

ADULT SERVICES COMMITTEE AGENDA



12 August 2013

at 10.00 am

in Committee Room B, Civic Centre, Hartlepool

MEMBERS: ADULT SERVICES COMMITTEE

Councillors Fisher, Hall, A Lilley, Loynes, Richardson, Shields and Sirs

1. APOLOGIES FOR ABSENCE

2. TO RECEIVE ANY DECLARATIONS OF INTEREST BY MEMBERS

3. MINUTES

- 3.1 To receive the Record of Decision in respect of the meeting held on 15 July 2013 (*attached for information*)

4. KEY DECISIONS

No items

5. OTHER ITEMS REQUIRING DECISION

No items



6. ITEMS FOR INFORMATION

- 6.1 Extra Care Evaluation 2013 – *Assistant Director, Adult Services*
- 6.2 Tender for the Provision of Low Level Support Services – *Assistant Director, Adult Services*

7. ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS URGENT

ITEMS FOR INFORMATION

Date of next meeting – 9 September 2013 at 10.00am in the Civic Centre, Hartlepool



ADULT SERVICES COMMITTEE DECISION RECORD

15 July 2013

The meeting commenced at 10.00 am in the Civic Centre, Hartlepool

Present:

Councillor: Carl Richardson (In the Chair)

Councillors: Keith Fisher, Brenda Loynes, Linda Shields and Kaylee Sirs

Also Present: Steve Thomas, Health Watch

Officers: Neil Harrison, Head of Service, Adult Social Care
Trevor Smith, Performance and Information Manager (Adults)
Denise Wimpenny, Principal Democratic Services Officer

18. Apologies for Absence

Apologies for absence were submitted on behalf of Councillor Ged Hall, Jill Harrison, Assistant Director and John Lynch.

19. Declarations of Interest

None.

20. Minutes of the Meetings held on 21 May and 17 June 2013

Received. The Chair requested that future agenda documentation should include a copy of the minutes of the previous meeting for information purposes.

21. Adult Social Care Outcomes Framework *(Assistant Director, Adult Services)*

Type of decision

For information only

Purpose of report

To provide the Adult Services Committee with an overview of the Adult Social Care Outcomes Framework (ASCOF) – the national reporting regime for adult social care.

Issue(s) for consideration

The report provided background information to the introduction and purpose of ASCOF. Details of the structure of ASCOF, a summary of the measures linked to the outcomes and domains together with details of data collection measures were provided as set out in the report.

With regard to Hartlepool's performance, Members were advised that Hartlepool recently received positive feedback from the Adult Social Carers Survey with over 92% of carers reporting that they had been included or consulted in discussion about the person they cared for and almost 85% of carers reported that they found it easy to find information about services.

In the discussion that followed the benefits of receiving information by number as well as by percentage were highlighted. The Performance and Information Manager stated that the reasons the information was provided in percentage terms was to comply with certain performance standards and to enable comparators to be made with other local authorities. Comparative regional performance data against the ASCOF measures would be collated during June and July and shared at a future meeting of this Committee. The Health Watch representative referred to a recent presentation regarding the process provided by the Performance and Information Manager and feedback received indicated that whilst the document included good useful information, it was considered that the information could be presented in a clearer format.

With regard to early feedback from the Adult Social Care Survey, the Health Watch representative was keen to establish the reasons as to why only 76% of respondents had indicated that the services they had used made them feel safe and secure. The Committee was advised that this issue could be examined in further detail once all responses from the Adult Social Care Survey had been received.

The Health Watch representative provided initial feedback from the consultation process with residents and their work with users of domiciliary care (home care). Whilst overall the vast majority of feedback was good some concerns had been raised regarding the following:-

- the number of different carers people received was too high and an example was provided in relation to one particular individual who had received visits from 18 different carers in one week.
- the length of visits by carers particularly to outlying villages was too

short resulting in some tasks not being completed and impacting on the quality of care provision.

The Health Watch representative indicated that the final report from Health Watch would be available to Members in October 2013.

Decision

The Committee noted the report and the use of the Adult Social Care Outcomes Framework (ASCOF) to measure performance in adult social care.

22. Winterbourne View Stock Take (*Assistant Director, Adult Services*)

Type of decision

For information only

Purpose of report

- (i) To provide the Adult Services Committee with an update on actions identified following publication of the Winterbourne View Hospital report and Concordat (December 2012) to provide assurance of collaboration between health and the local authority.
- (ii) To provide an update and stock take as requested by Chris Bull, Chair of the Winterbourne View Joint Improvement Board (NYHS England and Local Government Association).

Issue(s) for consideration

The report provided an update on actions identified following publication of the Winterbourne View Hospital report and Concordat (Dec 2012) to provide assurance of collaboration between Health and the Local Authority. The Department of Health review had responded to criminal abuse at Winterbourne View hospital revealed by the BBC Panorama programme in May 2011. The main actions identified for commissioners through the review and concordat were outlined in the report.

A letter received from Chris Bull, Chair of the Winterbourne View Joint Improvement Board, had asked Clinical Commissioning Groups (CCG's) and Health and Wellbeing Boards to assess their progress against commitments in the Concordat and to allow for good practice and progress from local areas to be shared nationally. A copy of the letter had been

appended to the report together with a copy of the report presented to the Health and Wellbeing Board on 24 June 2013 which provided an update on progress and a local stock take.

It was proposed that a joint plan would be developed once the individual patient requirements were known. Members were referred to the risk implications and financial considerations as detailed in the report.

The Head of Service, Adult Social Care responded to questions raised by Members in relation to financial responsibilities and service provision arrangements. Assurances were also provided regarding the safeguarding and inspection and monitoring processes already in place between the CCG and the Local Authority to ensure the appropriate standards of care were provided for these patients.

Decision

The Committee noted the report and assurances that plans were in place to work collaboratively between the Clinical Commissioning Group and the Local Authority to develop long term solutions for these patients.

The meeting concluded at 10.35 am.

P J DEVLIN

CHIEF SOLICITOR

PUBLICATION DATE: 22 JULY 2013

ADULT SERVICES COMMITTEE

12 August 2013



Report of: Assistant Director, Adult Services

Subject: EXTRA CARE EVALUATION 2013

1. TYPE OF DECISION/APPLICABLE CATEGORY

No decision required, for information.

2. PURPOSE OF REPORT

2.1 To inform members of the results of the Extra Care Evaluation 2013.

3. BACKGROUND

3.1 There are five extra care schemes within Hartlepool which offer 457 units of accommodation. These extra care schemes are Hartfields, Laurel Gardens, Albany Court, Richard Court and Bamburgh Court. The creation of the extra care housing schemes was to provide an alternative housing option for older people rather than the more traditional sheltered housing or residential /nursing care homes.

3.2 Extra care housing is a concept which consists of several key elements, which may include:

- Self-contained accommodation (flats or bungalows);
- Care and support staff on site;
- Care delivered flexibly;
- Catering and communal facilities which may include restaurant, lounge, activity rooms, library, and health suite;
- Social activities;
- Appropriate level of care for tenants based on individual assessments and care plans;
- It is primarily for older people; and
- It offers security of tenure for all residents regardless of whether they own or rent their property.

3.3 Extra care housing is designed to enable people to continue to be as independent as possible. It provides on site care and support services to

enable people to improve or maintain their independence. The whole ethos underpinning extra care housing is to maintain and improve a person's ability to remain independent within their own property and where possible to provide a home for life.

- 3.4 The overall aim of the evaluation was to evaluate to what extent extra care is effective as a means of long-term housing and care provision for older people. Within this aim there were five objectives:
1. Assess if extra care has reduced the use of residential placements;
 2. Assess if there has been a reduction in the level of care provided to users within extra care;
 3. Assess whether extra care maintains or improves an individuals' independence;
 4. Does extra care improve the quality of life for individuals within the schemes? and
 5. Do current working practices support the ethos of extra care?
- 3.5 This review did not attempt to evaluate the financial cost effectiveness of extra care and therefore did not include any cost estimates or financial evaluations.
- 3.6 A number of methods were used to evaluate the extra care schemes, which included:
- Resident Questionnaires;
 - Staff Questionnaires (Hartlepool Borough Council, Comfort Call and Joseph Rowntree Housing Trust)
 - Case Tracking; and
 - Statistical Data.

4. RESULTS OF THE EVALUATION

- 4.1 This evaluation (attached at **Appendix 1**) found that extra care housing is an effective way of providing housing and care for older people.
- 4.2 This evaluation found that:
- The number of residential placements has very slightly decreased since 2008, although this is not significant;
 - Overall, 269 people with care have entered into extra care and 228 (85%) either maintained or reduced their overall care levels. Only 15% of residents increased their care levels overall;
 - The average length of stay in extra care was only 1.8 months shorter than residential care;
 - In 57% of cases residents only exited from extra care on passing away, however 39% of residents left extra care due to a move to residential or nursing care;
 - Residents reported high satisfaction with extra care;

- The main things residents liked about extra care were social elements, care and support, and their own environment or property; and
- The main things that residents did not like about extra care all related to physical environment and included building maintenance and locations of schemes.

5. NEXT STEPS

- 5.1 This service evaluation of extra care has made a number of recommendations that all partner organisations will need to address. The Extra Care Strategy Group is comprised of all the extra care partner organisations and will be responsible for the development and the implementation of an action plan. This action plan will be reviewed annually and will address the recommendations made in the extra care evaluation.

6. RECOMMENDATIONS

- 6.1 The Adult Services Committee is asked to note the Extra Care Evaluation 2013.

7. REASONS FOR RECOMMENDATIONS

- 7.1 Following the report being considered by the Adult Services Committee, work will begin on an action plan to take forward the recommendations within the evaluation.

8. CONTACT OFFICER

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Hartlepool Extra Care Evaluation 2013

Hartlepool Borough Council
Child and Adult Services



Executive Summary

There are five extra care schemes within Hartlepool which offer a total of 457 units. This extra care evaluation has examined whether these extra care schemes offer an effective means of providing long-term housing and care provision for older people.

A number of methods were used to evaluate the extra care schemes, which included:

- Resident Questionnaires;
- Staff Questionnaires (Hartlepool Borough Council, Comfort Call and Joseph Rowntree Housing Trust);
- Case Tracking; and
- Statistical Data.

This evaluation found that extra care housing is an effective way of providing housing and care provision for older people.

This evaluation found that:

- The number of residential placements has very slightly decreased since 2008, although this is not likely to be significant;
- Overall, 269 people with care have entered into extra care and 228 (85%) either maintained or reduced their care levels overall. Only 15% of residents increased their care levels overall;
- The average length of stay in extra care was only 1.8 months shorter than residential care;
- In 57% of cases residents only exited from extra care on passing away, however 39% of residents left extra care due to a move to residential or nursing care;
- Residents reported high satisfaction with extra care;
- The top things residents liked about extra care were social elements, care and support, and their own environment or property; and
- The top things that residents did not like about extra care all related to physical environment and included building maintenance and locations of schemes.

The evaluation has only looked at a five-year period, during which not all extra care schemes were in operation. It would therefore suggest there is further evaluation required to assess the longer-term effectiveness of extra care.

This review does not include any financial analysis so the financial cost effectiveness of extra care will need to be examined separately.

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1. Introduction

The greatest challenge to face our society over the next thirty years is that of an aging population. Nationally the number of people aged over 65 years will increase from approximately 9.5 million in 2012 to nearly 13 million in 2030. This is a 43% increase in the number of older people aged 65 years and over. As a result, by 2030 25% of the population in England will be over the age of 65, compared to 19% now¹.

At present 30% of households are older households; this is where the main householder is someone over retirement age. By 2026, approximately 50% of household growth will be older households². It will be necessary to ensure that services adapt and provide for our growing aging population.

As the older population increases so too will the number of people suffering from age related illness such as dementia, disability or reduced mobility, and other long term limiting illnesses.

In 2010, the government published **A Vision for Adult Social Care: Capable Communities and Active Citizens** which set out prevention as one of the seven principles. The principle of prevention sets out to empower communities and people to work together to maintain their independence, if state intervention is required, it should seek to regain and retain people's independence³.

A key requirement to enable independence is to have appropriate accommodation that suits an individual's needs. Access to good housing is a key priority for a person's health and wellbeing⁴. Appropriate housing can help to increase health and wellbeing and can lead to increased independence. On the other hand, unsuitable housing can lead to stress, anxiety, and can increase isolation, poverty, poor health and injury⁵. Unfortunately, as people grow older many of our homes and communities are not designed to meet their needs. We must therefore seek ways to create more suitable and appropriate housing options for older people to avoid being faced with more older people in housing that is not only unsuitable for their needs but may be having an adverse impact on their mental and physical wellbeing. Unsuitable housing may increase their social and health care needs, which may require higher state intervention.

¹ POPPI (2012) Projecting Older People Population Information System

² Department for Communities and Local Government, Department of Health, and Department for Work and Pensions (2008) *Lifetime Homes, Lifetime Neighbourhoods: A National Strategy for Housing in an Aging Society*

³ Department of Health (2010) *A Vision for Adult Social Care: Capable Communities and Active Citizens*

⁴ Marmot, M. (2010) *Fair Society, Healthy Lives: The Marmot Review*. Strategic Review of Health Inequalities in England Post 2010

⁵ Local Government Group (2010) *Good homes in which to grow old? The role of councils in meeting the housing challenge of an ageing population*

The majority of older people live independently within their own communities and many people are reliant on their own resources, preferring to stay in their own homes. Only 19% of over 85 year olds live in institutional settings⁶, it is therefore important that we continue to look at ways to support older people to live independently in their own homes.

Over the last decade there has been significant investment in extra care housing. This is a housing model which has predominantly been designed for older people featuring individual properties which all share key communal facilities and have access to care on site. Unlike residential or nursing care, residents in extra care schemes have a right of tenancy, regardless of whether they rent or purchase their property. A key feature of extra care housing that sets it apart from sheltered housing is the provision of care and support on site.

Nationally extra care housing has been found to help increase independence and quality of life for residents. Although it is not the only housing option for older people it is increasingly becoming more widespread with over 1,300 housing developments across the UK that offer care services⁷.

The motivation to move into extra care housing appears to be a positive choice by many who are looking for a more supportive and sociable environment, rather than a response to a crisis which often leads to a move into a care home⁸.

Within Hartlepool there are five extra care housing schemes which provide a total of 457 units of housing for older people. The creation of so many units of extra care housing was to provide older people with an alternative housing option to the more traditional sheltered housing or residential/nursing care homes. Another rationale was that it may help to reduce the number of people who move to residential or nursing care as it provided an alternative option. The first extra care housing scheme in Hartlepool was opened in 2008 and by 2011 all five existing schemes were in operation.

In order to continue to offer suitable housing options to older people it is necessary to review the current models to ensure that current schemes provide effective and appropriate housing and meet the needs of their residents.

⁶ Commission for Architecture and the Built Environment (2009) *Homes for our old age: Independent living by design*

⁷ <http://lin.housingcare.org/housing-care/search.aspx>

⁸ Netten, A., Darton, R., Baumker, T. and Callaghan, L. (2011) *Improving housing with care choices for older people: an evaluation of extra care housing*. PSSRU, Housing LIN

1.1 Aims and Objectives

The aim of this review is to evaluate to what extent extra care is effective as a means of long-term housing and care provision for older people

There are a number of objectives that will be explored:

1. Assess if extra care has reduced the use of residential placements;
2. Assess if there has been a reduction in the level of care provided to users within extra care;
3. Assess whether extra care maintains or improves an individuals' independence;
4. Does extra care improve the quality of life for individuals within the schemes? and
5. Do current working practices support the ethos of extra care?

Please note that this review will not attempt to evaluate the financial cost effectiveness of extra care and will therefore not include any cost estimates or evaluations.

2. Defining Extra Care

Extra care housing is a concept and may not have a clear-cut definition. Although there may be variation across different extra care housing schemes the following are the key elements within an extra care housing scheme^{9,10}:

- Self-contained accommodation, this may be flats or bungalows;
- Equipment for care;
- Care and support staff on site;
- Catering and communal facilities which may include restaurant, lounge, activity rooms, library, and health suite;
- Social activities;
- Appropriate level of care for tenants based on individual assessments and care plans;
- Domestic support;
- Provision of appropriate care packages 'to a high level' if required;
- Care can be delivered flexibly;
- It is primarily for older people;
- It aims to be a home for life, and to allow people to age in place; and
- It offers security of tenure for all residents regardless of whether they own or rent their property.

Extra care housing is designed to enable people to continue to be as independent as possible and to provide access to care and support services on site to help to maintain their independence¹¹.

The whole ethos underpinning extra care housing is to maintain and improve a person's ability to remain independent within their own property and where possible to provide a home for life. Unlike residential or nursing care, extra care housing provides an individual property to each resident with full tenancy rights as underpinned by housing law¹².

The aim of extra care housing in Hartlepool is to provide suitable housing for older people to enable them to improve or maintain their independence for as long as possible.

⁹ Netten, A., Darton, R., Bäumker, T. and Callaghan, L. (2011) Improving housing with care choices for older people: an evaluation of extra care housing. PSSRU, Housing LIN

¹⁰ Croucher, K., Hicks, L., and Jackson, K. (2006) *Housing with care for later life: A literature review*. Joseph Rowntree Foundation

¹¹ Housing LIN (2008) Factsheet 1: Extra Care Housing, What is it?

¹² Housing LIN (2008) Factsheet 1: Extra Care Housing, What is it?

3. Background

The population of Hartlepool is 92,000 with around 40,400 households¹³ and by 2030 the population is expected to rise to around 96,600¹⁴.

Within Hartlepool, there is a self-contained housing market with most people tending to remain in the borough, with only a small in-migration to new housing areas. In most areas the housing demand exceeds the supply with only 9% of the housing stock being bungalows. Furthermore, 58% of the housing stock was built before 1965 and around 40% of the existing stock is terraced housing¹⁵. This means that a significant proportion of the housing stock is not suitable for older people who may require adaptations, level access accommodation, or homes built to Lifetime Standards to accommodate their needs.

About a decade ago, it was identified that different housing options needed to be provided if we were to provide appropriate housing options for older people. At the time the majority of housing options consisted of the general housing stock, sheltered or warden control housing, small number of bungalows, bedsits, residential and nursing care.

The council's original 2004 Extra Care Strategy identified that whilst there were 1,166 units of sheltered accommodation in the town many of these were unsuitable for older people with a disability or care need. Further, with the high proportion of terraced housing, in particular with narrow steep stairs, and an increase in older people it was felt that the current housing options would not provide for the future needs of the older population in Hartlepool.

Analysis of the demand and need showed that by 2016 it was estimated that there would be 700 people in Hartlepool who would have needs that meet a residential/nursing care level. The Department of Health suggested that around a quarter of people cared for in residential or nursing homes could be supported within extra care housing.

Local consultation with older people showed that many people would prefer to stay in their own home and would rather choose a property in extra care housing than a place in a residential/nursing home. It was therefore proposed to build at least 200 units of extra care housing by 2016.

Over the last decade, Hartlepool Borough Council, working in partnership with housing providers, has been able to exceed the initial target and provide a total of 457 units of extra care housing within the borough. There are now five extra care schemes which range in size from 38 units to 242 units with a mixture of tenures across the schemes enabling people to rent, part or full purchase a property.

¹³ Office for National Statistics (2011) Census Information

¹⁴ PANSI (2012) Projecting Adult Needs and Service Information

¹⁵ Hartlepool Housing Strategy 2011

4. Description of the Hartlepool Extra Care Housing Schemes

All schemes provide for people aged 55 years and over with personal care needs or aged 60 years and over with or without care needs. There are also a small number of properties that are available for individuals with a learning disability who may fall under the age criteria, however placement of residents must still be age appropriate. All schemes also provide care on site 24/7 with a registered care provider.

4.1. Hartfields Retirement Village

Hartfields Retirement Village is a purpose built retirement village based in the Bishop Cuthbert area of Hartlepool towards the north of the town.

It is the largest extra care scheme within Hartlepool providing 242 properties. It provides mixed tenure properties enabling those with enough assets to part or fully purchase a property. The facility provides 214 one or two bedroom apartments and 28 two bedroom cottages. Facilities include a licensed bar, hair salon, restaurant, shop, leisure pool and gym. There is also GP practice on site.

Joseph Rowntree Housing Trust own and manage all aspects of Hartfields, and have their own internal care service.

4.2 Laurel Gardens

Laurel Gardens is a purpose built extra care facility located in the Rift House area of the town. It is owned and managed by Housing Hartlepool however, all care and support on site is provided by Comfort Call.

It provides 60 two-bed apartments, which comply to lifetime home standards. It provides mixed tenure properties enabling those with enough assets to part or fully purchase a property. Facilities include a communal bistro, shop and hair salon.

Laurel Gardens contains six units that have been built to DDA standard to accommodate residents with physical disabilities residents. The facility also has four properties that can be allocated to individuals under the age of 55 years with learning or physical disabilities who can be supported to live within an extra care scheme. It is envisaged that over time the extra care scheme will support up to 25% of its residents who are affected with a dementia.

The site also contains one unit which is utilised as a rehabilitation facility. This unit enables people in need of rehabilitation following a stroke, major surgery or a period of ill health the opportunity to continue to live independently with a full rehabilitation programme including care and support being delivered on site.

4.3 Bamburgh Court

Bamburgh Court was previously a sheltered housing scheme. An onsite care provider was introduced in October 2010 and the scheme was reclassified as an extra care facility. It has not yet been fully refurbished since it was built, 20 years ago. It provides 71 properties, which are made up of a mix of one and two bedroom apartments and bungalows.

The facility also has a few properties that can be allocated to individuals under the age of 55 years with learning or physical disabilities who can be supported to live within an extra care scheme.

4.4 Albany Court

Albany Court was previously sheltered housing and underwent a full refurbishment programme to update and expand the accommodation on site. The scheme now consists of 38 properties with a mix of one and two bedroom apartments and two bedroom bungalows.

The facility also has four properties that can be allocated to individuals under the age of 55 years with learning or physical disabilities who can be supported to live within an extra care scheme.

4.5 Richard Court

Richard Court was previously sheltered accommodation but the apartment block was fully refurbished to provide extra care housing. The first residents were able to move in during January 2011. It consists of 46 properties, which are a mix of one and two bedroom apartments and one and two bedroom bungalows.

The facility also has four properties that can be allocated to individuals under the age of 55 years with learning or physical disabilities who can be supported to live within an extra care scheme.

Properties in Bamburgh Court, Albany Court and Richard Court are only available on a social rent basis. All three schemes have communal onsite facilities, which include a kitchen and residents lounge. The schemes are owned and managed by Housing Hartlepool with Comfort Call providing care services

5. Evidence Base for Extra Care

5.1 Introduction

The following is a review of relevant literature and research around extra care housing which has helped to shape and inform this evaluation.

With the increase in the number of extra care housing schemes across the UK there has been a growing evidence base of research and literature.

There is wide variation in the way that extra care housing is designed and delivered, which makes it difficult to compare and evaluate schemes against each other. Results from one scheme or study should not be generalised across all extra care schemes due to this variation.

5.2 Comparing Extra Care to Residential Care

One of the key arguments for extra care housing is that it can provide an alternative to residential care.

A study comparing 19 extra care schemes with residential homes found that those moving into extra care were on average younger, male, and less likely to be widowed than those moving into care homes. Approximately 65% of residents from these extra care schemes had previously been living in ordinary housing. In contrast, the majority of people who moved into a care home had come from hospital. Perhaps unsurprisingly then, residents in the care homes were more likely to have received informal care or home care prior to their move. It was found that 42% of residents in the care home received intensive home care (>10hours a week) compared to 31% of residents in the extra care scheme.

A significantly higher number of residents who had severe cognitive impairment as measured on the MDS CPS score¹⁶ were found to be living in care homes as opposed to extra care housing, 39% and 3% respectively. Similarly, those in extra care housing were much less likely to have been diagnosed with dementia or depression than those in residential care.

Using the Barthel Index¹⁷ residents in the extra care schemes had lower needs with scores ranging from 11.4 to 17.7 across the schemes, the average score within a care home was 10.4, which showed higher needs. There was an exception where one extra care scheme had 36% of residents with high level needs (Barthel score 0-8)

¹⁶ MDS CPS (Minimum Data Set Cognitive Performance Scale) score of 4-6 was considered as severe cognitive impairment

¹⁷ The Barthel Index consists of 10 items that measures a person's ability to independently perform activities of daily living

which was higher than the average care homes which had 35%¹⁸. This illustrates that extra care schemes do have the capacity to deal with high level needs.

5.3 Reasons to Move

The fact that many of the residents in the extra care schemes were in better health, younger, and had moved from home rather than hospital may also tell us something about the motivation or timings of the move.

There are a number of key issues that can affect a person's motivation or need to move. This may include; friends and family within the area, as people are more likely to move if they have few ties to an area; amenities and activities in the surrounding area; and their health and wellbeing. This last factor is particularly important as people will consider their current and perceived future health needs and look at which options will provide them with the best services.

Other issues that may affect a house move are the type of tenure, as owner occupiers are more likely to move due to concerns around health whereas those who are not homeowners are more likely to be concerned with the affordability of their living situation¹⁹.

It was shown that people make a more positive decision to move to extra care housing²⁰ and that most of the issues influencing an individual's choice to move can be considered as either push or pull factors. Push factors were often related to health or a long-term condition, particularly the need for housing adaptations, which was a push factor in half of cases for residents with care needs moving into extra care. Difficulty managing with their home was also a large push factor for many. Amongst the pull factors were tenancy rights, being able to have your own front door, having care and support on-site, and the security of the scheme. The social aspect of extra care housing was also important in terms of expectations with many people feeling that their social life would improve with the move and many people stating that social issues was one of the push factors to move to extra care²¹.

Netton *et al.*, found that most people made a positive lifestyle choice to move to extra care housing, which may explain why on average people were younger and in better health than those in residential care, who are more likely to have moved in response to a crisis rather than as a proactive choice.

¹⁸ Darton, R., Baumker, T., Callaghan, L., Holder, J., Netten, A. and Towers, A. (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

¹⁹ Croucher, K., Hicks, L., and Jackson, K. (2006) *Housing with care for later life: A literature review*. Joseph Rowntree Foundation

²⁰ Netten, A., Darton, R., Baumker, T. and Callaghan, L. (2011) Improving housing with care choices for older people: an evaluation of extra care housing. PSSRU, Housing LIN

²¹ Netten, A., Darton, R., Baumker, T. and Callaghan, L. (2011) Improving housing with care choices for older people: an evaluation of extra care housing. PSSRU, Housing LIN

5.4 Benefits of Extra Care Housing Schemes

A comparison of the self-reported health status of residents within an extra care scheme and those within the community showed that over time, the community residents reported poorer health, with extra care residents reporting few changes in their health²².

Studying an extra care scheme in Bradford, Baumker *et al*, found that the proportion of residents who accessed hospital services, including accident and emergency, outpatient and inpatient stays was slightly lower following the move to the scheme²³. They also used ASCOT (Adult Social Care Outcome Tool) to measure any improvements in social care outcomes. The tool looks at seven outcome domains, which include personal care, social participation, control over daily life, meals and nutrition, safety, accommodation and occupation. The study found that extra care residents perceived more of their needs to be met across all the seven domains²⁴.

A review of some extra care schemes found that residents in extra care were less likely to be admitted to hospital for an overnight stay compared to a matched group living in the community, however when residents from extra care were admitted to hospital they tended to stay for longer. The average number of nights spent in hospital across a year was also lower for those in extra care housing with an average of 5 nights. Those in receipt of domiciliary care in the community spent an average of 6 nights in hospital, both groups were over the age of 80 and of similar demographics. The proportion of residents who moved from extra care into residential or nursing care was only 10% compared to 19% for residents in the community receiving domiciliary care; furthermore residents in extra care schemes also appeared to have fewer falls²⁵. Further studies found that physical functional ability tended to either improve or remain the same after moving into an extra care scheme even after 30 months²⁶.

In addition to the physical health and wellbeing benefits, social wellbeing was also seen as a key benefit. Social wellbeing includes good quality social relationships, social participation, social networks and social²⁷. Within the reviewed extra care schemes it appears that social wellbeing increases after moving in²⁸. In another study

²² Croucher, K., Hicks, L., and Jackson, K. (2006) *Housing with care for later life: A literature review*. Joseph Rowntree Foundation

²³ Baumker, T., Netten, A., Darton, R. (2008) *Costs and outcomes of an extra-care housing scheme in Bradford*. Joseph Rowntree Foundation

²⁴ Baumker, T., Netten, A., Darton, R. (2008) *Costs and outcomes of an extra-care housing scheme in Bradford*. Joseph Rowntree Foundation

²⁵ ²⁵ Kneale, D. (2011) *Establishing the extra in Extra Care: Perspectives from three Extra Care Housing Providers*. ILC UK: London

²⁶ Netten, A., Darton, R., Baumker, T. and Callaghan, L. (2011) *Improving housing with care choices for older people: an evaluation of extra care housing*. PSSRU, Housing LIN

²⁷ Evans, S., and Vallyelly, S., (2007) *Best practice in promoting social well being in extra care housing: A literature review*. Joseph Rowntree Foundation

²⁸ Kneale, D. (2011) *Establishing the extra in Extra Care: Perspectives from three Extra Care Housing Providers*. ILC UK: London

90% said they had now made friends, 85% felt positive about their social life and did not feel lonely, and a further 75% felt they were fully occupied in activities of their choice and were not bored²⁹. A study conducted in Canadian hospitals found that patients with higher social engagement were more likely to have higher levels of wellbeing³⁰. Kingston et al., also found that residents' physical and mental wellbeing was supported in extra care schemes by the sense of security, peer support, and the reassurance and knowledge that care needs could be met by the scheme staff³¹.

One benefit that has been reported, perhaps unintentionally, is that over a period of time resident attitudes towards disability became more positive as residents become more accustomed to their neighbours and everyone creates their own boundaries for neighbourly support and activities³².

Another positive element that supports social relationships was how often family members continued to provide substantial care and support for their relatives even when they moved into the schemes. Extra care schemes allowed the continuation of the family relationships and allowed them to continue their role in caring whilst sharing the responsibility with the care provider. This was something that both residents and their families felt was very important³³.

The research and studies presented here show that extra care schemes can provide a wide range of benefits to residents and their families. Research about the needs and values of older people with high support needs found there were three key elements to improve the quality of life. These are social relationships and interaction, ability to be in control of their lives, and living in a safe, secure and pleasant environment³⁴. The above examples illustrate that extra care schemes may be able to provide positive social relationships, security, an adaptive environment and an element of control as you have your own property and tenancy rights.

5.5 Limitations of Extra Care Housing Schemes

There are benefits to extra care housing schemes however, it has also been highlighted that there are limitations and these will be considered in this next section.

²⁹ Callaghan, L., Netten, A., and Darton, R. (2009) The development of social well-being in new extra care housing schemes. Joseph Rowntree Foundation

³⁰ Evans, S., and Vallely, S., (2007) Best practice in promoting social well being in extra care housing: A literature review. Joseph Rowntree Foundation

³¹ Croucher, K., Hicks, L., and Jackson, K. (2006) *Housing with care for later life: A literature review*. Joseph Rowntree Foundation

³² Croucher, K., Hicks, L., and Jackson, K. (2006) *Housing with care for later life: A literature review*. Joseph Rowntree Foundation

³³ Croucher, K., Hicks, L., and Jackson, K. (2006) *Housing with care for later life: A literature review*. Joseph Rowntree Foundation

³⁴ Joseph Rowntree Foundation (November 2011) A Better Life- what older people with high support needs value

One of the most commonly cited benefits of extra care housing is reduced social isolation. Whilst this may be the case for some residents it is evident that there are groups of residents who remain socially inactive and may be alienated³⁵. These residents tended to be older, have significant hearing loss, cognitive impairment, physical disability, are widowed or were carers³⁶. Equally, those who received care services, rated their health as poor, were unmarried or living in a smaller scheme were also more likely to report social isolation and feelings of loneliness³⁷. For those who suffer from mental health problems or cognitive impairment this seems to be a particular problem. In a number of studies reviewed, residents commented that life could still be lonely³⁸.

There were examples where extra care schemes had put additional staff in place to overcome some of these barriers by helping residents get around and to participate³⁹. The well-considered design of schemes can also help to reduce social isolation for some residents, for instance the provision of shopping and communal eating facilities can help to provide places for residents to interact with both each other and the wider community⁴⁰. Although it is still not possible to ensure that everyone, who wishes to be, is socially active. Furthermore, determining whether individuals who felt isolated in their extra care scheme would have the same level of social isolation within the community is extremely difficult⁴¹. It does however illustrate that we must not assume that social isolation will improve for everyone with the move to extra care.

In the extra care schemes reviewed there were also reports from residents that there are tensions between “fitter” and “frail” residents. In some instances, this was displayed with extreme prejudice and hostility towards residents who were disabled and in others it was simply concern or dissatisfaction that the scheme was evolving into a nursing home and that there were too many residents who were frail or disabled⁴². This was particularly a problem in schemes that had been remodelled from a sheltered scheme to an extra care housing scheme, as many established residents felt that new residents were more likely to be frail⁴³. Larger village schemes

³⁵ Evans, S., and Valletly, S., (2007) Best practice in promoting social well being in extra care housing: A literature review. Joseph Rowntree Foundation

³⁶ Croucher, K., Hicks, L., and Jackson, K. (2006) *Housing with care for later life: A literature review*. Joseph Rowntree Foundation

³⁷ Callaghan, L., Netten, A., and Darton, R. (2009) The development of social well-being in new extra care housing schemes. Joseph Rowntree Foundation

³⁸ Croucher, K., Hicks, L., and Jackson, K. (2006) *Housing with care for later life: A literature review*. Joseph Rowntree Foundation

³⁹ Callaghan, L., Netten, A., and Darton, R. (2009) The development of social well-being in new extra care housing schemes. Joseph Rowntree Foundation

⁴⁰ Evans, S., and Valletly, S., (2007) Best practice in promoting social well being in extra care housing: A literature review. Joseph Rowntree Foundation

⁴¹ Croucher, K., Hicks, L., and Jackson, K. (2006) *Housing with care for later life: A literature review*. Joseph Rowntree Foundation

⁴² Croucher, K., Hicks, L., and Jackson, K. (2006) *Housing with care for later life: A literature review*. Joseph Rowntree Foundation

⁴³ Croucher, K., Hicks, L., and Jackson, K. (2006) *Housing with care for later life: A literature review*. Joseph Rowntree Foundation

seemed more likely to be aimed towards active and able older people rather than frailer residents⁴⁴.

Improved independence is something that is regularly attributed as a key benefit for extra care. In a review of an extra care scheme in Bradford it was found that residents did not report any reduction in their level of care needed after six months within the scheme. They did report better quality of life after six months, but there was no evidence that people had lower levels of need or increased independence. Furthermore, following a move the residents reported a decrease in their unmet needs and there was often a reduction in the informal care they received, which suggests that they were receiving a higher level of formal support than previously.

The overall cost for each person also increased following a move to the extra care scheme. However, the increased levels of care required after their move may be one of the reasons that individuals decided to move to the scheme in the first place due to ever increasing care needs⁴⁵. Although the quality of life improved for residents this review does illustrate that their independence may not necessarily increase within extra care and there does appear to be a lack of evidence around the maintenance/improvement of health and social care needs⁴⁶.

Linked to the principle that extra care will increase independence is the idea that it can provide a home for life until the resident passes away. Although this may be possible within some extra care schemes, there is a general lack of evidence to support whether extra care is really a home for life⁴⁷. Residents who develop very high care needs or significant nursing needs may still have to move out of extra care into either a residential or nursing care home. In particular, the continued provision of care for residents with dementia throughout the whole course of their illness has been highlighted as an issue. One review found that out of 24 extra care schemes there was no evidence that they could accommodate residents with severe dementia towards the end of their life⁴⁸. It should be noted that this review is seven years old and a more recent review may highlight different findings. It is however important to ensure that we continue to critically evaluate whether extra care schemes are able to provide a home for life and in instances where this is not possible seek ways to resolve this.

⁴⁴ Callaghan, L., Netten, A., and Darton, R. (2009) The development of social well-being in new extra care housing schemes. Joseph Rowntree Foundation

⁴⁵ Baumker, T., Netten, A., Darton, R. (2008) Costs and outcomes of an extra-care housing scheme in Bradford. Joseph Rowntree Foundation

⁴⁶ Kneale, D. (2011) Establishing the extra in Extra Care: Perspectives from three Extra Care Housing Providers. ILC UK: London

⁴⁷ Kneale, D. (2011) Establishing the extra in Extra Care: Perspectives from three Extra Care Housing Providers. ILC UK: London

⁴⁸ Croucher, K., Hicks, L., and Jackson, K. (2006) *Housing with care for later life: A literature review*. Joseph Rowntree Foundation

It is necessary to acknowledge and understand the limitations of extra care housing to ensure that professionals, residents and their families are fully aware of what extra care can and cannot offer.

5.6 Financial Costs of Extra Care

In conjunction with the idea that extra care housing schemes can provide an alternative to traditional residential care and improved independence is the notion that extra care housing may be more cost effective. As with much of social and health care provision however, it can be difficult to clearly define costs and savings.

Looking at the wider picture we can see that there has been significant investment into extra care housing. Between 2004 and 2010 the Department of Health invested £227 million with the Homes and Community Agency into extra care. A further £800 million was also invested from other funding sources.

The most significant benefits have been when extra care or other specialist housing has reduced the need for institutional care, such as residential or nursing care. Research by Frontier Economics found that there was a capital net benefit of nearly £220 million pounds from specialist housing for older people⁴⁹.

When we examine individual extra care schemes for cost effectiveness it becomes less clear-cut. Looking at a matched group of people entering residential care and extra care it was found that the overall cost per person increased following a move to extra care housing. This increased cost however was associated with improved social care outcomes and improved quality of life⁵⁰. Another study in Bradford also found that costs increased following a move to extra care (from £380 to £470) however, this was again associated with improved outcomes for social care and improved quality of life. Despite the higher costs for accommodation and social care support, the health care costs decreased following the move to extra care⁵¹.

In a study that compared the costs for those moving into institutional settings, extra care housing and receiving domiciliary care the upfront cost of social care alone appears to be higher for those in extra care. However once this is examined over a longer time period it was found that after nine years the social care costs for those with domiciliary care becomes much higher as they are more likely to have entered into institutional care. It is difficult to clearly determine the true costs as it has been found that extra care housing has a much lower rate of falls, which is likely to save costs and is an obvious benefit to the individual. There is also a lower rate of hospitalisation within extra care schemes, which could be estimated to save approximately £512 per person in terms of hospital bed use and once again the benefit to the individual of reduced hospitalisation is significant. It is therefore

⁴⁹ Housing LIN (2011) Viewpoint 21 Prevention and Early Intervention

⁵⁰ Netten, A., Darton, R., Baumker, T. and Callaghan, L. (2011) *Improving housing with care choices for older people: an evaluation of extra care housing*. PSSRU, Housing LIN

⁵¹ Baumker, T., Netten, A., Darton, R. (2008) *Costs and outcomes of an extra-care housing scheme in Bradford*. Joseph Rowntree Foundation

difficult to ascertain whether the slightly higher initial costs are cost effective when compared to the potential for improved outcomes for the individual⁵².

A final study examining the cost effectiveness of an extra care housing scheme found that for the same level of care provision via domiciliary care in the community the council would be paying an additional £46,000 annually. Although there are additional factors to take into consideration, such as the proportion of residents paying contributions and those on full benefits, it still remains that extra care was found to be cost effective within this example. One of the key things to consider within this example was that many of the residents on lower levels of care paid relatively more for their level of care and as a result subsidised some of the costs for the higher levels of care. It is therefore important to consider that an imbalance of care levels within this example may influence whether or not it is still cost effective⁵³.

5.7 Summary

Although there has been a significant amount of research into extra care it is still not possible to state with a high level of certainty how effective overall extra care is as a housing option for older people. There appear to be benefits such as improved quality of life, social interactions, reassurance and improved tenancy rights. There are however a number of limitations and it appears to be dependent on the extra care scheme as to how much it encourages independence. The financial costs associated with extra care are perhaps even less well understood and there seems to be conflicting evidence as to whether it saves money. Although it does appear to be cost effective for the improvements in quality of life experienced.

It can be tempting to see extra care as the solution to older people's housing needs but we must ensure that we do not overestimate the benefits and underestimate the limitations.

⁵² Kneale, D. (2011) Establishing the extra in Extra Care: Perspectives from three Extra Care Housing Providers. ILC UK: London

⁵³ Sue Garwood, (2011) Evaluation of Reeve Court Retirement Village, St Helen's.

6 Methodology

This evaluation examined all five extra care schemes within Hartlepool. The information used within this evaluation has included both quantitative and qualitative data.

6.1 Staff Questionnaires

6.1.1 Care Provider Staff

Staff questionnaires were sent to all of the care staff within the five extra care schemes. The staff questionnaires were also required for the Quality Standards Assessment for the care providers; Comfort Call and Joseph Rowntree Housing Trust.

The staff questionnaires focused on a number of elements, which included:

- Induction process;
- Staff training;
- Staff supervision and support;
- The delivery of care and support;
- Safeguarding residents;
- Resident independence and choice; and
- General staff understanding which was assessed through a number of case studies looking to explore understanding of the reablement ethos, safeguarding and standards of safe care.

There was a slight variation in the questionnaire sent out to the Comfort Call staff which asked staff which extra care scheme they worked in and also whether they had received a buddy book as part of their induction. These questions were not included within the Joseph Rowntree Housing Trust (Hartfields) staff questionnaires as they were not relevant.

All staff questionnaires were sent and returned by post.

6.1.2 Hartlepool Borough Council Staff

A staff questionnaire was sent electronically to all care managers within Hartlepool Borough Council (HBC). The questionnaire included three questions based on the Working Together for Change method:

1. Please list three things that work well in extra care;
2. Please list three things that don't work well in extra care; and
3. Please can you suggest any ideas to change/improve extra care?

6.1.3 Extra Care Staff Feedback

As well as consulting with the care staff from both care provider organisations, semi-structured interviews and focus groups were conducted with key members of staff within the various extra care schemes. The semi-structured interviews and focus groups were based on three questions:

1. What works well in extra care housing?
2. What doesn't work well in extra care housing?
3. What needs to change in the future for extra care housing?

These three questions provided a framework to focus participants but also gave the freedom to explore other areas or topics they felt necessary. None of the interviews were audio recorded however notes were taken and whenever possible recorded verbatim.

The following person was interviewed:

- Neighbourhood Manager at Hartfields.

The following people formed the focus group:

- Care Manager for Hartfields;
- Care Manager for Comfort Call;
- Housing Manager for Laurel Gardens; and
- Allocation Manager for Hartfields.

6.2 Resident Consultation

Central to this evaluation was the involvement of residents themselves. Qualitative methods such as questionnaires, feedback sessions and semi-structured interviews were utilised to gather the views and opinions of residents.

All residents were informed by letter about the questionnaires and the extra care review. Posters were also placed in public areas around the schemes to notify residents. Residents were given the option of filling out the questionnaire themselves, attending a resident consultation session, or requesting a home visit. This last option was provided in case residents were unable to leave their properties or had difficulty completing the written questionnaires by themselves

Two resident consultation sessions were also held in each extra care scheme to allow residents to come along and discuss any queries they had or to provide feedback face-to-face.

Scheme managers and wardens were notified about the letters and questionnaires, and in several schemes they helped to arrange home visits for residents who were unable to respond by questionnaire.

6.2.1 Questionnaires

Questionnaires were chosen as the best method for resident engagement as it would reach all residents within the schemes. It was important to ensure the questions asked were as open as possible to allow residents to share their opinions and views on all aspects of living in extra care.

The questions were developed based on the Working Together for Change method. The following questions were included:

1. What are the top three things you like about [name of scheme]?
2. What are the top three things you don't like about [name of scheme]?
3. What three things do you think could be better, or anything you would like to see in the future in [name of scheme]?
4. Do you receive any help, care and support?
5. What are the top three things you like about the care and support provided in [name of scheme]?
6. What are the top three things you don't like about the care and support provided in [name of scheme]? and
7. Thinking about the care and support in [name of scheme] what three things do you think could be better, or anything you would like to see in the future?

All questionnaires were anonymous and sealed collection boxes were placed in the communal areas or entrance of each scheme for people to return their forms. This was to ensure anonymity and enable residents to feedback any of their issues without worrying that this may impact on their tenancy or care they received. When analysing the information from the questionnaires responses were simply titled with their corresponding scheme name and a number, for instance Albany Court1.

6.2.2 Interviews

There were a number of residents in each scheme who requested home visits, preferring this to completing the questionnaire. All interviews were conducted either within the resident's property or on site at the extra care housing scheme.

The interviews were semi-structured which allowed the interviewer to adapt the questioning and structure of the interview in response to the individuals answers. The questions from the questionnaires were used as the basis for all of the interviews as this ensured that there was a clear framework and direction for the interview discussion.

Interviews were not recorded, as it was felt that this would be rather intrusive for individuals. Interview notes were recorded and wherever possible written verbatim. All interview notes were recorded and typed up into the same questionnaire format.

It was explained to all residents interviewed that their answers would remain anonymous. In a few instances there were some issues that were raised during the interviews which residents wished to be explored on their behalf. In these instances residents agreed to being identified.

All anonymous feedback from the questionnaires and interviews has been provided to the relevant housing and care providers.

6.2.3 Resident Feedback Sessions

There were ten resident feedback sessions held. Unfortunately, no residents were present for the two sessions within Hartfields. In the remaining eight feedback sessions the number of residents who attended ranged from one to groups of approximately ten residents.

Albany Court and Bamburgh Court were the only schemes where a number of residents had a group discussion. Questions asked during this discussion were based on the questions from the questionnaires. The comments from these group discussions were recorded and it became apparent that several residents within the groups had responded to the questionnaire in addition to attending the feedback session. To avoid double counting these answers, the notes from the Albany Court and Bamburgh Court feedback sessions were recorded separately. In Richard Court and Laurel Gardens there were several residents present throughout the feedback sessions, however residents took it in turns to talk to the interviewer and as such it was possible to record their responses individually on the questionnaires. For these two sessions instead of a group discussion there were shorter individual interviews with each resident.

6.3 Case Tracking

Case tracking consists of examining a sample of residents and looking in detail at all their supporting documents and care plans held by the care provider. This method examines the quality of care documentation, policies in place and how staff provide care and support as recorded in the daily log sheets.

Nine residents had their cases tracked in total across both care providers. Residents from each care level were randomly sampled.

Case tracking was used as part of this review but it also formed a key element of the Quality Standards Assessment for the care providers Comfort Call and Joseph Rowntree Housing Trust.

6.4 Statistical Data

Statistical data held within the Adult Social Care Controcc system was used to illustrate the changes across the extra care schemes over a number of years. This quantitative data has allowed patterns and trends within all extra care schemes to be compared and analysed. The start date of the data is the opening of each scheme to the present year and therefore provides information over a four-year period from August 2008 to 13th February 2013. The information obtained from the Adult Social Care systems only provides information about individuals who receive care and therefore does not include residents with no support needs.

Furthermore, the data is only provided for individuals where the council fund part/all of their care. Within Hartlepool the maximum contribution social service users pay is 75% of their costs. This means that even for individuals who are eligible to fund the full cost of their services the council will pay 25% of the costs. Therefore, it was possible to obtain information for most individuals who receive care and support. There will be some instances where individuals may have a privately arranged package of care with another care provider and information for these individuals is not included within this evaluation.

7. Results and Findings

The following section will present and analyse all the findings obtained through this evaluation.

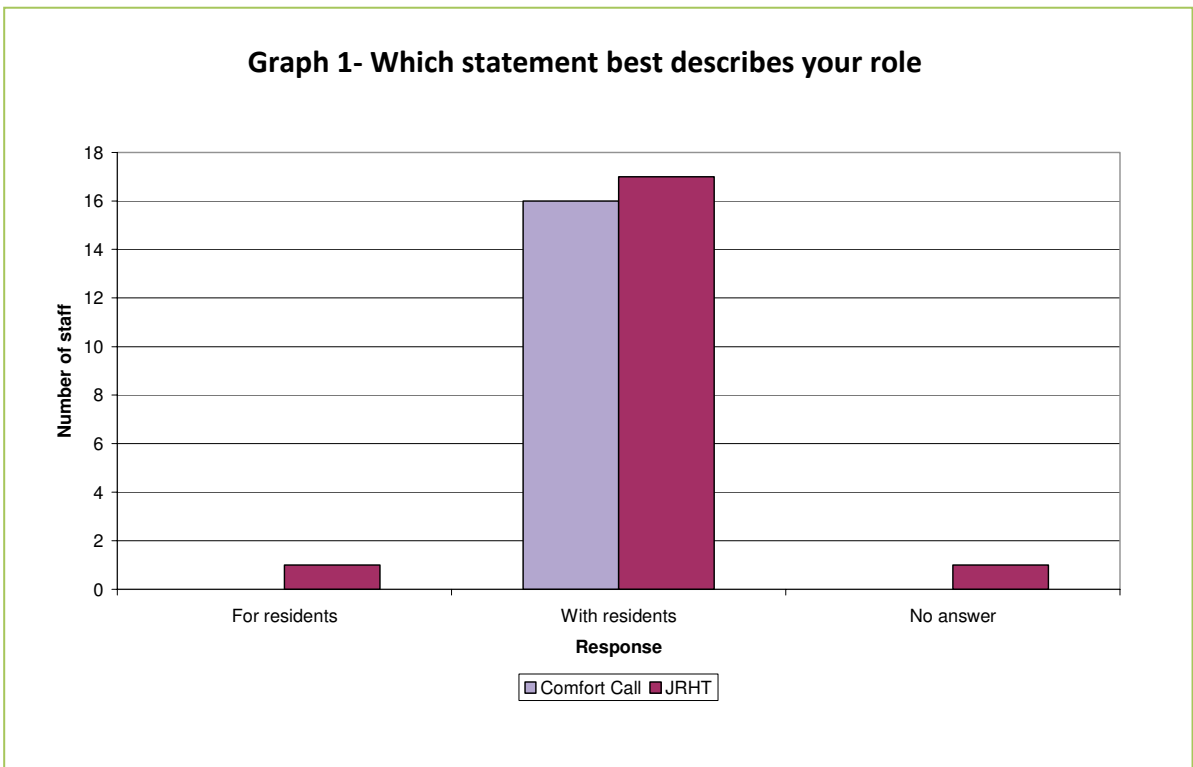
7.1 Staff Feedback

7.1.1 Care Provider Staff questionnaires

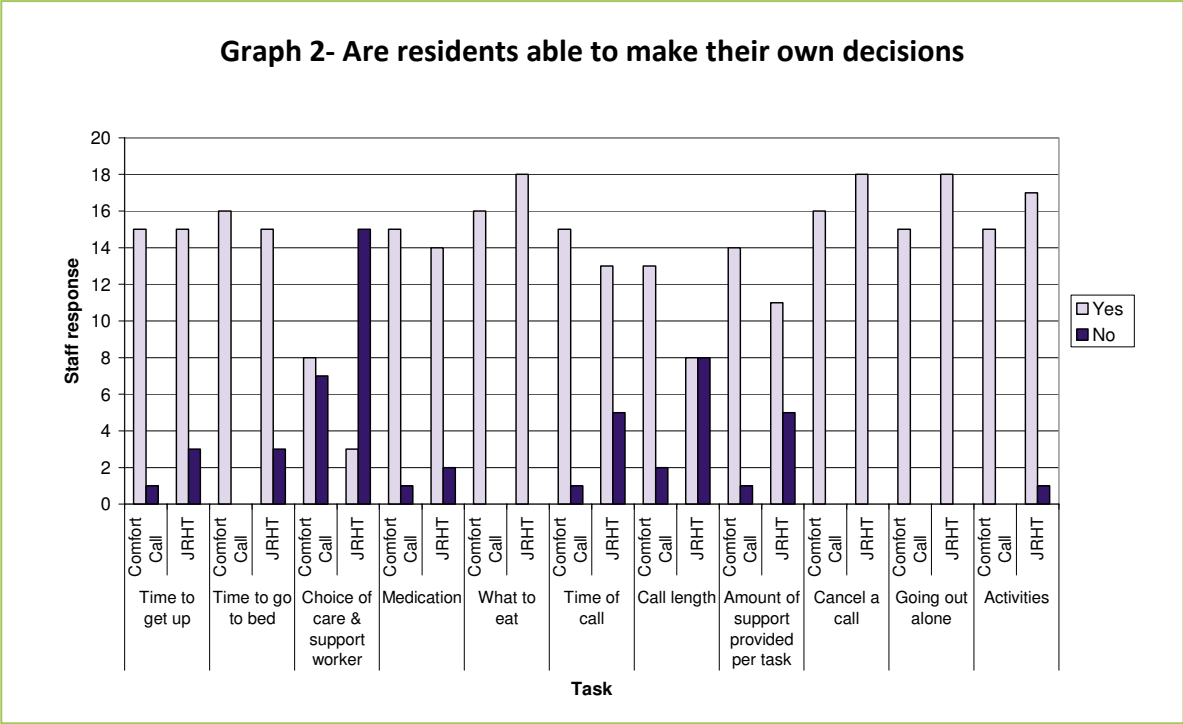
Over 60 staff questionnaires were sent to Comfort Call staff with 16 (27%) completed questionnaires returned. For Joseph Rowntree Housing Trust staff 54 questionnaires were sent out and 19 (35%) were returned.

7.1.1.1 Promoting independence

Staff were asked which statement described their role best, 'I do things for residents' or 'I do things with residents'. The results (see Graph 1) showed that of the staff who responded only one person said that they do things for residents. This links in with the ethos of extra care, which is based on increasing resident independence and doing things with residents rather than for them.



Staff were asked about whether residents were able to make their own decisions in a number of areas; the results are shown in Graph 2.



In the majority of cases staff thought that residents were given the opportunity to make their own decisions. There were a few incidences where staff felt that residents were not given the option to make their own choice particularly for:

- Choice of care and support worker; and
- Call length.

For the length of calls this is something that is scheduled and based on the assessed need of the resident. Length of calls are designed to ensure that all needs of the resident are met, at times there may be residents who would like longer calls but do not need them to meet their needs. We would therefore expect resident choice to be taken into account but that some individuals may want over and above the call length that they actually require.

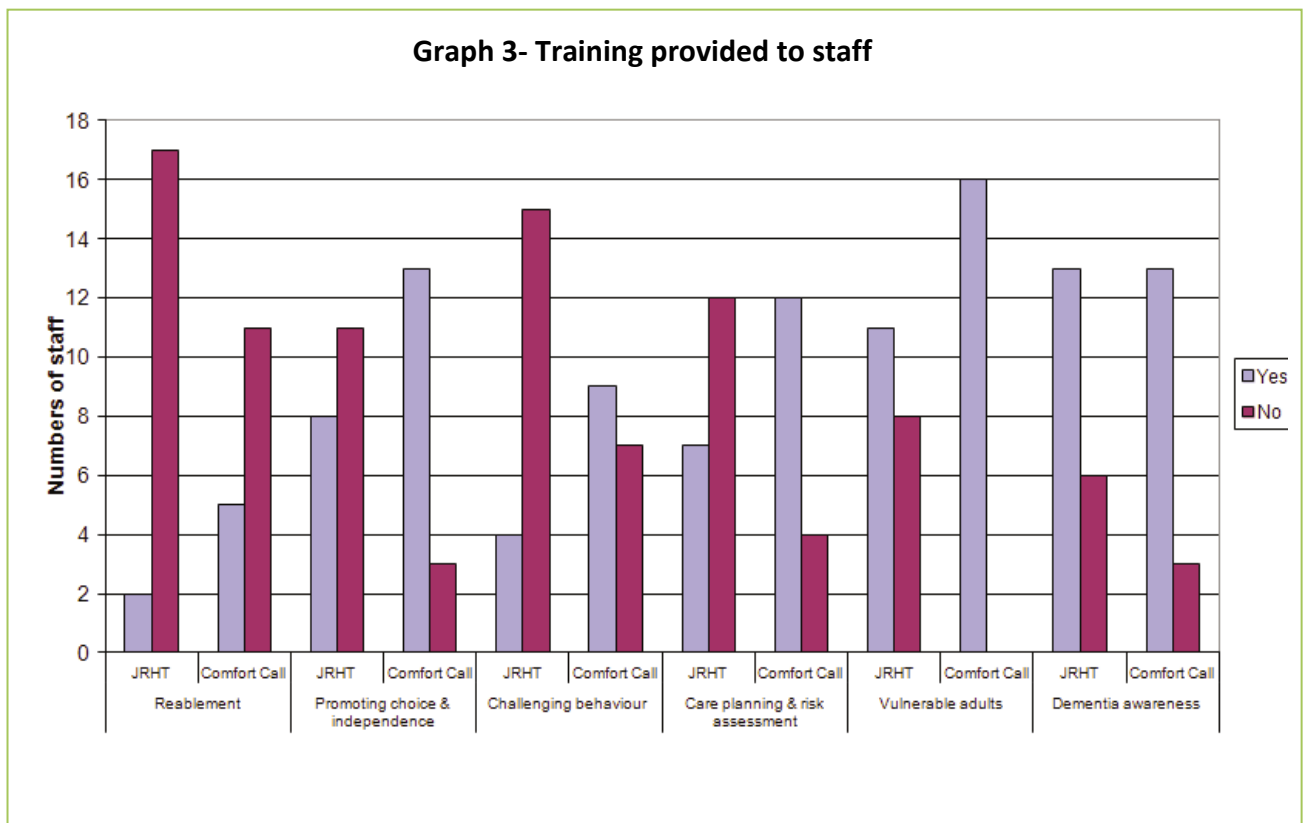
7.1.1.2 Staff training

Staff were asked whether they felt they have been given appropriate training to deliver the service to residents. The majority of staff answered yes and felt they had appropriate training. Across both the care providers only three members of staff answered no and felt that they did not have the appropriate training.

The staff training results are shown below in Graph 3. There were a number of additional staff training questions included within the staff questionnaires. This evaluation has only looked at six of the most relevant training aspects that focus on

safe care and promote independence. The training question topics included were: Reablement, Promoting Choice and Independence, Challenging Behaviour, Care Planning and Risk Assessment, Vulnerable Adults and Dementia Awareness.

Overall, the results indicate that staff training is inconsistent across most of the areas focused on, although the majority of staff felt they had enough training to undertake their roles and provide services to the residents.

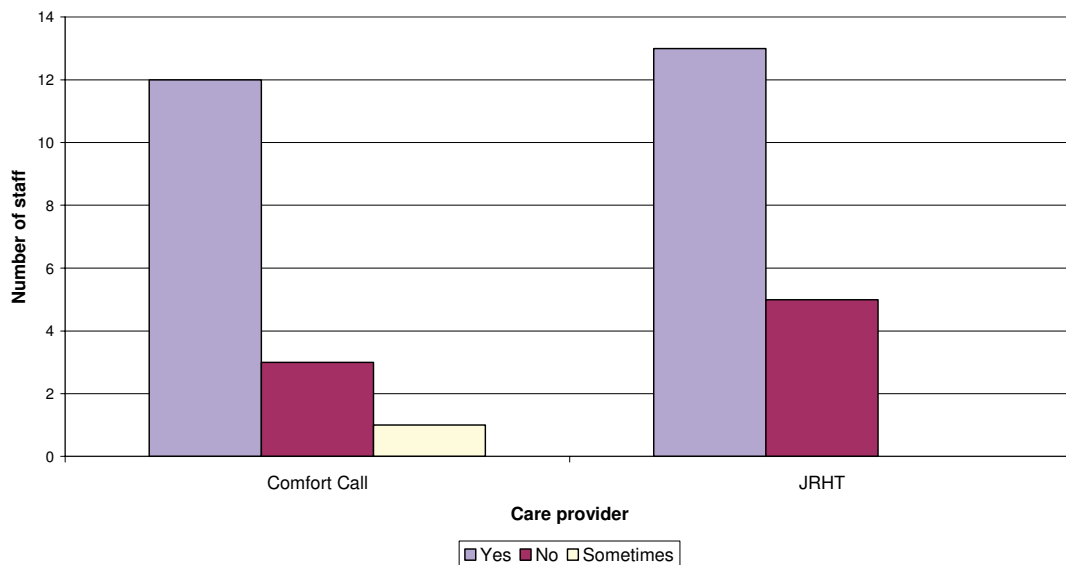


7.1.1.3 Providing safe care

As shown in Graph 4 below, the majority of staff from both care providers said that they would be confident to report any concerns or issues without being worried that they would be victimised or treated differently if they did. When asked what staff would do if they suspected a resident was being harmed or abused they all said they would report it and would talk to a senior member of staff.

Staff were asked “Are the arrangements sufficient to ensure you understand what care and support is required for each person?” The majority of staff answered yes. Only 1 person from Comfort Call answered no to this and three people from Joseph Rowntree Housing Trust staff answered no.

Graph 4- Are staff able to report any concerns or issues without being worried that they would be victimised or treated differently if they did



In relation to adequate staff on duty to meet the needs of residents 50% of JRHT staff said there were enough staff with the remaining 50% stating there were not enough staff. Only two Comfort Call staff felt staffing levels were inadequate.

The majority of staff were not included in resident support plan reviews, however staff suggested that they should be included in reviews as they often know a lot about the individual and can provide relevant information.

7.1.2 Hartlepool Borough Council staff questionnaires

Social workers and occupational therapists were asked to feedback their experience of extra care housing. A summary of all the issues and responses have been recorded below.

“What worked well in extra care” the following was identified:

- Familiarity of carers for residents;
- Communication between care managers (providers) and social workers;
- Residents encouraged and supported to use facilities and to be social;
- Carers are proactive and can offer a quick response;
- Flexible care provided to suit a resident’s need;
- Residents feel safe;
- Medication is provided safely; and
- Independence and privacy balanced with access to support.

“What doesn’t work well in extra care” the following was identified:

- Financial cost;
- Locations of the schemes, need more transport to some and need one in the south of the town;
- Door entry system for visiting district nurses;
- Not all wardens understand the needs of all their residents;
- Only having one carer on overnight, there may be a need for a double transfer and will have to wait for backup;
- Funding arrangements when renting/purchasing a property can be difficult;
- Some care staff within schemes are family members;
- Hours of care and various levels of care is confusing;
- Staff not always knowledgeable about care provider procedures; and
- Not always staff capacity to provide additional support at short notice.

“Ideas to change or improve extra care” the following was identified:

- More staffing on overnight;
- Offer carer support to residents so that they can go on holiday i.e. short breaks;
- To allow residents to rent at Laurel Gardens whilst their property is on the market;
- To make it easier for residents to transfer between extra care schemes;
- To provide more extra care schemes in other areas of the town, such as the south;
- To have indoor walkways around the various blocks at Hartfields; and
- Allow district nurses to have security fobs to entry the building.

7.1.3 Extra Care Staff Feedback

The following are the key areas and issues identified within both the interviews and focus groups with the extra care staff.

“What worked well in extra care” the following was identified:

- Gives people ability to remain in own property and to live independently;
- If we get it right their quality of life is better;
- Accessible accommodation which reduces their care and support needs;
- Opportunity for residents to be social and less isolated;
- Helps the family to spend more quality time with their loved ones not just providing care;
- Providing social activities and groups to promote wellbeing such as reminiscence groups;
- Providing some of the care for dementia residents who have maintained their care and support;
- Dementia support provided by mental health colleagues;
- Can provide respite care for someone in their own property;
- Residents feel safe and secure very quickly;
- Residents can become more independent and reduce their care hours; and
- Relationship with residents and care staff are better now that the schemes have been in operation for a while.

“What doesn’t work well in extra care” the following was identified:

- Expectations of what care should be provided can be very high from family, residents and care managers;
- Care plans can be too restrictive and not always outcome focused;
- Not everyone (residents and family) understands what extra care can and cannot do, especially in terms of nursing care;
- Demand is very high with some residents who want everything done for them
- Many people are using the highest level of care within their care level;
- Resources are stretched particularly with demanding residents, reduces time to spend doing additional “extra” support with people;
- Social worker is not always realistic in what they tell people they need verses what they want;
- A few residents have been prioritised with care needs for allocation but upon arrival are not using any care from anyone;
- Can be difficult to evidence all the additional care and support provided such as hospital visits, social activities, reassurance etc;
- Residents with dementia are moved only if they can adapt and its in their best interest, people moving with dementia too late is very detrimental;
- Information or help from social services can be late or delayed;
- Relationships and sharing of information between extra care and social services, not always included within the reviews; and
- There can be barriers in place when trying to reduce care levels.

“Ideas to change or improve extra care” the following were identified:

- Need clarity over some elements such as the intermediate care flat;
- Provide a social worker who is attached or based within extra care;
- Ensure social workers and care providers work together better and meetings with residents are conducted by both partners; and
- Work with the Reablement team to help residents realise what they can do independently.

7.2 Summary of Staff Feedback

There were several key benefits for extra care that were mentioned by both staff groups (HBC care managers and extra care staff), these focused on: social benefits, ability to live independent and safety and security

The extra care staff also talked about benefit of reducing care and support, which was not discussed by the HBC care managers. This may be of concern as this was a key aim within Hartlepool’s extra care schemes however no care manager from HBC mentioned this.

In terms of what does not work well in extra care there was no overlap or similarities between the responses from the HBC care managers or the extra care staff.

The feedback that “hours of care and various levels of care is confusing” highlights that there is still work to be done in ensuring that all care managers understand the basic levels within extra care. This is particularly important as extra care does not work on hours of care but rather flexible bands or levels of care. An explanation of extra care levels has been included within Appendix 1.

This apparent misunderstanding of care levels or notion of hours also appears to influence some of the problems that extra care staff have experienced. In particular, the following issues were identified:

- Care plans can be too restrictive to start with and not always outcome focused;
- Many people are using the highest level of care within their care level;
- Social worker is not always realistic in what they tell people they need verses what they want;
- A few residents have been prioritised with care needs for allocation but upon arrival are not using any care from anyone; and
- There can be barriers in place when trying to reduce care levels.

These issues were all said to arise from HBC care managers who utilise extra care in terms of hours or are too prescriptive on care plans around how hours or levels should be delivered.

One key issue identified by extra care staff was the working relationship between themselves and HBC care managers. The following issues were identified issue:

- Care plans can be too restrictive and not always outcome focused;
- Social workers are not always realistic in determining what people need verses what they want;
- Information or help from social services can be late or delayed; and
- Relationships and sharing of information between extra care and social services, not always included within the reviews.

Although it was noted that HBC care managers did work well with the extra care staff overall it was found that they did not work in partnership enough and did not provide enough freedom or trust in handing over responsibility of delivering the service to the extra care staff.

Around ideas to change or improve extra care there were again no similarities between the response from the two staff groups. The HBC care managers focused more on issues relating to the housing aspect of extra care, such as ability to transfer between schemes or the location of schemes. The responses from the extra care staff with the exception of one focused on working closer with either HBC care managers or other HBC social care services, such as reablement.

7.3 Resident questionnaires

The overall results for the resident questionnaires can be seen below, there was a 23% response rate across all five extra care schemes.

Table 1- Response rate for resident questionnaires

Extra Care Scheme	No of units	No of responses	Response Rate
Laurel	60	27	45%
Bamburgh	72	20	28%
Albany	38	20	53%
Richard	46	11	24%
Hartfields	247	27	11%
Total	463	105	23%

Table 2- Number of residents (who responded) receiving care and support

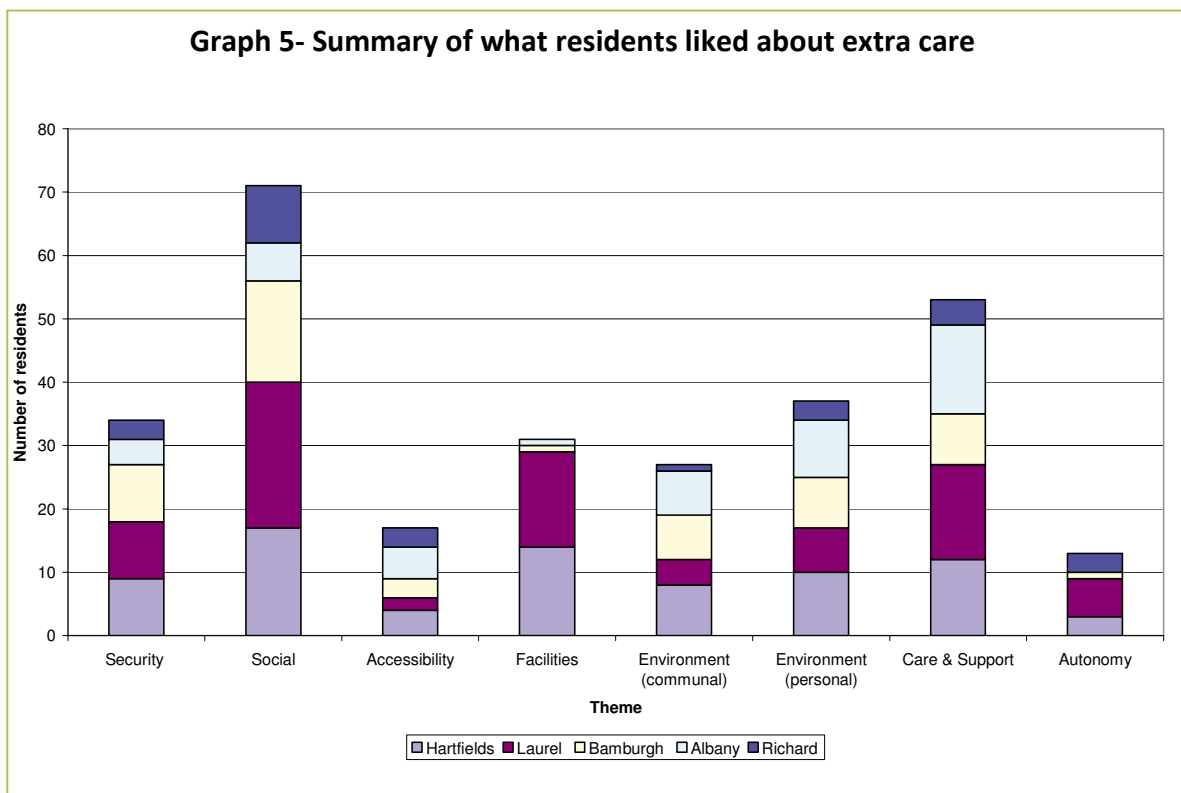
Extra Care Scheme	Yes	No	Didn't State
Laurel Gardens	15	7	5
Bamburgh Court	5	6	9
Albany Court	10	6	4
Richard Court	4	6	1
Hartfields	6	20	1
Total	40	45	20

The responses from the resident consultation were grouped into key themes, there were 17 themes in total.

Security-	the notion of safety, privacy and security
Social-	any social elements, including social relationships, activities, and events
Accessibility-	this related to whether people could get access within and out of the schemes
Facilities-	this included any of the schemes facilities such as a bistro, laundry room, lifts etc.
Communal Environment-	this related to the communal areas of the schemes and the outside environment
Personal Environment-	this was the individual's own environment
Care & Support-	this incorporates any care and support provided by any staff member
Autonomy-	this refers to people's ability to be independent
Building Maintenance-	this included any issues around the building maintenance, upkeep, and housekeeping issues
Reassurance-	reassurance, peace of mind and confidence
Reliability-	reliability , consistency and dependability
Attitudes-	staff personalities, characteristics and manner
Staff-	staffing management or issues with the work of staff
Expectations-	this related to expectations of the care provided
Training-	this related to any training or development required by staff
Inconsistency-	exact opposite to the Reliability theme
Communication-	this included communication between either residents or staff within the schemes

7.3.1 What residents liked about extra care

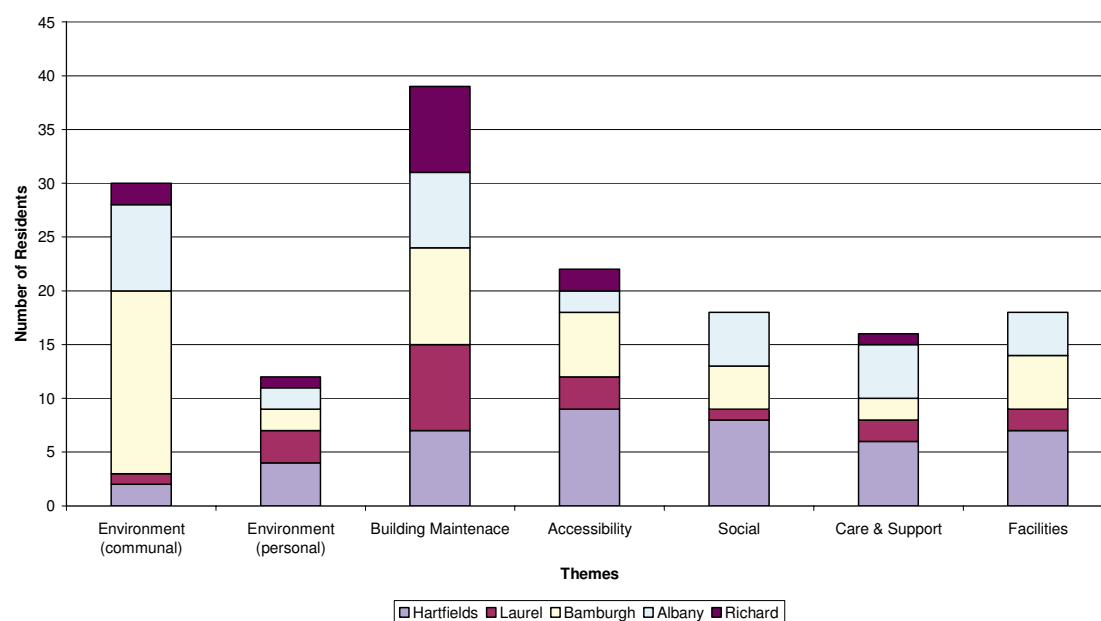
The three top themes which were seen as a positive about extra care overall were the **social, personal environment, and care and support**. The main focus on the social theme was improved social interactions with many residents discussing how their social lives had improved. The availability of care and support from staff within the schemes was rated as the second most important thing and formed the basis for the care and support theme. The third top theme was the personal environment with residents rating their flats as one of the key features they liked.



7.3.2 What residents did not like about extra care

The top three themes that were seen as negative overall were **building maintenance, communal environment and accessibility**. The biggest complaint within the building maintenance theme was heating: this was mentioned in all schemes either because it was too hot or too cold. Issues with the communal environment were more varied and ranged from lack of a garden and outdoor seating to the layout of the corridors. Finally, accessibility was the third theme. This theme focused on either accessibility within the scheme with some issues found for residents in wheelchairs or mobility scooters who found it more difficult to get around or on accessibility from the scheme to the community where issues focused on poor bus provision and difficulty getting access to public transport. This was particularly a problem for the two schemes in the north of Hartlepool.

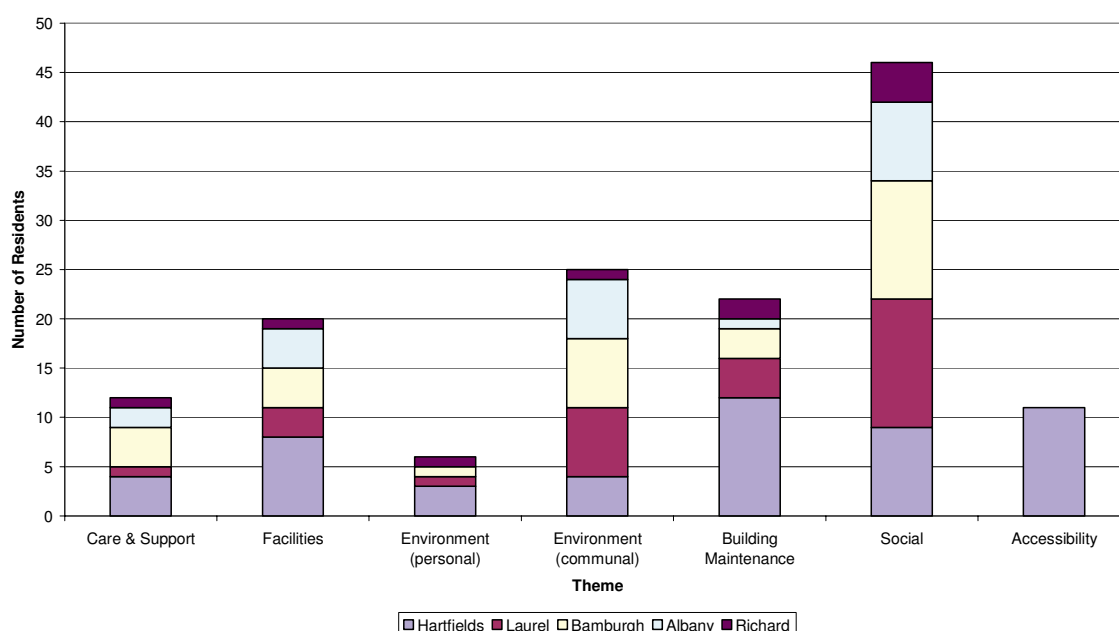
Graph 6- Summary of what residents did not like about extra care



7.3.3 What residents thought could be better

The top three themes that residents wished to make changes to in the future included **social, communal environment and building maintenance**. Although the social theme was the top rated theme, residents in all schemes stated that they wanted more activities or events going on. It was evident that the social activities and events were something that most of the respondents enjoyed and were keen to increase. Changes to the communal environment were often around better access and use of outdoor space, such as planted gardens or seating. Finally, changes to building maintenance focused around heating issues.

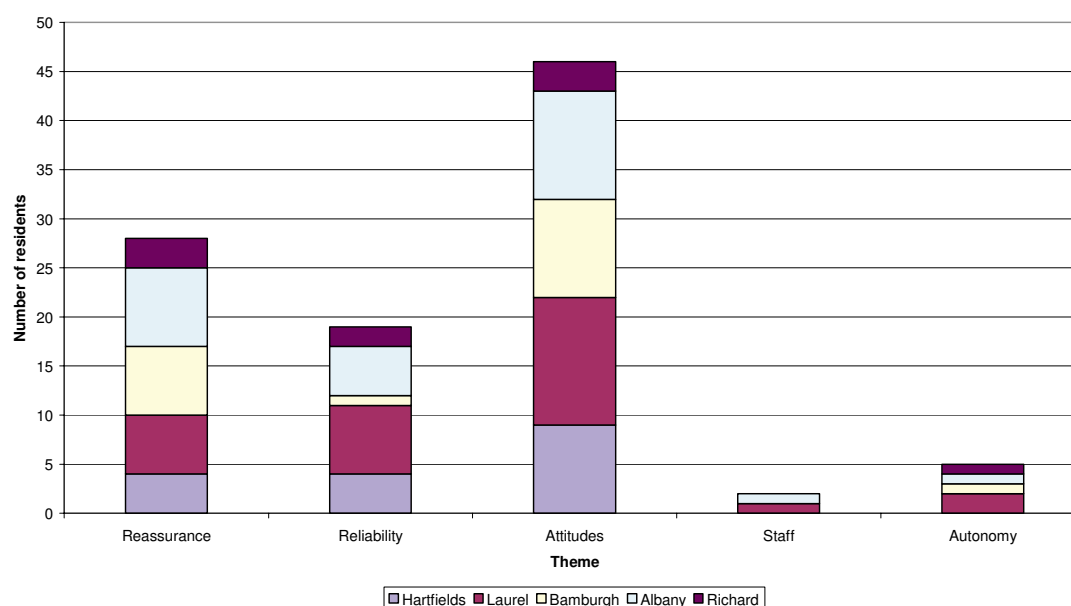
Graph 7- Summary of what residents thought could be better, or would like to see in the future in extra care



7.3.4 What residents liked about care and support

The top three themes that residents found positive about the care and support were **attitudes, reassurance and reliability**. The top theme attitudes reflected positively about carers who were described as ‘canny’, friendly and caring. Some residents commented that carers were “always willing to help” or would “do anything for you”. This is positive that residents felt carers were helpful and willing but does raise the question of whether carers are fully encouraging residents to be as independent as possible. The second theme was focused around residents’ reassurance about having care available if/when it was needed and knowing that there is always someone to support you. The third theme, reliability, included residents receiving the same carers but also focused on the reliability of the care and support provided.

Graph 8- Summary of what residents liked about the care and support in extra care

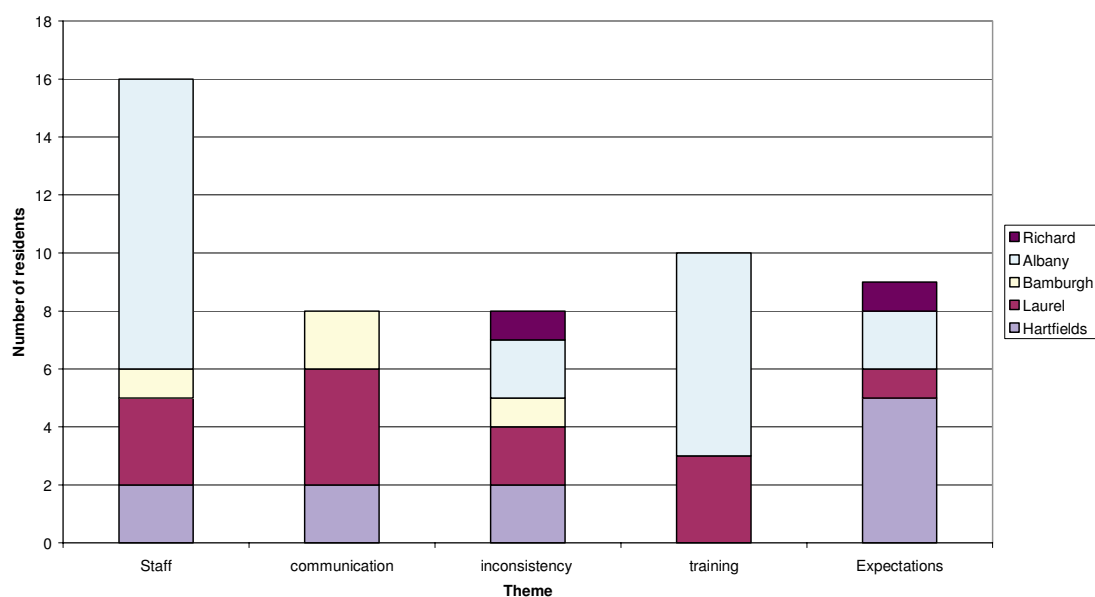


7.3.5 What residents did not like about care and support

The top three themes that residents did not like about the care and support were **staff, training** and **expectations**. The staff theme focused on issues around staff management, staffing levels, and any complaints directed about staff (no individual staff names were provided in the questionnaire responses). In particular, Albany Court residents reported more issues within the staff theme, these focused specifically on care staff who were family members and the lack of an office space for care staff so that they had to share the communal lounge with residents.

The second theme of training was only an issue in two of the schemes, Albany Court and Laurel Gardens, it focused on staff training particularly with residents feeling that some staff members were trained on the job rather than prior to starting. The final theme focused on the expectations of residents of the care they received. There were issues for some residents with the way support was or was not provided, or the length of calls which all arise from what they have come to expect from extra care rather than what the service is actually required to provide.

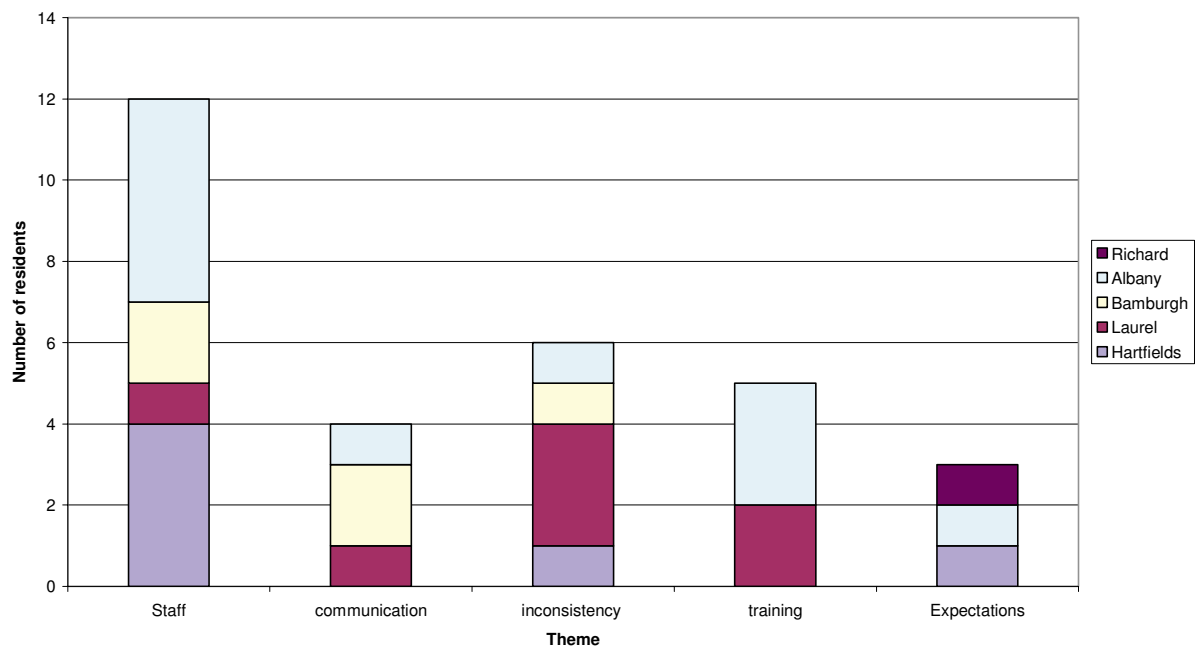
Graph 9- Summary of what residents did not like about the care and support in extra care



7.3.6 What residents thought could be better about care and support

The top three themes that people wanted to change about care and support in the future were **staff, inconsistency and training**. Changes that residents suggested within the staff theme focused on more staff and a qualified nurse on site. Resident suggestions within the inconsistency theme focused on being able to have the same or familiar carers and being able to know them. Finally, changes suggested within the training theme were only relevant to Albany Court and Laurel Gardens and related to the previous issue around perceived lack of staff training, including first aid training.

Graph 10- Summary of what residents thought could be better, or would like to see in the future about the care and support in extra care



7.4 Case Tracking

The results from the case tracking gave another opportunity to examine how the extra care schemes, in particular the care aspects, have been working.

It was evident that there is a need for more written evidence to be included within resident's care files for both care providers. It can be difficult to document all of the care and support, particularly emotional support, provided to residents. It was felt that at the moment both care providers were providing more care, particularly ad-hoc and emotional support, which was above that recorded. Providing flexible care on site is one of the key benefits of extra care, however it is important that we can measure this to some degree to truly reflect the level of support that is provided to residents to help them achieve their outcomes.

One issue that was highlighted was that there was not always evidence of reviewed care plans for some residents in the schemes. In some instances no date was provided on care plans or documents so it was not possible to tell how recently they had been completed. The daily care records provided a lot of information about what the calls consisted of, frequency and nature of tasks undertaken. It was also through the daily care records that changes in care needs were identified and care seemingly adapted.

Through examining the cases it was possible to see that the level of care provided was of a good standard. It was felt however that some of the care documents sometimes lacked clarity or relevant information, which could help assist care staff, particularly those who do not know the resident, in providing care. It was evident that sometimes there is a lack of clarity within the initial social services care plan that translated into the care providers care plan and associated documents.

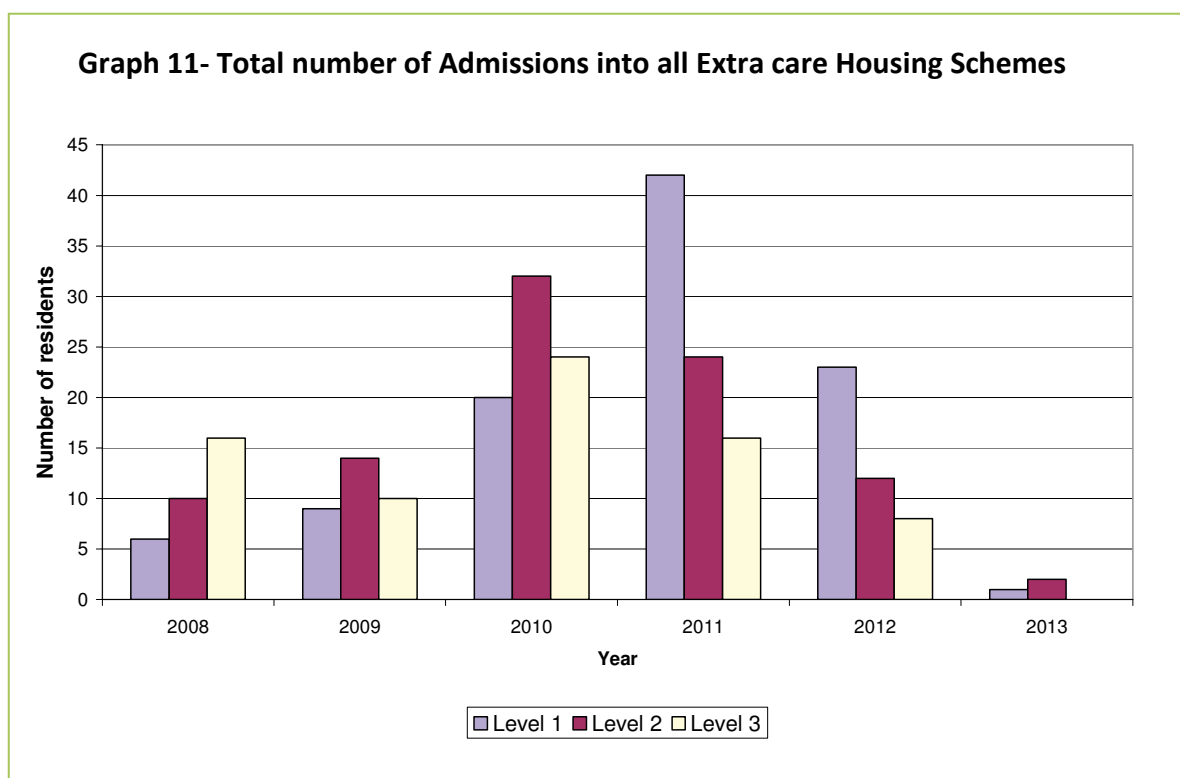
Another area that was concerning was whether care plans were outcome focused and linked to the person's outcomes. This was not always the case and this is an area that needs to be addressed.

There were varying degrees of how much the documents reflected a person centred approach and were specifically written for an individual as there were one or two instances where pick lists had been used.

7.5 Statistical Data

This gives a much wider understanding of extra care as it provides data on all residents within extra care who receive care and support. All information is from August 2008 until February 2013. Unfortunately, no information is currently collected for residents who do not receive care and support or those who do not access care through social services and fund their entire care privately.

7.5.1 Extra care admissions



Between August 2008 and February 2013 there have been a total of 269 residents, with care needs, who have moved into the extra care housing schemes. Examining the care level on entry to the schemes there have been 101 residents on level one, 94 residents at level two, and 74 people on level three.

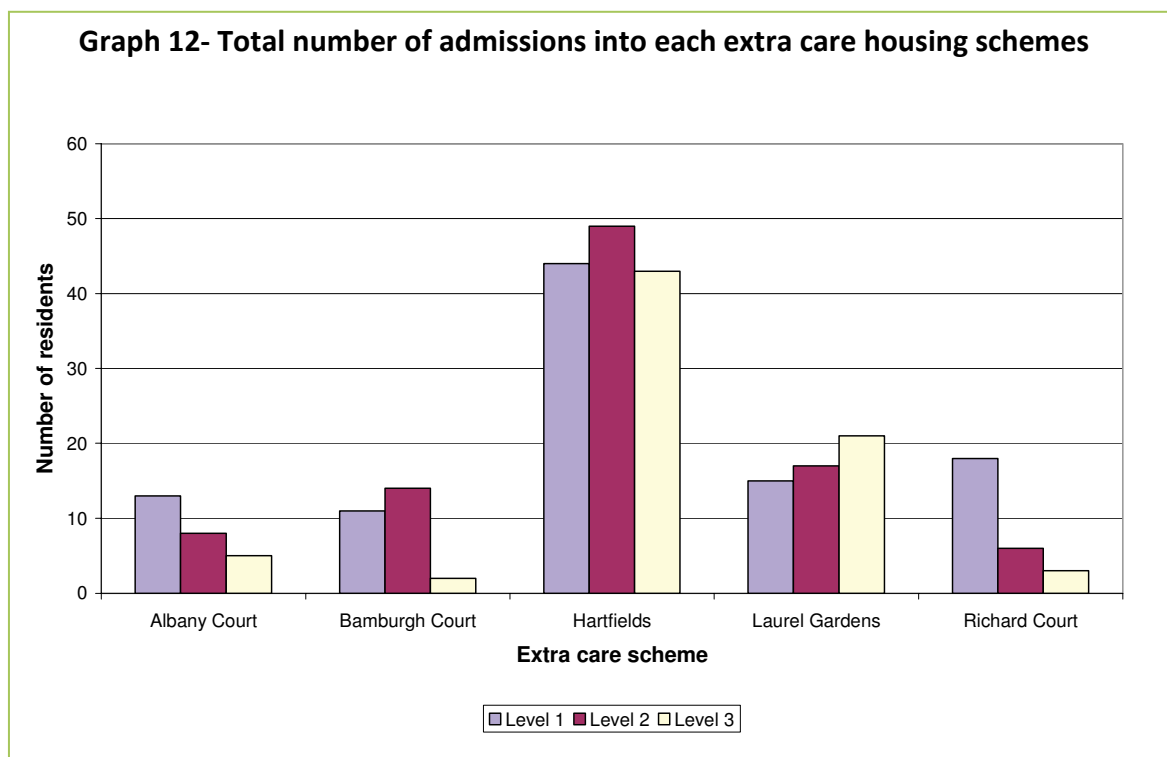
It is not possible to determine how many residents in total (including those without care) have moved into extra care throughout this period as this information is currently not collected.

The number of individuals who have been admitted to residential care and extra care since 2008 can be seen in Table 3. Please note that only residents who were receiving care at the time of their entry are included; it is not possible to provide the total number of residents.

Table 3- Admissions to residential care compared to extra care

Year	Residential Care	Extra Care
2008	504	32
2009	477	33
2010	503	76
2011	497	82
2012	493	43

Overall from 2008-2012 there has been a decrease of 11 people within residential care.



Hartfields is by far the largest extra care scheme and has been open the longest so it is to be expected to see a much higher number of residents moving in with care.

An important aspect of the extra care schemes within Hartlepool was to ensure there was a balanced community within each scheme. This means that there would be one third of residents with no care or level one care, one third with level two care needs and one third with level three care needs. Graphs 11 and 12 show that there are fewer residents moving in with level three care meaning that many of the schemes do not or have not had the proposed balance of care.

Overall Laurel Gardens and Hartfields have both had a balanced number of residents moving across all care levels, however this represents the total number of residents who have moved in with care and does not mean that the schemes are necessarily balanced at any one point in time.

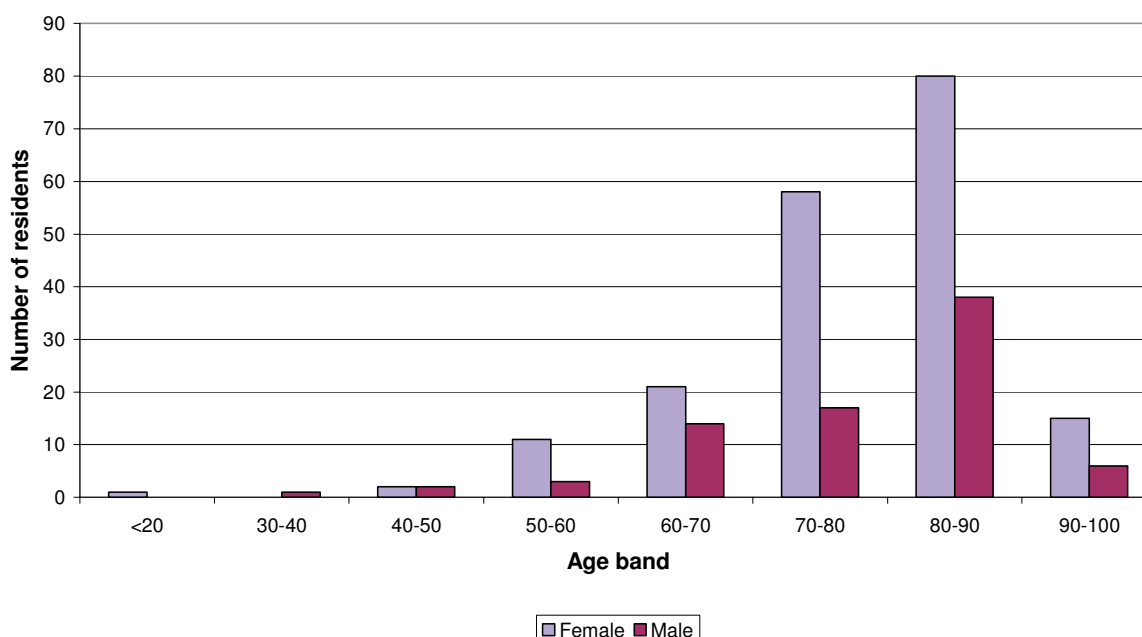
All schemes continue to have a high proportion of residents with no care needs as illustrated in Table 4. It is interesting to note that there was a perception from residents, particularly in Albany Court and Hartfields, that these schemes had a very high level of people with care and were turning into care homes. The perception of residents however, is unmatched to the actual mix of care.

Table 4- Proportion of residents with care within each scheme¹

Extra Care Scheme	Residents with care	Total number of residents	Percentage with care
Albany Court	20	41	49%
Bamburgh Court	18	78	23%
Hartfields	71	290	24%
Laurel Gardens	34	69	49%
Richard Court	19	60	32%

¹ Number of residents recorded in April 2013

Graph 13- Age and Gender balance across all extra care schemes from 2008-2013



There are double the number of women who have moved in with care and support compared to men (188 and 81 respectively) and the highest proportion of residents are aged between 70 and 90 years. There have been six residents under the age of 50 who have moved in to extra care, this is because there are a small number of properties available for people under the age of 55 years with a learning disability.

7.5 Exits from extra care

Between 2008 and 2013 there have been 107 residents who left the extra care housing schemes. The table below shows the split within care levels of those who have exited extra care.

As shown in the graph the main reason for exit from extra care is the death of a resident, which occurred in 61 instances, the second highest reason is admission to residential care (28 people) followed by admission to nursing care in 14 cases. Of the 28 individuals who moved to residential care, 11 of these cases were EMI (elderly mentally ill). This means that approximately 39% of residents exiting extra care have required residential/nursing care and 26% of residents required residential care. Of this 26% moving to residential care, 10% went to EMI residential care and 16% went to residential care. Only three residents have moved back into the community following their move to extra care. There was one resident who had to move into more specialist supported housing, unfortunately the communal element of extra care proved detrimental to the individual and highlighted the need to ensure that the ability to adapt to a communal setting is something that must be considered.

Graph 14 Discharge reasons for resident exits across all extra care schemes

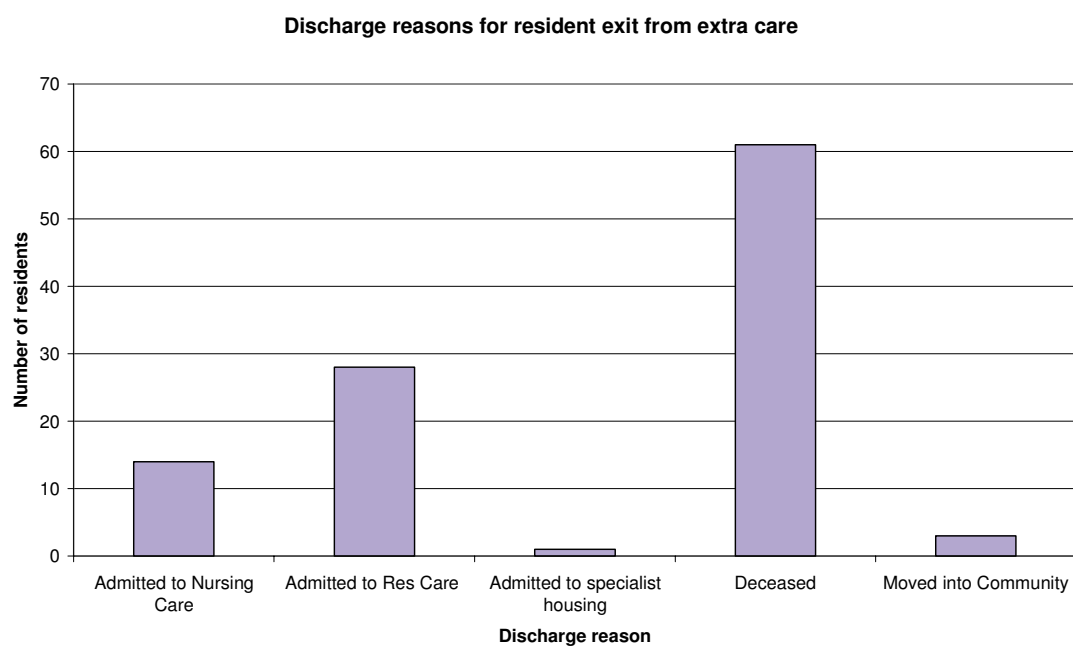
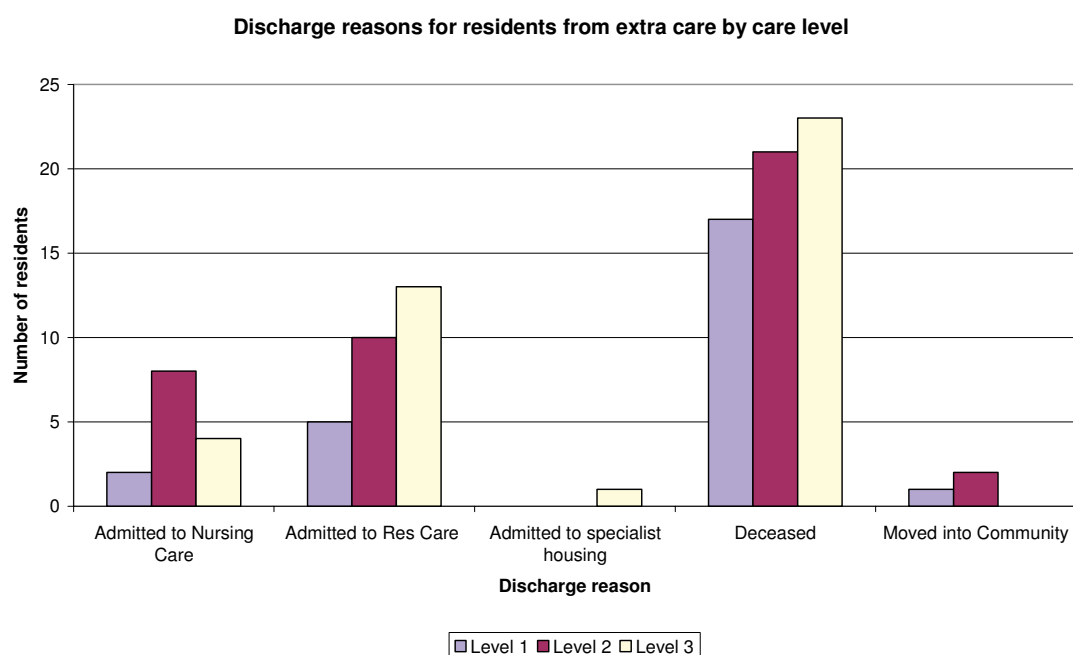


Table 5- Residents exits from extra care split by care level

Care level	Number of residents
Level 1	25
Level 2	41
Level 3	41
Total	107

Graph 15- Discharge reasons for resident exits from extra care split by care level



There were 11 cases where people were moved into EMI residential care however in the remaining 17 instances individuals went to residential care. Without examining the individual cases where residents transferred to residential care it is difficult to determine why the residents could not be supported in extra care and a move to residential care was required.

Within all the extra care schemes in Hartlepool level three care can provide a level of direct personal care which is equal to, and in some instances greater than, the average provided within residential care. It is therefore worth exploring why there are 11⁵⁴ residents who were transferred into residential care on a level one or level two. There is a need to examine these cases individually to understand the reason for the transfer.

Prior to January 2012, only Hartfields and Laurel Gardens provided care staff on site 24/7, the other three schemes (Bamburgh Court, Albany Court and Richard Court) provided overnight care staff as and when required. Anecdotal evidence suggests that there have been cases prior to January 2012 where residents have moved to residential care on lower levels as it was perceived by care managers that there was not sufficient overnight care support within Bamburgh Court, Richard Court or Albany Court. However, there are still five cases after January 2012 where lower level residents have moved to residential care.

There have been examples of cases where residential care has been used after discharge from hospital and for respite care in the short term, which has then resulted in some residents moving to residential care in the long term. This has at times been due to a lack of communication with extra care staff from HBC care managers or health professionals who have not always understood the full remit of extra care. It would be prudent to explore these cases further and consider this within any action plan that may result from this report.

7.5 Length of stay

The average length of stay for all residents⁵⁵ is 19.4 months. In comparison, the average length of stay for individuals within residential care is 21.2 months, a difference of 1.8 months, which is not significant.

Length of stay for both residential care and extra care was calculated from the same start date in 2008 until 13th February 2013, this ensured that the same period of time was compared.

Furthermore, only Hartfields was open in 2008 and it was only in 2010 that all extra care schemes were fully open and able to accept residents.

⁵⁴ There were 17 residents transferred to residential care from level 1 and 2 however six of these went to EMI residential care

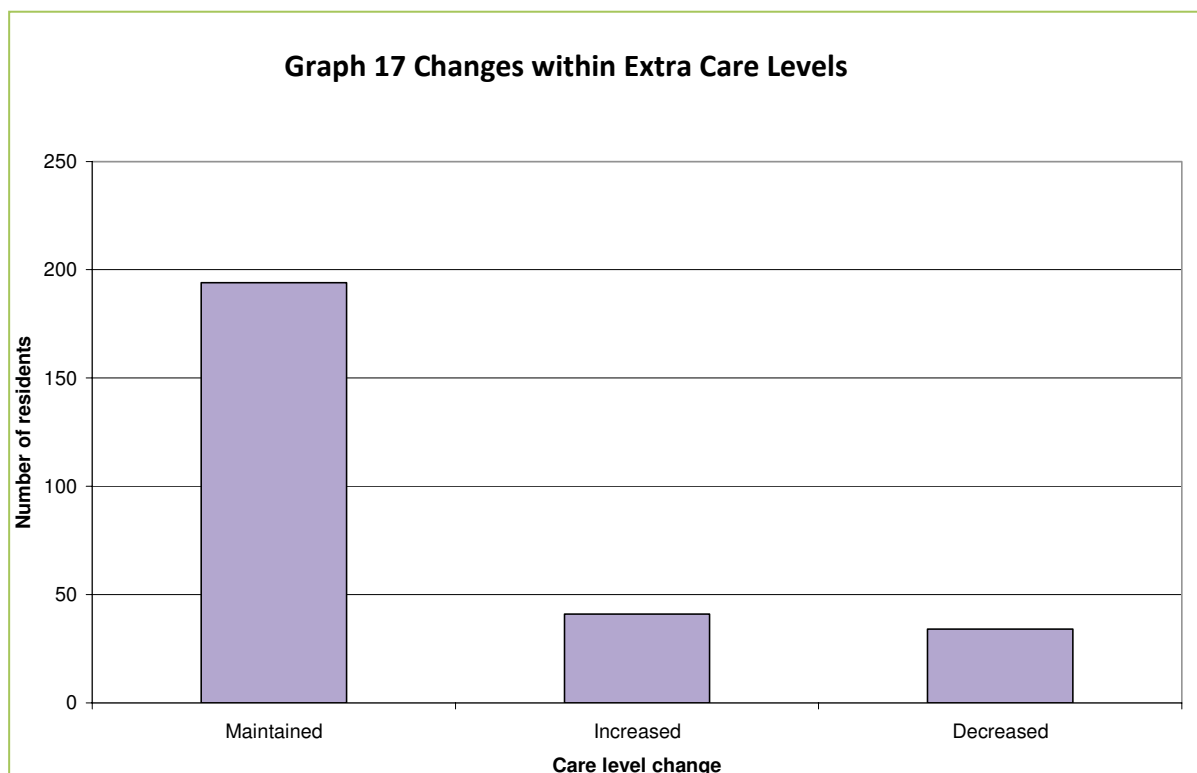
⁵⁵ This includes both current residents and historic residents who are no longer within extra care

7.5 Variation in care

Overall, there have been 194 residents who have remained on the same level of care as when they entered and 34 residents who have reduced their overall care level. This means that 228 residents have remained the same or decreased whilst 41 residents have increased their care level overall⁵⁶.

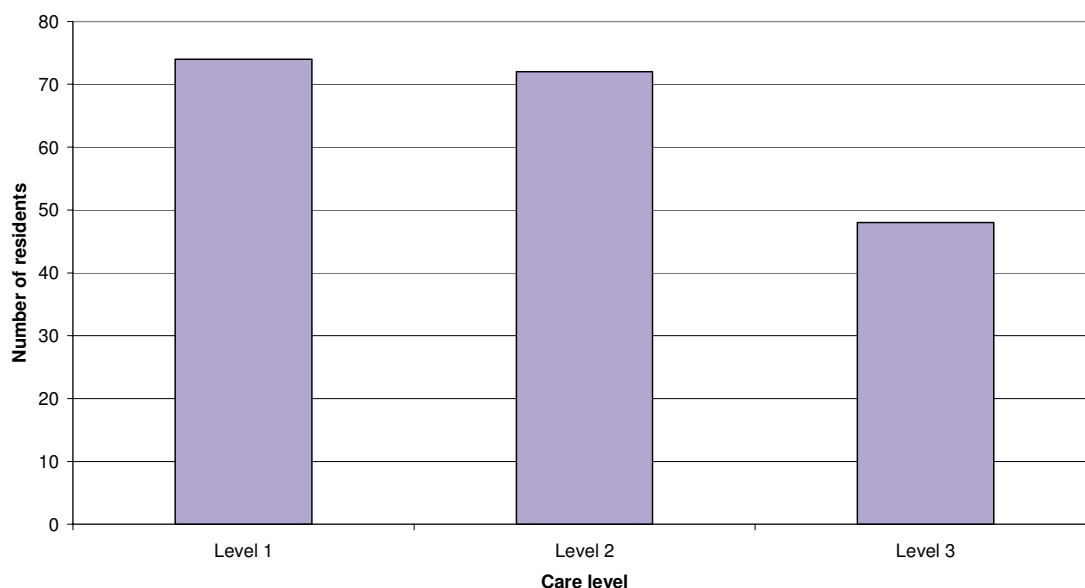
There have been a small number of residents where it has been identified that their care levels have reduced down to such a degree that they no longer require support, this was identified for 11 residents. It was possible to identify these individuals because they were originally coded as exiting extra care due to a reduction in care level. In five of the cases the residents went from a level two and in six cases the residents reduced from a level one to zero care. This is important as it illustrates how residents have increased their independence.

Unfortunately the information gathered does not provide information about residents without care needs, in the 11 cases identified it was possible to manually check where the resident was living and what care they received. It is not feasible with the number of residents in extra care and the resources available to manually check whether there are any other residents who have completely reduced their care package.



⁵⁶ Overall change in care analysed an individual's starting level of care and end/current level of care. This does not take into account variations that may have occurred throughout their tenancy

Graph 18 Overall results for residents who have maintained their care levels



When we examine the results for all residents who maintained their care level overall we can see that 74 residents remained on level one, 72 on level two and 48 remain on level three. We can use the average length of stay for current residents (19.4 months) to estimate that on average these care levels have been maintained for approximately a year and a half.

Graph 19 Overall results for residents who have increased their care level

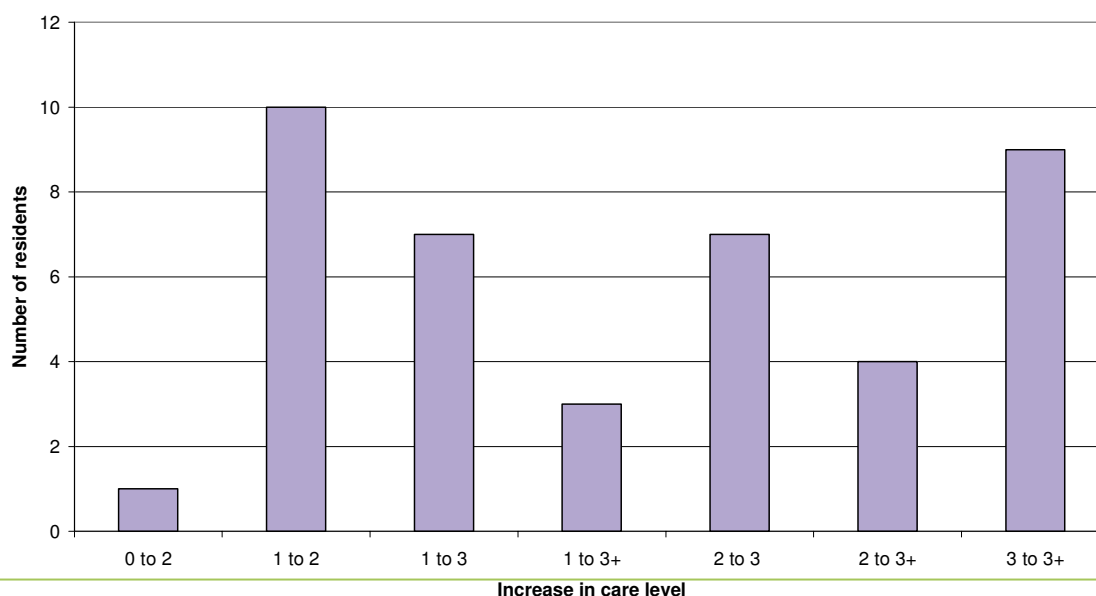


Table 7- Increase in Residents Care Levels

Increase in Care Level	Number of residents
Level 3 to Level 3+	9
Level 2 to Level 3+	4
Level 2 to Level 3	7
Level 1 to Level 3+	3
Level 1 to Level 3	7
Level 1 to Level 2	10
No care to Level 2	1
Total	41

Graph 20 Overall results for residents who have decreased their care level

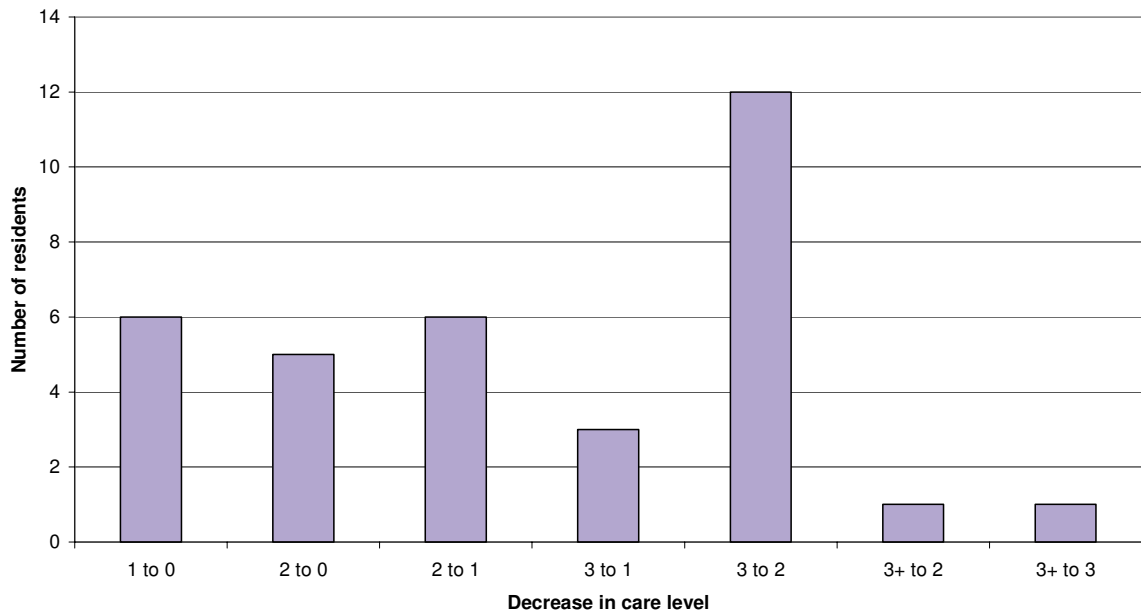


Table 8- Decrease in Resident Care Level

Decrease in Care Level	Number of residents
Level 3+ to Level 3	1
Level 3+ to Level 2	1
Level 3 to Level 2	12
Level 3 to Level 1	3
Level 2 to Level 1	6
Level 2 to No Care	5
Level 1 to No Care	6
Total	34

8. Summary and Conclusions

8.1 Summary of results

It was evident from the resident consultation results that the social benefits of extra care was the thing that people liked most about extra care and that many people felt that their social lives had improved as a result. The care and support provided was also highly regarded.

In terms of negative elements these focused much more around the built environment and the location of the schemes, which is often constrained by the availability of land for development. This does illustrate the importance of a well designed environment since many of these complaints are difficult to address once a scheme is established.

Changes that residents wished to see included more social activities, which would suggest that whilst people felt their social lives had improved there were still some people who felt that there was not enough social interaction within the schemes. It should be noted that there were far more positive comments about things that residents liked rather than comments made around things that did not work or suggested changes, which would indicate that overall residents were happy with extra care.

There were far less residents who responded about the care and support in extra care although there were a number of residents who included answers for this section even though they stated they did not receive care. The main benefit of care and support was a sense of reassurance and reliability from the care staff, implying that residents felt safer and assured that there was care available and that when required it was reliable and of a good quality. The comments around the attitudes of care staff were also positive which reflects well on the care providers. Although it may be necessary to revisit to ensure that carers are not simply doing everything for residents and are encouraging them to be independent. Evidence from the staff training showed the nearly all staff state their role is to do things with the resident, however residents often said carers will do anything for them.

The main issues around care and support were staffing, particularly training and staffing levels. Some residents had some unrealistic expectations of their care and support around what support should be provided and the amount of care provided in minutes. The key suggestions for changes to care and support focused on more staff training and staffing levels, and to improve consistency so that residents have the same carers.

In relation to the responses from extra care staff and HBC care managers there were some similar responses around what worked well notably social benefits, ability to live independently and safety and security. However, it was noticeable that there were quite different responses around what did not work well and potential future

changes; this would suggest that staff members in different organisations saw extra care working differently.

It is evident from the proportion of people with no care needs that there is not a balanced level of care within the schemes. In order to achieve the proposed balance of care required within extra care there is a need for significantly more residents with care.

It is necessary to examine further the fact that 26% of residents exiting extra care have entered residential care, with 10% moving into EMI residential and 16% moving into residential care. In particular, it is essential to understand why there have been a number of low care level residents placed in residential care. It should be positive that overall the main reason for exit from extra care is due to death (56%) as this shows that the majority of residents have been supported to remain in their homes.

When looking at residential care admissions from 2008-2012 we can see that residential care has decreased by 11 people. Although there has been a small decrease in residential care, overall it is difficult to determine whether this is due to the provision of extra care as an alternative. Furthermore, the small decrease is not likely to be significant.

The average length of stay across extra care and residential care was quite similar. The average length of stay for all residents within extra care was 19.4 months. In comparison, the average length of stay for individuals within residential care was 21.2 months, a difference of only 1.8 months. Considering several of the extra care schemes have only been open for a couple of years it would be expected that over time the length of stay in extra care would match or exceed that for residential care.

Overall residents in extra care were more likely to reduce or decrease their care level in extra care. Overall, 228 residents (84%) have either remained on the same care level as when they entered or reduced their care package. Only 15% of residents (41 people) increased their care level.

8.2 Conclusions

The aim of this evaluation was to determine whether extra care was an effective means of providing long-term housing and care provision for older people. In order to answer this question the evaluation objectives will be re-examined.

Please note that this review has not attempted to evaluate the financial cost effectiveness of extra care and has therefore not included any financial cost estimates or evaluations. A separate financial evaluation will need to be conducted before any financial conclusions can be drawn.

8.2.1 Objective 1: A reduction in the use of residential care placements

The number of residential places has slightly decreased since 2008.

Although there has been a reduction in the use of residential care it has only been by 11 places so is not a significant amount. It will be necessary to examine and compare this in the long term.

8.2.2 Objective 2 & 3: A reduction in the level of care and maintenance or improvement of an individual's independence

Care levels were reduced overall in 34 cases and were maintained in 194 cases. This means that 228 residents (85% of all residents with care) maintained or reduced their care levels. Overall, only 15% of residents increased their care levels.

Extra care achieves both objectives 2 and 3 and we can therefore say that extra care can be successful in maintaining and reducing care levels and increasing independence.

8.2.3 Objective 4: Improve quality of life

Objective four examined whether extra care improved the quality of life for residents. Quality of life is a very subjective measure however common features include good social relationships, sense of control, sense of safety and security all of which were reported by residents within the questionnaire. Equally the overall improvement or maintenance of care for residents would suggest that their health and social care needs have either improved or been maintained.

This evaluation found that extra care achieved objective four and should therefore be seen as one means to improve a person's quality of life.

8.2.4 Objective 5: Do working practices support the ethos of extra care

There does appear to be some improvement required in terms of practices. In particular, there is a need to improve communication between extra care staff and providers and HBC care managers. It may also be necessary to ensure that all professionals understand the full remit and capacity of extra care. There was some question as to whether care staff may do too many things for residents, however the overall care levels have reduced or been maintained suggesting that the care provided within extra care supports the ethos of increasing or maintaining independence.

Overall, there is room for improvement around communication and working practices, staff training and care documentation. However, this evaluation has found that extra care does achieve its outcome and promotes the ethos of independence.

9. Recommendations

There are a number of recommendations from this extra care evaluation

1. Improve working relationships between HBC care managers and extra care staff.
2. Ensure care planning by HBC care managers is flexible to give care providers flexibility in providing care to residents.
3. Ensure care providers receive enough information to appropriately plan and record the residents care plan within extra care.
4. Examine and where possible eliminate actual and perceived barriers to reducing care levels.
5. Improved the understanding of extra care for professionals (both within and outside of HBC), residents and families.
6. Explore options to gather information on residents who do not receive care to improve accuracy of future data analysis.
7. Continue to reinforce the ethos of independence by working closely with the HBC reablement team.
8. Housing and care providers to respond appropriately to complaints made by residents.
9. Reduce the number of residents placed in residential care and ensure residents are discharged from hospital to their home within extra care.
10. Examine how extra care in Hartlepool is set up to deal with residents with dementia.
11. Continue to measure the relationship between extra care and residential care placements.
12. To ensure evaluation is carried out periodically to further demonstrate the long-term effectiveness of extra care.

ADULT SERVICES COMMITTEE

12 August 2013



Report of: Assistant Director, Adult Services

Subject: TENDER FOR THE PROVISION OF LOW LEVEL SUPPORT SERVICE

1. TYPE OF DECISION/APPLICABLE CATEGORY

No decision required, for information.

2. PURPOSE OF REPORT

- 2.1 To inform members of the outcome of the tender process relating to the provision of a Low Level Support Service

3. BACKGROUND

- 3.1 The current contract for low level support services was awarded to Who Cares (NE) on 1 November 2011 and ended on 31 March 2013. The contract had a total value of £340,000 per annum (part year effect in 2011/12) and covered Care Navigation, a Handyperson Service and a Supported Access to Independent Living Service (SAILS) including advice, information, sign-posting, luncheon clubs, welfare notices and social activities.
- 3.2 Funding was used to provide:
- A navigator service available in North, Central and South Hartlepool, supporting people to access other services and providers and directly providing a service where appropriate;
 - Benefit and Welfare Advice Service available in North, Central and South Hartlepool;
 - Handyperson Service across the borough, providing low-level adaptations to support people to live independently at home;
 - Luncheon Clubs predominantly in the South but now being set up in North and Central Hartlepool;
 - Welfare notice system across the borough enabling people to self-refer or be referred into SAILS and receive that 'little bit of help' which may

prevent the escalation of their difficulties and the need for more costly intensive services.

- 3.3 On 4 February 2013 a Cabinet meeting took place and a report was sent for information to provide Cabinet with an update on services commissioned from Who Cares (NE).
- 3.4 At this meeting Cabinet decided that the Low Level Service contract would be put out to tender with the existing contract being extended until such time as the tendering process could be reasonably completed.

4. TENDER TIMESCALE, AWARD CRITERIA & EVALUATION

- 4.1 The tender timescale is detailed in **Appendix 1**.
- 4.2 The tender award criteria was based on a 70/30% split, with 70% being based on 'quality' related elements which were examined through evaluation of responses to the tender questionnaire and a follow-up interview and the remaining 30% based on analysis of a completed financial spreadsheet.
- 4.3 A team of officers from Adult Services, Finance and Corporate Procurement undertook a detailed analysis of the tender submissions on 5 July 2013 and interviewed bidders on 8 July 2013. Bids were reviewed and responses to questions considered against a consistent set of undisclosed 'model answers'. The relative strengths and weaknesses of responses were assessed and scores allocated on the basis described in the tender documentation.

5. OUTCOME OF TENDER PROCESS

- 5.1 Two tender submissions were received and evaluated. The outcome of the process was as shown in Table 1 below.

Table 1

Bid	Score from Quality Questionnaire (70%)	Score from Financial Evaluation (30%)	Total score
Bid A	91	120	211
Bid B	201	100	301

- 5.2 The two bidders were sent written notification regarding the outcomes of the tender process on 11 July 2013.

- 5.3 The contract has been awarded to Hartlepool Voluntary Development Agency (HVDA) and will commence on 1 October 2013, ending on 31 March 2014.

6. RECOMMENDATIONS

- 6.1 The Adult Services Committee is asked to note the outcome of the tender process relating to the provision of a Low Level Support Service.

7. REASONS FOR RECOMMENDATIONS

- 7.1 The contract award will enable the Low Level Support Service to be provided until 31 March 2014.

8. CONTACT OFFICER

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