeholders

6.1 Each of the 10 schemes was visited by the author and the operational manager of Bolton Cares. Discussions were held with tenants, the landlord scheme manager and care staff. Additionally, we consulted with social workers and social work managers separately.

Key points from tenants

- Whilst some of them had come to visit the scheme before taking up a place, the full extent of what was available was not made clear because they only talked with the landlord not the care staff. In some schemes, expectations from tenants about care provision were not managed well.
- Care staff and landlord staff often work in isolation from each other.
- As the landlord representative was not always on site, some tenants approached the care staff. This led to care staff dealing with non-care related matters. This was of particular importance at weekends when landlords are not present at any of the schemes.
- Support in forming an active tenants association was not always available from staff. Some tenants would have favoured landlords being more active in encouraging tenants in joining in activities. Some tenants said that landlords were often not at the meetings, and often did not produce minutes as requested
- Whilst tenants were generally in favour of the ideal model of extra care housing, some tenants liked the approach of how care was provided and did not want to change, even though the delivery of care appeared institutional, such as scheduled tea rounds and activities that were timetabled by staff rather than tenant groups.

Key points from social workers and social work managers

- Due to their experience of Bolton extra care housing schemes, most professionals misunderstood how these schemes were meant to work.
- Some thought that extra care housing was for high level care needs but others thought it played a role in re-ablement and prevention.

- Whilst there was agreement about having a balance of differing care needs, some thought that all care needs should be unconditionally accepted but others said that community living could only be achieved by implementing a threshold system for admission to avoid the current institutional look.

Each of the stakeholder groups were asked to comment on the desirable features of a purpose built extra care housing scheme.

- All stakeholders wanted safety. Many said that being frightened to open their front door prompted a move to extra care housing. They saw a 24/7 emergency service as essential to their safety.
- Whilst there was agreement that these schemes should be for the over 55s, some social workers and their managers believed that the schemes might be suitable for younger adults with disabilities, especially as an alternative to going into residential accommodation.
- There was unanimous approval that all the units in these schemes should self contained accommodation which incorporated technology enabled care that was hardwired into the fabric of the building so that it can develop with an individual’s care needs. Moreover, these rooms ought to be sufficiently large to accommodate couples and mobility equipment.
- It was essential amongst stakeholders that there was emotional support at times when tenants felt lonely or needed encouragement. They saw staff proficiency as important to balance the need to be responsive to the changing needs of tenants as well as enabling an ethos of independence and enabling a vibrant community living.
- There was consensus for extra care housing schemes to be part of the community by providing co-location opportunities. Successful schemes have a combination of restaurants, GP surgeries, pharamcies, day centres, meeting rooms and well- being suites.
- All stakeholders supported the notion of ensuring a balance of care needs within the schemes that promoted vibrant community living.
- Other comments are given in tabular form at appendix1.

7 Other considerations

Technology enabled care

7.1 Technology enabled care is essential to any new Bolton extra care housing scheme. Each unit can be configured according to the individual tenant's level of need of. Such smart technology will allow those with more intensive needs to continue to be accommodated instead of being moved out. It is expected that a purpose-built extra care scheme will include features which will address the specific needs of those with visual, physical and sensory deficits as well as being designed to be dementia-friendly. Such purpose-built extra care housing schemes will comply with the HAPPI (Housing our Ageing Population Panel for Innovation) and the King's Fund Dementia Friendly standards.

Commercial and co-location opportunities

7.2 The difficulty for some tenants in extra care housing schemes is accessing the community. Research strongly suggests that communal facilities promote community living, especially where tenants are frail or have ambulatory or sensory needs that prevent them from going out into the community[17]. Typical commercial opportunities range from but are not confined to restaurants, hairdressers, florists and convenience shops.

7.3 Co-location opportunities of the extra care schemes examined for this report included a dementia Day Centre, NHS mental health teams, therapy rooms and gymnasium studios for exercises.

Delivery of care

7.4 Nationwide, there has been a shift towards outcome based objectives for the delivery of care. This shifts the focus to people's wellness and reflects on the value delivered by care providers rather than the activity undertaken. As the nation's older population is set to grow by around 50% in the next 25 years, an increasing number will be living longer with long-term and often, multiple conditions[18]. The focus must be on enabling and supporting people to live as long as possible whilst ensuring that their quality of life and effectiveness of care is outstanding.

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[17] Housing Learning and Improvement Network (2003) *extra care Strategic Developments in North Yorkshire.* Case study No 1. Housing Learning & Improvement Network, Health and Social care Change Team, DOH, London.

[18] Office for National Statistics, Mid-Year Estimates 2016

8 Specific recommendations

Project implementation group

8.1 To undertake delivery of this strategy, it is proposed that a project implementation group be set up. Given the stakeholders identified in this paper, the group should consist of representatives from

- Bolton Council's Commissioning, Finance and Quality teams
- Social care
- Health
- Bolton Cares
- Landlords

The terms of reference can be discussed amongst the group using this paper as a guide.

Delivery of care

8.2 It is proposed that the delivery of care be revised from the time and task model to accommodate outcome based objectives. A new care plan will be developed that is consistent with personalised care and looks at outcomes for individual tenants. Personalised delivery of care will be trialled in one scheme. The project implementation group will examine the lessons learned from the trial and will look at ways of implementing personalised care delivery in the other schemes untill all ten operate in this way.

Staffing: Care giving team and Response team

8.3 To accommodate personalised care delivery and planned care delivery over a 24 hour period, the most successful schemes have a staffing structure with two functions. It is therefore, proposed that the care provider, Bolton Cares will operate a team with two functions so that there is an active 24/7 staff presence. The two functions will be a Care Giving team and a Response team. This will enable staff to respond flexibly to the changing needs of tenants and give emotional and practical support, which is a central feature of extra care housing. Importantly, this is a feature that was universally acclaimed by all stakeholders during the consultation process.

Care Giving team

This team will be responsible for meeting the assesed eligible needs of tenants during the day shift. Support will be delivered based on objectives agreed with the tenant. The numbers of this team can be increased and reduced depending on demand. Ensuring sufficient staffing will be an operational matter.

Response team

The role of the team members will include:

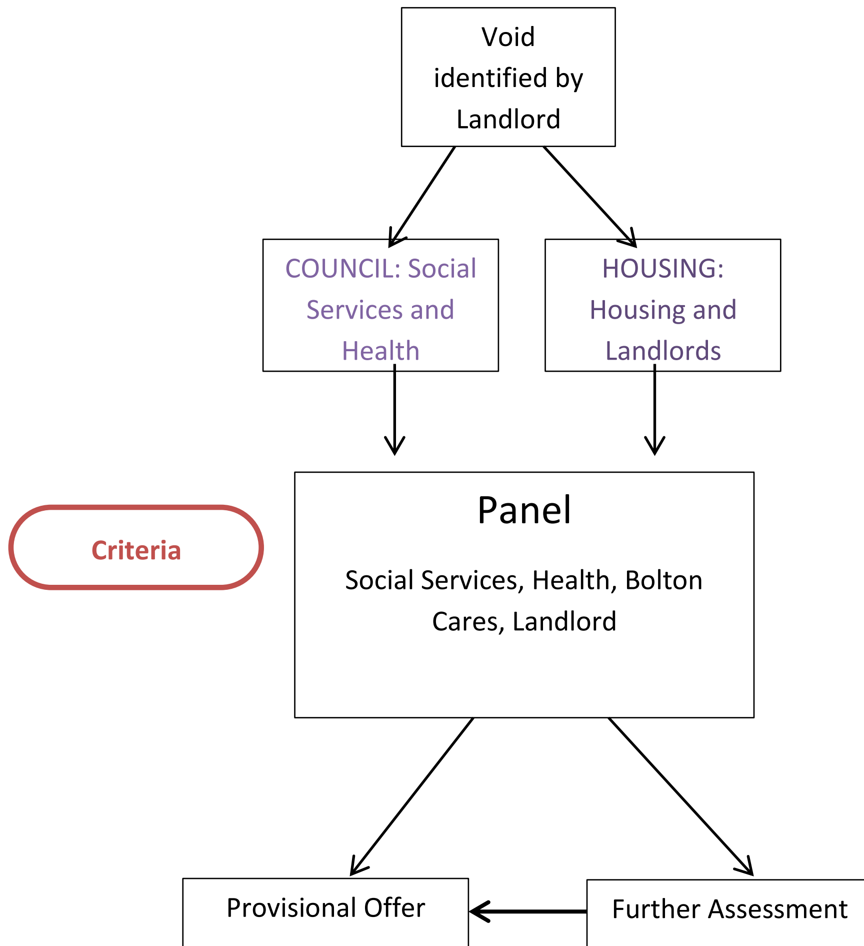
- 24/7 presence within the scheme
- Responsibility for health and safety of tenants in partnership with the landlord;
- Support with moving-in;
- Security checks and proof of life checks;
- Emergency response – to pendant calls;
- Responsive to telecare calls such as falls alarms, door sensors, motions sensors or bed sensors;
- Additional short–term care (tenants who are unwell–coughs and colds; following a fall, administering medication).This will reduce the pressure on care management to review cases and prevent hospital admissions;
- Support tenants to access events including enabling tenants to participate in groups and activities;
- Support to participate in leisure and community activities;
- Emotional support (prevent deterioration and promote well-being and independence);
- Liaison with professionals – GPs, pharmacists;
- Supporting the tenants association and community groups; and
- Undertaking night time eligible care needs

It is expected that the response team and the landlord team will work colloboratively for the tenants' benefit. The project implementation group is expected to oversee the working arrangements.

8.4 Referral process

It is evident from this report that the Bolton schemes are not consistent with features found in successful extra care housing schemes. A new design is needed to manage access into the Bolton schemes. One such used by successful schemes is where access is controlled by a Panel consisting of representatives from care management, the care provider and the landlord. They work collegiately to ensure that there is a balance of care needs amongst the global population within a scheme to promote community living. Research suggests that the model in figure 4 may be suitable.

Figure 4: Suggested referral process



The nomination process will be extended to the landlords/housing. A panel will consider referrals. A criteria will be applied and a decision will be reached in a collegiate manner. Indicative criteria might be:

- Preserve the balance of tenants to promote community living
- Can the care needs of the prospective tenant be addressed?
- Can the prospective tenant participate in community living, with assistance?
- Is the prospective tenant likely to be disruptive?

9 How Bolton will implement this strategy

9.1 A Project Implementation Group will be established to oversee the implementation of this strategy. This will involve working corporately with Bolton Cares, Bolton at Home, Anchor and Places for People. Additionally, we will closely with the Telecare Enabled Care Strategic Group and social care and health colleagues and the Quality team.

9.2 Extra care housing will take a central role with the continuing integration of health and social care. Therefore, commissioners and practitioners who support individuals and familes will consider extra care housing schemes a choice amongst other housing provision.

9.3 A new referral model will be implemented,which will ensure that extra care housing schemes attract a tenant population with a range of care needs (or none) to promote community living. This will be undertaken on a scheme by scheme basis.

9.4 The Project Implementation Group will oversee the implementation of care delivery on an outcome basis rather than the current time and task model. We will work closely with Bolton Cares and Bolton Council's Quality Assurance Team.

9.5 We will implement this model to the exisiting extra care housing schemes in a phased manner. The model described in this strategy will be most effective within a new purpose-built extra care housing schemes.

9.6 The Project Implementation Group will oversee the change management process and modify plans according to the lessons learned – see table 6.

Table 6: Implementation of change strategy in extra care housing schemes

Step	Task
Creating urgency – open and honest communication to obtain buy-in.	Discuss models of extra care housing with stakeholders. This will include an analysis of strengths, weaknesses, threats and opportunities. Using what if-scenarios, and third parties from existing schemes to demonstrate the benefit of extra care housing.
Forming coalitions – leading not managing change	Identify significant leaders within the stakeholders. Get emotional commitment to the new model. Team building within coalitions ensuring that weaker members are given a voice to express their views
Create the vision	Link the views of individuals to the overall model of extra care housing. Determine the values required for change (particularly personalisation and tenant involvement). Create an implementation plan with stakeholders for the implementation of the strategy. Good place for configuring Mission/Vision statements.
Communicating the vision – saying it loud and proud	Talk often about the vision with stakeholders. Address their anxieties. Imbed the vision to all aspects of the performance management including commissioning intentions and performance reviews.
Removing obstacles	Put in place the structure for change, and continually check for barriers to it. This can be achieved by (a) Identifying, or hiring change leaders whose main roles are to deliver the change.; (b) Look at the organisational structure, job descriptions, and performance and compensation systems to ensure they're in line with your vision. (c) Recognising and rewarding people for making change happen. (d) Identifying people who are resisting the change, and help them see what's needed. (e) Taking actions to quickly remove barriers (human or otherwise).
Creating short term wins	Carefully analyse where change is likely to happen. Choose tasks that are inexpensive and can be undertaken without strong critics and can motivate staff.
Building on change	Analyse successes so that they can be repeated. Set new goals and process of continuous improvement. Create momentum by talking with stakeholders about successes.
Anchoring change	Advertise successes. Include change ideals when hiring new staff. Publicly recognise good staff. Ensure key leaders are replaced to continue the legacy.

10 Commissioning intentions – We will:

10.1 Ensure that extra care housing will be at the heart of how we manage older people's housing aspirations. The method of care and support delivered by Bolton in these schemes will match that found in the most successful extra care housing schemes. The management of the health and well-being of our tenants will be a model for others to follow;

10.2 Implement a continuous review and excellence programme in partnership with Bolton Cares and health and social care as well as the landlords;

10.3 Work in partnership with care management to ensure that practitioners and managers understand the role of extra care housing amongst other care and housing provision;

10.4 Plan for a number of new schemes to accommodate the rise in demand. A review of the evidence suggests that a new scheme should be approximately 60 units. Larger schemes can contribute to staff being unresponsive because they cannot cover the whole building. Smaller schemes do not have the economies of scale to be financially viable and may not allow the right balance of tenants with varying care needs to promote community living;

10.5 Ensure that new purpose built extra care housing schemes provides value on the basis of the triple bottom line[19] by achieving:

- excellent social outcomes where tenants needs are met and their outcomes contribute towards greater well-being, stronger social networks, improved physical health and greater autonomy;
- environmental outcomes such as ensuring the use of green spaces, reducing waste and using renewable energy; and
- economic outcomes that offers value for money for tenants, a positive impact on the local ecomomy and good quality jobs, training leading to a skills uplift.

10.6 The council will be obligated to fund the response crew as a fixed cost that is known in advance. The cost of the care giving staff will vary according to the care hours delivered. This may be funded in arrears by invoice as currently undertaken for domicillary services. Alternatively, to create certainty for the care provider and the council, a balance of care needs with a threshold might be agreed in advance. This will allow care hours and funding to be fixed. The benefit of this method is that new payment systems do not need to be created. There will be flexibility to allow the care providers to manage peaks and troughs in demand around an agreed threshold. Any deviations are envisaged to be short term variations as the balance of care needs will be actively managed by the referral process.

[19] Social, environmental and economic benefit

Action Plan

Outcomes	Start	Led by	Task	Update	Review
PLANNING					
Ensure that cost is less or neutral than current schemes.		Bob Charles	Undertake indicative costing review		
IMPLEMENTATION					
Deliver personalised care		Bob Charles Project Implementation Group	Develop a pro forma with care management, commissioning , Quality team and care providers for objective based care. Role out program of personalised care in one scheme. Using lessons learned, roll out in other schemes in a phased way.		
Balance of care needs in schemes			Implement new referral procedure		
New staffing arrangements are delivering care and support			Appoint new Care Giving and Response team.		
EVALUATION					
Quality of life		Quality team and Bolton Cares	Modify current questionnaire, using Likert scale to confirm improved quality of life.		
Quality of care		Quality team and Bolton Cares	Assess quality of care through bespoke questionnaire.		
Effectiveness of care		Bolton Cares	Assess quality of care through bespoke questionnaire. Personalised delivery of care to tenants to include their subjective		

			experiences. This will include both a hedonic and eudaimonic dimensions.		
AUDIT					
Balance of care needs in schemes			Check how the new Panel system works and modify to suit.		
Smooth working arrangements between Care Giving Team, Response Team and Landlord Team			Hold regular meetings between the Teams to iron out difficulties		

Appendix 1: Design features from stakeholders

Design features from published research	Design features from Scheme tenants	Design features by social work managers and social workers	Design features by landlords
Independent living that is safe and secure	✓	✓	✓
Primarily for older people (55/65)	✓	✓ Some thought the schemes should be open to younger adults with disabilities.	✓
Self-contained accommodation (single/doubles)	✓ Tenants wanted doubles for couples and to allow room for mobility equipment.	✓ Large rooms sufficient to take mobility aids.	✓
Communal services/facilities including a reception	✓	✓	✓
24/7 emergency on-site response service	✓	✓	✓
Vibrant community living – balance of tenants' care needs	✓	✓	✓
Planned care interventions delivered flexibly and sensitively	✓	✓	✓
Responsive to the changing needs of tenants	✓	✓	✓
Ethos of independence	✓ Emphasis on reablement.	✓	✓
Emotional support for tenants on a 24/7 basis	✓ This was separate from assessed eligible care needs. It included the ability to talk with tenants informally especially at night.	✓ Social workers/managers expressed the tension between this and assessed eligible needs. Many thought that emotional support should be an eligible need.	✓
Partnership working with families and friends	✓	✓	✓
Mixed equity and rented accommodation	Manor Gardens was the only scheme with equity holders. Some felt that they did not appreciate the implications of buying into the scheme. Tenants at other schemes said that there should only be rented accommodation.	Social workers were undecided about equity schemes because of the experience of those in Manor Gardens and the need for having schemes in areas where there are high levels of deprivation making equity schemes unaffordable.	Landlords were divided about equity schemes, specifically about how they work in practice. They thought, in practice, rented units are the best idea.
Use of technology enabled care	✓ Alarm cords and CCTV in communal areas.	✓	✓
Community resource: GP, Pharmacist, subsidised restaurant, hairdresser	✓ Other facilities should include a bar, shop, swimming pool and hydrotherapy.	✓	✓
Suitable for most service users with exceptions	✓	Allocation panel approach. Decision to use the in-house care agency and adhere to the community aspect of the scheme **before** accepting a place in extra care housing	✓