

## Charging in Extra Care Housing

This report considers approaches to charging people living in Extra Care Housing for the various services provided, with a particular focus on social care.

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## **About the Housing LIN**

The Housing LIN is the national network for promoting new ideas and supporting change in the delivery of housing, care and support services for older and vulnerable adults, including people with disabilities and long term conditions. The Housing LIN has the lead for supporting the implementation and sharing the learning from the Department of Health's £227m Extra Care Housing Grant arrangements and related housing, care and support capital and revenue programmes.

## 1. Introduction

This report for the Housing Learning and Improvement Network (LIN) considers approaches to charging people living in Extra Care Housing for the various services provided, with a particular focus on social care. It explores the implications of differing funding sources and commissioning structures on these charges, as well as key policy initiatives such as the personalisation agenda and mixing tenure within schemes. It should be noted that the planned introduction of free personal care for those with the highest level of need will raise further questions about the most appropriate contractual and charging models.

However, as has been well stated elsewhere:

*"the most successful schemes are healthy partnerships where all partner organisations and departments share the same objectives and aspirations, and whose operations are characterised by a high degree of trust. This is probably more important in achieving a successful scheme than which particular funding, management and charging models are employed."*<sup>1</sup>

The paper draws on existing research and materials, and the experience of a small number of authorities through information gained from telephone interviews.

## 2. Extra Care Housing

### Characteristics of Extra Care Housing

The nature of extra care housing creates challenges for commissioning and funding structures not necessarily designed for the flexibility it entails. It may take a number of different formats and designs, but primarily it is housing which *"has been specially designed, built or adapted to facilitate the care and support needs that its owners/tenants may have"* with *"access to care and support available 24 hours per day either on site or by call."*<sup>2</sup> It is the importance of the availability of 24 hour care which creates particular additional challenges with the more recent introduction of the personalisation agenda, as is discussed below.

The majority of extra care housing is for rent, but increasingly schemes are being developed which are mixed tenure, with accommodation available for sale or shared ownership. This paper focuses on schemes developed by social housing providers, but commissioners will increasingly be working with private developers to enable existing and future demand to be met in their authorities. Such private developments are likely to include residents who will need to access social care and housing related support in time, and for whom charging mechanisms will also be relevant.

### Commissioning and Contracting Relationships

There will be a number of partners involved in the commissioning of extra care housing (ECH), and the contracting of services provided within it: *"It is the number of potential partners and funding streams, the provision of both buildings and services and the relatively*

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<sup>1</sup> Housing LIN Factsheet 21: Contracting Arrangements for Extra Care Housing 2007

<sup>2</sup> Extra Care Housing Toolkit, 2006, Department of Health

*small scale (where individual schemes are concerned) that makes contracting for Extra Care housing challenging.”<sup>3</sup>*

The approaches taken to the contracting of the main services within ECH vary:

- Is there to be an integrated service combining housing management, social care and housing related support?
- Is each aspect of the service to be contracted and provided separately?
- Are there differing combinations of the three?
- Is there another arrangement with PCT to meet specific health outcomes such as continuing care, prevention or re-ablement at home?
- Is there a widespread adoption of personal budgets or self directed care and/or support?

The separation of these services, particularly whether there are separate providers or greater personal decision-making/autonomy, can be confusing for the service user in terms of understanding who is responsible for which tasks. It is more usual to see a combination of the housing management and support functions, or a combined support and social care service, but there are also examples where one provider provides a fully integrated service and others where residents have greater control through the use of personal budgets.

## **Charges in Extra Care Housing**

Residents in extra care housing pay for the range of services provided through a number of charges. The main charges are rent and service charges, and social care and support charges, however residents also could be paying for meals, activities and other services such as housework and hairdressing.<sup>4</sup> Where services are integrated arrangements need to be made to account for combined charges, such as a combined care and support charge, or a combined housing management and support charge. This is discussed in more detail below, but one approach would be to look at the percentage of staff time spent on different tasks, say housing management or housing support, and allocating costs to the various funding sources accordingly, eg, to rent or Supporting People charges.

The table on the following page describes the main services, the charges relating to them, the approaches to attributing costs to residents, and the benefits or subsidies available to individual residents.

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<sup>3</sup> Housing LIN Factsheet 21: Contracting Arrangements for Extra Care Housing 2007

<sup>4</sup> See further discussion of this in Housing LIN Technical Brief 2: Funding Extra Care Housing, 2005 and Factsheet 19: Charging for Care and Support in Extra Care Housing, 2007

**Table 1: Potential Charges in Rented Extra Care Housing**

Main Services	Charges	How cost is attributed to residents	Potential benefits and subsidies for individuals
Landlord and housing management	Rent	Cost relates to the size and attributes of the accommodation.	Housing Benefit (HB)
Additional housing services, eg, grounds maintenance, depreciation and maintenance of equipment.	Service charges	Total cost distributed between all units of accommodation with variation according to the size of the unit.	HB
Housing related support	Support charges	Traditionally distributed equally between residents, but there is now a move towards being based on assessed need.	HB or Fairer Charging assessment for subsidy from Supporting People Administering Authority
Social care	Care charges	Charges will be based on an individual's assessed need as identified through the Single Assessment Process (SAP) assessment and care plan.	Fairer Charging assessment identifies level of charge payable <sup>5</sup>

In leasehold properties, where a lease is purchased for the whole property, the resident will not pay rent but will pay a maintenance contribution. In shared ownership properties, where a lease is purchased for a “share” of the property with the remainder rented, residents will pay a smaller amount of rent in addition to a smaller maintenance contribution. Residents who are not eligible for financial help through the Housing Benefit or Fairer Charging systems may be entitled to Attendance Allowance that could be used to pay for these services.

### **Self-directed support**

The development of self-directed support suggests that there will be growing numbers of older people living in ECH who will use mechanisms such as Direct Payments to purchase their care from their own choice of provider<sup>6</sup>. In addition, there will be self-funders, particularly, but not only, within shared ownership and leasehold schemes, who will wish to make their own purchasing decisions.

Where residents choose to purchase care and support from external providers, this has the potential to create longer-term difficulties for commissioners and providers. Often the financial viability of an on-site care team (seen as inherent to ECH) depends on the

<sup>5</sup> Fairer Charging Policies for home care and other non-residential Social Services: Guidance for Councils with Social Services Responsibilities, 2003, DH

<sup>6</sup> Department of Health LAC (DH) circular (2009) 1 Transforming Adult Social Care

provision of a given amount of care.<sup>7</sup> However, equally the option to purchase externally presents a challenge to commissioners and providers to ensure the quality of their on-site care provision, including waking night time care, makes it a first choice for people moving in to the scheme, and is marketed accordingly.

Commissioning authorities need to find a balance between protecting the ethos of their ECH in terms of the accessibility of services on a 24-hour basis, and the right of the individual to choose the best provider of their services. As will be discussed below, some authorities have seen the requirement to contribute to the cost, for example, of night time staffing, as inherent to the decision to move into ECH. Residents may then choose an external provider for the remainder of their care. Other authorities have relied on the benefits in terms of responsiveness and flexibility of the on-site team to “sell” the service to residents. Another option would be to enable the on-site team to provide care to people living in the surrounding area to enable the service to remain financially viable.

An additional issue for the individual will be the affordability of individually purchased care, particularly 24 hour care, and whether there are options for pooling purchasing or drawing down on a local authority contracted service.

The key issue must be that the service is seen to provide value for money for the individual, as well as meeting their expectations in terms of its quality. How the costs of the service are charged to individuals will clearly affect how it is seen in terms of value for money; the remainder of this paper discusses the range of approaches to charging for social care.

### **3. Charging for social care**

#### **Introduction**

There are a number of factors affecting the way authorities charge for the care provided in extra care housing, but the overriding aim must be to develop a system that protects the ethos of the scheme whilst being transparent and fair for individuals being charged, and takes account of their ability to make choices.

As has been described above, one of the core characteristics of ECH is to provide “*individually tailored, flexible and responsive care and support services to individuals in their own homes, cost effectively and efficiently*”<sup>8</sup>. Guidance on charging for non-residential services<sup>9</sup> requires authorities to ensure their charging policies are “*demonstrably fair as between different service users*” as well as promoting “*the independence and social inclusion of service users.*”

This section considers the way the contractual arrangements for social care within ECH can vary, and how this impacts on charging arrangements. It then discusses the various approaches to charging. It looks at how these approaches meet the potentially competing

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<sup>7</sup> See discussion in Housing LIN Viewpoint 13: Individual Budgets, Micro-Commissioning and Extra Care Housing, 2008 and Housing LIN Case Study 43: Reeve Court Retirement Village: Block Contracting Care in Bands, and Individual Budgets, 2008

<sup>8</sup> Housing LIN Factsheet 19: Charging for care and support in extra care housing, 2007

<sup>9</sup> Fairer Charging Policies for home care and other non-residential Social Services: Guidance for Councils with Social Services Responsibilities, 2003, DH

requirements of fairness and choice for the individual, and an ability to provide flexible and responsive care and support services.

## **Contractual arrangements**

Although some authorities have applied the same approach to contracting care in ECH as in the community, this does not always allow providers the flexibility to reflect the changing needs of the individual in ECH. In particular, providers and individuals need to be able to increase or decrease levels of care as circumstances change, and without going through lengthy reviews and assessments. On the other hand, commissioners need to ensure they maintain accountability for the service provided. Whilst some authorities have in-house teams providing care in ECH, more have contracted with external providers and thus need to consider how the contractual model will best work for all stakeholders. This has led to the development of a range of contract models, but probably one of the most important considerations here is developing the model through dialogue with providers. Providers may have experience of a number of approaches, and will be able to contribute their knowledge to the development process. Being involved in these development stages will also help develop the trust needed between commissioners and providers to enable an effective service to be provided.

An individual authority's vision for ECH is an important starting point for developing contract models. Where an authority is seeking to develop "balanced communities" within schemes, the definition used will often be reflected in the approach to the contract. A number of authorities have defined a balanced community as one where there is a mix of needs assessed in bandings. Typically, there will be three bands (low, medium and high) as defined by the assessed need for care and support, and the authority will have fixed a percentage of each banding within schemes (such as one third of each). An alternative approach to defining "balance" looks at a range of issues across the community more flexibly, taking into account levels of physical frailty, mental health, and community issues such as levels of participation in social activities. This requires a different approach to enabling flexibility within contracts.

Contracts for care provision within ECH have in the past taken one of a number of forms:

- A block contract with a fixed cost, and a fixed number of hours provided.
- A block contract but with additional "spot" purchased hours as needed.
- A contract entirely on a "spot" purchased basis according to the assessed needs of individuals.

The last of these is arguably the most accountable for the commissioner with costs reflecting actual care assessed and provided. It is, however, likely to be the most administratively clumsy, does not encourage providers to flex the service to meet an individual's changing needs, and is potentially more expensive to reflect the uncertainty for providers. It may sit more easily with an approach to charging where the individual paid for the actual care hours provided, as described below. It also creates an environment in which individual purchasing of care sits very easily.

The forms of block contract can appear to create a tension with the approach to personalisation.<sup>10</sup> Arguably, a core block service which includes overnight care, enables this service to be maintained, and allows individuals to purchase care themselves on top of this.

In developing a block contract, the use of the bandings may assist the commissioner to determine the total hours for the block by averaging across the numbers in each band. Alternatively, a total may be determined by looking at average packages in the community for the different levels of need expected within the scheme. The key issue here in terms of enabling flexibility is the degree to which providers can change the level of care for individuals within the block contract, and there are a number of approaches:

- Contracts that reflect bands of care needs, with flexibility allowed within these bands, and with formal approval needed for movement between bands. In other words, the provider is able to fix the hours of care provided for an individual as long as it remains within the assessed banding.
- Contracts where short term changes can be met by the provider, but where these changes last more than a fixed period of time a review is needed to formally assess the new level of care.
- Contracts fixing a core service (typically including night time cover and a minimum number of care hours) but with spot purchasing of any service provided above that level.

Another consideration in designing a contractual model is the degree to which services are to be integrated, and the number of providers involved in providing and accounting for the service as a whole.

The Housing LIN Technical Brief “Funding Extra Care Housing”, describes various approaches with one possibility being the combination of care and support, hence adult social care and Supporting People jointly funding the 24 hour care and support service, but with the housing management remaining separate. This is currently being updated but the table on the next page from the original Technical Brief sets out how the costs were allocated between the different services.

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<sup>10</sup> See further discussion of approaches to contracting in A Guide to Fairer Contracting Part 1, 2005, Care Services Improvement Partnership



**Table 2: Allocating costs in a combined care and support model<sup>11</sup>**

Post	Rent	Service Charge	Supporting People	Social Services
Scheme Manager	15%	45%	40%	
Care and Support Team Leader			30%	70%
One care and support – day time			50%	50%
Night care and support worker			50%	50%
Additional care and support workers for care plan delivery				100%

The integrated approach arguably provides a more coherent service for the individuals within a scheme, with fewer concerns for the service user about individual staff responsibilities, but it will require some form of agreement as to how costs and charges are allocated to ensure accountability both to commissioners and service users.

### Approaches to charging

Whilst there are a number of factors that will need to be taken into account in developing an approach to charging, the objective must be as set out in the Government’s guidance for local authorities on charging for non-residential services: “*Councils need to ensure both that their charging policies are demonstrably fair as between different service users and that the overall objectives of social care, to promote the independence and social inclusion of service users, are not undermined by poorly designed charging policies.*”<sup>12</sup>

In developing an approach, authorities will also need to consider the more detailed application of the approach, including such issues as:

- Is care charged for when a resident is away or in hospital?
- How will temporary increases or decreases in levels of care be accounted for?
- How will charges be collected?

Decisions on these issues will have an impact on how a service is perceived or experienced on a day-to-day basis in terms of its flexibility and accountability to the service user.

This section considers some of the main approaches to charging for care, although there are many variations in the detail of how these approaches are currently applied. However, commissioners and providers also need to be mindful of the planned guidance and regulations, the implications of Individual Budgets for charging in Extra Care and the proposals for a National Care Service, set out in the forthcoming government White Paper.

<sup>11</sup> Housing LIN Technical Brief 2: Funding Extra Care Housing, 2005

<sup>12</sup> Fairer Charging Policies for home care and other non-residential Social Services: Guidance for Councils with Social Services Responsibilities, 2003, DH

### Charges related to banding

Where levels of need for care and support have been defined in terms of bands, with the intention of developing a balanced community based on the mix of bands, this creates the opportunity for charging using the same categories. This means that everyone within a particular band is charged the same amount, with the charge remaining the same as long as their care needs remain within that band (the case study from Cheshire on page 10 provides an example).

This approach has the advantage of being relatively simple, and should encourage a flexible approach to the provision of care within the bands. However, there is a risk that individuals at the upper boundaries of the bandings will be reluctant to be re-assessed because of the extra cost of the next band. There may also be a question around value for money for the individual at the bottom of the band who is paying the same as someone at the top of the band. This issue may be minimised by keeping the bandings relatively small, but that in itself could reduce the level of flexibility for the provider.

This banding approach would only work in terms of the personalisation agenda where it is argued that the choice is in moving to the extra care housing scheme, rather than in the individual's choice of care provider. However, it may be that exploration of pooling budgets or using budgets to draw down on local authority contracted services could provide an alternative approach.

### A core and top-up approach

In this approach all residents, regardless of their care needs, pay for a "core" service, with the remainder provided as a "top-up" and based on their assessed needs. Typically the core element covers the costs of staffing at night. It is argued that it is important to protect this night service as it provides a level of security and reassurance that all residents benefit from, although they will not all necessarily use it. Where residents have chosen external care providers it is often the night time response, particularly in an emergency, which is more difficult to organise because the service is not based in the scheme.

Where there is a minimum level of care required to be eligible for a scheme (for example a minimum of 4 hours per week) this core service can encompass this, with additional hours covered by the top-up service. Here the equity of the charge is not an issue, and there is the benefit for the provider of a consistent basic level of funding. In terms of the personalisation agenda, the choice here would be both in the move in to a scheme with a core service, and then also in the choice of provider for the top-up service.

It is important to note that the requirement to buy this core service should not form part of the tenancy agreement, given the risk that combining the accommodation and care in this way could require registration as a care home by the Care Quality Commission. The requirement would form part of a separate care contract with the individual.

### An individualised approach

In an individualised approach the charges paid by the individual reflect the actual number of hours of care they receive, and vary in accordance with the variation in hours. This provides what is probably the most transparent and equitable approach, however the process of varying care packages and administering the variation in charges could inhibit the responsiveness and flexibility of care service that is seen as a key characteristic of ECH.

This approach would fit most easily with contracting on a spot basis and may have the same impact on the cost of the service.

#### Insurance based model

A very different approach has been adopted in community care retirement communities such as the Joseph Rowntree Housing Trust's, Hartrigg Oaks, where care is financed through an insurance-based model.<sup>13</sup> A funding pool is created on which all residents can draw as they need care, through each paying a capital sum on entry to the community, as well as an annual fee. This approach relies on the assumption that the majority of residents at any given point in time will be contributing to the funding pool rather than drawing care and support from it. Therefore it is very important that there is the right "balance" of residents (hence a health assessment at the application stage), and also that the community attracts people who are likely to live independently for a number of years.

At Hartrigg Oaks, the capital fee and the annual charge can be paid in several ways. There are three types of capital fee:

- A 'fully refundable' fee, which can be repaid, without interest, to the resident (or their estate).
- A smaller 'non-refundable' fee.
- A monthly payment, rather than a one-off capital sum.

There are two main types of annual charge:

- The flat-rate 'standard fee', which covers service charges and any care or support that a resident requires (including permanent residential care).
- The 'fee for care' arrangement, whereby a resident pays a lower annual service charge only, but has to meet the costs of any use of care and support services themselves.

This approach is seen as being attractive to wealthier individuals who want the security of being able to make provision for future care needs, and spread the costs over a number of years.

## **4. Case studies**

These case studies have been developed through telephone interviews with key staff, and are designed to illustrate some of the different approaches to charging for services in ECH.

### **Cheshire**

#### Background

Cheshire County Council<sup>14</sup> have a major programme developing extra care housing, with the aim of providing sufficient ECH in each natural community amounting to 4,000 units by 2014.

<sup>13</sup> Living at Hartrigg Oaks: Residents' views of the UK's first continuing care retirement community, 2003, Joseph Rowntree Foundation. Mixed Tenure in Extra Care Housing, Technical Brief No.3, 2005, Housing LIN.

There are currently five schemes in management, with a further five due to open in 2009 through their Private Finance Initiative (PFI) programme, and further schemes in the pipeline. Their schemes include rented (the majority) and shared ownership accommodation.

Cheshire's vision is for ECH to support a balanced community, with communal facilities providing a range of active ageing programmes open to the surrounding community. The focus is on the preventative nature of ECH for its residents and neighbouring older people. It is recognised that for some people this will be a replacement for residential care, and the intention is that placements in residential care will not increase in line with demographic trends.

### Balanced Community

All residents have access to waking night staff (and all pay their share of the cost of this), so the banding is based on a care assessment that looks at daytime needs only. The community is banded according to the hours of assessed need for care per week, with the assumption that all residents will have some level of care need.

High banding (one third of residents)	=	10+ hours per week
Medium banding (one third)	=	3 < 10 hours per week
Low banding (one third)	=	1 < 3 hours per week

These bandings were based on average community care packages as follows:

- *High:* based on typical care hours within the day in a residential care home (14 hrs per week is allocated to provider for high band).
- *Medium:* based on typical care packages within the community of about 6 – 7 hours.
- *Low:* People who were relatively independent in terms of personal care needs but maybe had an hour's shopping or cleaning a week.

The contract allows for flexibility within each banding, but moves between bands (unless they are short term) require a formal care review. The flexibility within the banding enables the care provider to deliver a responsive personal service which aims to maximise individual independence.

### Charging and value for money

The amount paid by residents depends on the band allocated to them, and the charge will only vary if they move into another band. All residents pay a proportion of the cost of the night time cover. The same approach is taken for self-funders.

Cheshire have found that the care contract within ECH is more economic than that provided in the community, as well as having the added value of 24 hour on site responsive provision.

Self-funders pay the following weekly charge, inclusive of night time cover. It allows residents up to six weeks free support at a higher band if they experience greater needs for a temporary period.

<sup>14</sup> Since this case study was prepared Cheshire County Council ceased to exist and two new Unitary Authorities were created Cheshire East and Cheshire West and Chester

- *High:* £222 per week (which compares to an average fee of £366 per week in a residential care home in Cheshire).
- *Medium:* £128 per week (which is equivalent to less than 5 hours per week in the community).
- *Low:* £17.50 per week.

There has not yet been anyone moving into ECH with direct payments or individual budgets, but given the number of schemes coming into management over the coming years, this is expected to change. The approach being taken is to focus on promoting the added value for residents of receiving on-site care in a responsive and flexible way.

#### Communication

In addition to a general leaflet about charging for social care covering fairer charging assessments etc, Cheshire has developed a specific leaflet about ECH. This was developed with and tested by group of older people, and covers the ethos of ECH, the flexibility of the on-site care service, and the approach to charging. The leaflet is sent out to people when they first express an interest in ECH.

### **Hartlepool**

#### Background

Hartlepool BC is part of the 'In Control Total Transformation Programme', and now operates personal budgets across all groups of the population, with a focus on the outcomes achieved for individuals.

In August 2008, Hartlepool opened Hartfields - a retirement village operated by Joseph Rowntree Housing Trust - consisting of 242 bungalows and flats. The village provides a mix of social rent, shared ownership and outright sale for people over the age of 55 with a range of care and support needs. The care is contracted on through an outcomes based specification.

#### Costing for Extra Care

Hartlepool operates a banded system of costing for care in ECH. In effect there are four bands, although only the top two bands attract social care funding. The bottom two bands are for people without any support or care needs, and then for people with only support needs. The banding reflects an assessment of need at a particular time, and therefore the cost of the care charge within ECH.

Given the use of personal budgets, the approach to assessing the contribution an individual will pay for their care is as follows:

- The allocation of funding is made based on a self directed assessment questionnaire complete with the individual by a social care professional.
- A means test is carried out to identify the maximum contribution the individual will need to make.
- A support plan is produced to identify the support package wanted by the individual.

- Hartlepool will always pay first 25% of the cost of the support package
- For the subsequent 75% the individual pays up to the maximum contribution as assessed through means testing.

For example, if the weekly care cost is £100, then for all people Hartlepool will pay £25, and then individuals pay up to £75 depending on the maximum contribution identified for them through means testing.

#### Personalisation and value for money

Hartlepool has recognised that there could be a perceived conflict between the personalisation agenda and ECH, given that care provision is usually provided by an on-site team where the individuals delivering the care will not necessarily be chosen by the resident. However, they consider the element of choice is in the decision to move into ECH and therefore the residents are buying in to the lifestyle and the package on offer. Theoretically, people could choose to continue with care bought through their direct payment, but then they would not routinely have access to night time cover and the flexibility of care provided within the bandings. It is anticipated that should an individual need care in an emergency that would be provided but generally at an additional cost to themselves. There is a risk that constant use of the on-site care team in this way could severely impact on those whose needs the level of care and support is based upon.

The “value” of ECH is beyond the purely financial value for money but takes into account the value of the concept in terms of outcomes for the individual. These outcomes could include a sense of security, wellbeing, and being part of an active community.

## **East Sussex**

### Background

East Sussex is coming to the final phase of the initial five year ECH Strategy. They have three schemes in management, one in development, and one at the planning stage. This will result in one extra care housing scheme in each Borough and District. Revenue funding has been agreed for a second phase of extra care housing. Initial work is underway on two further development opportunities in the strategic commissioning priority areas of the county.

Extra Care Housing in East Sussex is seen as offering an alternative to residential care (but not nursing home care). There is also a focus on the preventative nature of the service.

### Balanced Community

Schemes aim for a 20:40:40 mix (low:medium:high) of dependency as follows:

- *High:* 12+ hours.
- *Medium:* 7 – 12 hours.
- *Low:* 2.5-7 hours (originally allowed people with no care needs to move in, but there is now a requirement for a minimum of 2.5 hours of care).

### Commissioning and Contracting approaches

Different models of housing management, care and support are in operation in different schemes. The first two schemes have a fully integrated service. The RSL's involved are also care and support providers. Whilst there are advantages to having a seamless service, there have been issues relating to the separation of care and support in funding terms. This model allows for less transparency for both commissioner and provider. The third scheme has a different model in operation with a split between housing management and intensive housing support and general support and care. There are 41 flats at this scheme, 30 are rented and 11 are shared equity. There is waking on site night care provision.

- Housing Provider (RSL) provides housing management and SP-funded “specific” or “intensive” housing related support (e.g. support with HB claims, benefit claims, attendance allowance). This is normally appointment-based rather than responsive.
- Care provider provides “general” support (small amount of SP funding – supervision, checking and monitoring, particularly linked to people with dementia) and social care.

The RSL agreed to take on the lead for the Supporting People (SP) monitoring and reporting, with the information on the “general” support provision coming from the care provider. It has been agreed that the care and support is commissioned for the 30 rented units whilst people moving into shared equity flats can choose to buy into the onsite care and support provision or purchase from another provider.

There is ongoing discussion about SP funding in extra care housing, but to date all schemes in operation and the scheme currently in development do have SP funding in place in recognition of the key role played by housing support in an extra care housing scheme.

### Charging

East Sussex currently takes the same approach for charging for care in ECH as in the community. Charges are based on the assessed band of care. In the future charging in extra care housing is likely to be the subject of further discussion in the broader context of maximising income and value for money.

Although there have been few, if any, people moving in with direct payments, there have been examples of self funders choosing to switch care provider to the on-site team because of the flexibility and responsiveness of the service.

## **5. Conclusion**

Developing a charging policy for social care provided within extra care housing presents commissioners with a complex set of issues to consider. These include:

- Being clear about and promoting the strategic vision for ECH within the authority
- The affordability of the service for residents.
- Developing the most efficient and accountable procurement approaches.
- Maintaining value for money and equity for residents.

For many authorities, the approach will have evolved from that used within community services, but the specialist nature of ECH suggests a more tailored approach is needed. There are three key areas that need consideration as described below.

### **i) The configuration of provision:**

As this paper has described, social care is just one of a range of services provided and charged for within ECH, and it is important approaches to charging for it are considered within that context. This includes considering the affordability of the scheme as a whole for its target community, but also needs to take account of the different approaches to allocating costs of services and how care charges will compare with others in terms of equity and accountability. Where services are integrated, which is seen as perhaps a more coherent and flexible approach to service provision, this does create issues around allocating costs to the various funding sources, and hence passing on charges to individuals. However, there are a number of ways of tackling these administrative issues, and they should not be seen as a reason for not exploring the possibility of integration.

### **ii) Personalisation and Equity:**

A more difficult challenge is balancing the benefits of particular approaches for service users, against those for commissioners and providers. This becomes particularly apparent when considering the impact the personalisation agenda could have on ECH. What is needed is an approach which is fair and transparent, which allows personal choice, but which enables the commissioner, through the provider, to ensure a financially viable service which can provide the desired outcomes for the individual.

At one end of the spectrum is a service where the charge is based on actual service received, and is probably contracted on a spot basis. Here there is no doubt the service user is being treated fairly, but it is arguable whether a spot purchase basis will provide best value for money (for the service user or the commissioner), and the administrative requirements of this approach can inhibit the flexibility and responsiveness of the service. The contrasting approach where costs are distributed equally between residents regardless of how they use the service, is administratively simpler and does enable the provider to flex the service for individuals depending on need, but does not provide a fair nor equitable distribution for residents and is probably more reminiscent of approaches to charging in residential care homes.

### **iii) The basis of charging:**

There are two main approaches to charging described in this paper:

- The first is based on banding levels of need with charges set according to a resident's assessed band of care. It has been argued that this is successful in allowing a degree of flexibility within the banding levels, but there are potential problems at the boundaries of the bandings where residents may feel they are not getting value for money, or are concerned about being re-assessed up into the next, more expensive band. This structured approach will also help in defining and maintaining a balanced community.
- The second approach is around defining a core service, and therefore a core charge for living in ECH, with the remaining service charged for on an individual basis or



through banding. The debate here is around the requirement for residents to pay a care charge when they move in to ECH, regardless of their assessed need. Clearly, this approach protects what it is argued is a fundamental characteristic of ECH, the night time staffing, but it could be regarded as removing the element of choice and fairness for the individual resident.

There are ways of combining or developing these approaches that can reduce some of the problems associated with them, including considering the size and number of the bands. However, there remain clear local 'policy' choices about to what degree residents will be able to choose their service providers within the scheme, and whether, so as to protect the nature of the service, an element of choice is removed around, for example, having availability of staff at night. Although there is still limited experience of the potential impact of the personalisation agenda on the management of ECH, commissioners and providers will clearly need to ensure the benefits of the service from the on-site team are well known and marketed to ensure their service becomes the preferred choice<sup>15</sup>.

## **6. Other relevant Housing LIN publications**

### ***Guidance Notes/Reports***

Older People Service's and Individual Budgets

Extra Care Housing and Personal Budgets: A briefing from a Housing Learning and Improvement Network workshop

### ***Factsheets***

- No.19 Charging for care and support in Extra Care Housing
- No.21 Contracting arrangements for Extra Care Housing
- No.27 Attendance Allowance, Disabled Living Allowance in ECH
- No.28 Day care and outreach in Extra Care Housing

### ***Technical Briefs***

- No.1 Care in Extra Care Housing (being refreshed, 2010)
- No.2 Funding Extra Care Housing
- No.3 Mixed Tenure in Extra Care Housing

### ***Case Studies***

- No.10 Direct payments for personal assistance in Hampshire
- No.24 Commissioning an ECH scheme from a social services perspective
- No.43 Reeve Court Retirement Village: block contracting care in bands and individual budgets

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<sup>15</sup> Housing LIN Report "Marketing Extra Care Housing"

No.48            Personalised Supporting People services in Norfolk

***Viewpoint***

No.13            Individual budgets, micro-commissioning and Extra Care Housing

All of the above Housing LIN resources and many more can be seen and downloaded at our website:

[www.dhcarenetworks.org.uk/housing](http://www.dhcarenetworks.org.uk/housing)

The Housing LIN welcomes contributions on a range of issues pertinent to Extra Care housing. If there is a subject that you feel should be addressed, please contact us.

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