26/05/23

Extra Care Housing Provider Engagement Event

Meeting notes

Pressures, challenges, and opportunities

- Move away from term Extra Care to one that reflects meeting needs. The term 'care' can be off putting and associated with 'care home' – leads to confusion for potential future residents, their families and for professionals. Housing LIN evidence supports the need to reconsider the term ECH.
- Funding reablement flats within schemes (short term e.g., 6-12 weeks) – example of this working in Gloucestershire was provided
- Also, opportunities for D2A with people moving form D2A flats into long term ECH

End of life

- Broad agreement that ECH should be considered home for life and can provide end of life support, with care team providing the end-of-life extra care.
- In retirement villages only 8/9% move to residential care for end of life
- Cheaper/more efficient to have integrated nursing care on site, or specialist nursing team across number of sites, as opposed to bring in district nurse (redefine model).
- Some landlords don't want to provide this, want 'vibrant' facility rather than higher needs.

Demand/ level of care and support needed at point of referral and after moving in

- What is forecast of housing needs – Helen/Susy to share Housing LIN report.
- ECH referrals have lower levels of planned care and support than in the past
- Some people reduce their support once moved into ECH - as their needs reduce, due to receiving more suitable/ flexible support.
- Question: Is there data to show if the level of care reduces when move from own home to ECH? e.g., lunch time call, dropped because now accessing restaurant. Susy is looking at this with the ECH care management team.
- Question: What is the price point/tipping point for cost of home care to ECH? Although cost is a consideration, need to recognise that people have choice over where they live.
- Suggestion: Social Value – could measure how much therapeutic support provider offers. This could be asked part of the tender process. But will impact smaller providers, so could have joint bids with VCSEs.
- Capturing added value - Activities within ECH – not paid for by Local Authority but activities reduce need for days centres etc.

Complexity – Mental Health (MH) and addiction

- There are difficulties in accessing support for people with MH and addiction – substance misuse teams, crisis teams etc.

- Providers need to know who they can call/ask for help and know that the request is being responded to.
- Could link to Help When You Need It mental health funding?
- State % of individuals with specific complex needs in schemes – therefore providers can know they need to have staff with speciality
- Need to look at impact on schemes - impact of service users with complex needs on other residents and community.

D2A/ hospital pathways in to ECH

- Consider pilot - looking at pathway 3.
- ECH providers would like Sirona to look at appropriate housing options when people move on, supporting aging in the right place, not just age in place - consider ECH.

Publicity

- Offer for practitioners visit schemes and for commissioners to talk to other Local Authorities
- Agreement that there is limited awareness of ECH among the public and health and social care professionals.

Panel (for nomination and allocation to ECH)

- Panels need to work effectively to ensure people given right support and voids are filled within agreed time scales.
- Need clarity in the specification on roles and responsibilities within allocation process
- Further work on a tri-party agreement is planned (enabling clarity of roles/ responsibilities/ processes, shared between LL/care and support/BCC)

Breakout Session 1: Moving Forward (ECH provider suggestions/ ideas)

- Night cover (2 waking nights?) on block contract to support complexity. Different models needed dependent on care needs.
- One provider currently uses external OOH services to support night calls, alongside their own staff
- Block good option – but not at lower hourly rate – rates need to be accommodated within block.
- Block to include core care hours and support elements.
- Block could include core support and support for moving in
- Need to calculate block with contingency to ramp up (base and uplift) – e.g., block funding could be 60% of nominations and 40% flex/increase. Provider suggestion: this would be a budget with contingency and if provider demonstrates savings whilst delivering quality care then share savings between provider and Council.
- Outcomes - smaller block to support everyone in service with flexibility to react, manage activities, improve goals and outcomes, this could be floating support. Currently not funded to support achieving outcome/goals.
- Outcomes - how measure this and what is incentive (share of savings).
- Could support more people with resource, i.e., people needing support between calls.
- Target of reducing residential care spend – this is about reducing numbers of people moving from ECH into care homes and avoiding moves into residential care though offering ECH alternative

- Specification– KPIs – score on cost and quality, also in specification include value added requirements and real living wage (what does this include).
- Need to have consistency of process within BCC with social care workforce understanding what ECH is and taking same approach to allocation of unplanned/ support hours – providers have had quite different experience of this (requests for increases refused / accepted)
- Restaurant service. One LL makes it a condition of tenancy to sign up to use of restaurant, use and external company.
- **Conclusion:** yes, to block but needs to be flexible with shared incentive to keep hours within a certain criteria and efficiency.
- Support – IT needs to be included – very beneficial, technology can improve wellbeing. Not all schemes Wi-Fi enabled.

Breakout Session 2: Specialist vs non specialist ECH (ECH provider comments/ suggestions)

- For specialist ECH – schemes need to be smaller units/standalone or costed into existing model.
- Spectrum of need – highly complex individuals could have different tenancy to manage relapse, for example.
- Specialist ECH may work for some needs e.g., dementia, but not for drug/ alcohol dependency
- Could consider 'corridor' specialists (see Housing LIN), e.g., a corridor where people with similar needs live
- An increase in number of people with autism at a scheme – a member of staff with autism set up a support group that has brought people together/ created positive relationships

Work with localities/Sirona

- Upskill carers to do Sirona work i.e., wound dressing – good workforce development but Sirona's support to do this.
- Would be useful to have initial conversations with Sirona together, not in each locality.