

Housing Learning & Improvement Network

Care Services Improvement Partnership 

Health and Social Care
Change Agent Team

Developing Extra Care Housing for Black and Minority Ethnic Elders: an overview of the issues, examples and challenges

This report focuses on issues around providing specific extra care housing to BME elders as well as improving access more generally. It also offers a self-assessment checklist for commissioners and providers to consider when developing their extra care housing strategies and delivery plans.

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Introduction: housing an essential anchor in meeting basic needs

Today an increasing number of Black and Minority Ethnic (BME) people are ageing in the UK. As with any person, housing is an essential anchor in providing for basic needs as well as giving a sense of location particularly at a later stage in one's life. These factors become critical when many BME elders are aware of shifting family and cultural patterns in their own families and communities.

Now in their old age with increasing illness and poverty, a home where they can age with comfort and support is the least that they can expect. But meeting these hopes and expectations require policy and practice change. Just as new and more flexible systems of health and social care are developing to respond to majority older people's changes (from life expectancy, increasing numbers, values about choice, autonomy, all in the context of affordability and costs – as set out in the recent Department of Health White Paper, *Our Health, Our Care, Our Say: a new direction for community services*, 2006), so too are changes happening among BME elders and their families. Extra care housing has emerged as an appropriate *continuous* housing response to changing needs of older people than the conventional forms of provision like residential care.

The development of extra care housing as an appropriate housing response to BME elders however is relatively in its infancy. Housing solutions for BME elders has recently come on the policy and providers' agenda. It is clear from PRIAE (the Policy Research Institute on Ageing & Ethnicity)'s survey of providers and commissioners from the membership of the Housing Learning &

Improvement Network (LIN), that they regard this area as an important one to develop, and would like more information and support. It is to their latter requirement that this report has been commissioned by the Housing LIN at the Department of Health (DH).

Why this Report?

- Current demand for BME extra care housing outstrips provision
- Demand for extra care housing from BME elders will increase substantially over the next twenty years as the numbers rise as well as awareness and improvements in access takes place.
- There is a lack of knowledge about the issues faced by BME elders in accessing housing, health and social care services
- Many housing commissioners and providers are uncertain about the need for BME specific extra care housing
- Many housing commissioners and providers are unclear about what providing extra care housing to BME elders involves

Section 1.1: Extra care housing

What is extra care housing?

Extra care housing, or very sheltered housing, is a form of housing provision that allows people in need of care to remain independent, or 'age in place' in specially adapted housing. It is a concept rather than a specific type of home, and allows for a flexible and adaptive approach to the care of older people. To this end, design incorporates the usual components of purpose-built self contained accommodation for independent living, but might also include specifically equipped bathrooms, communal areas and space for support staff. Its flexibility makes it more cost effective than more conventional forms of care, such as residential care, and this makes it an increasingly popular lifestyle choice among older people.

Extra care housing can fulfill a number functions including:

- An alternative to residential care for those who need some support but wish to remain independent
- Respite and intermediate care
- Rehabilitative care for people recovering from an illness or operation.

(For more information see the Housing LIN Factsheet 1: Riseborough, M & Fletcher P (2004) *Extra Care Housing-What is it?* Department of Health)

The policy agenda

A plethora of Government documents, including the aforementioned DH's White Paper, *Our Health, Our Care, Our Say: a new direction for community services*, and the recent Office of the Deputy Prime Minister's (ODPM) Supporting People consultation paper, *Creating Sustainable Communities: Supporting Independence*, place an increasing emphasis on creating links across strategies and policies, particularly between housing, social care and health.

Furthermore, for the period 2004 to 2008, the Department of Health has allocated £147million to support the development of extra care housing, with the support of the ODPM and the Housing Corporation. The Housing LIN has been instrumental in helping local authorities and PCTs deliver local housing-based solutions in response to locally assessed needs. One element of this is increasing the use and development of extra care housing:

The Department of Health wishes to encourage the future development of extra care housing which extends the choices available to older people. An increasing number of local authorities and their health partners are starting to make the strategic shift away from residential care and towards a broader range of supported housing models, including extra care housing. This will result in a wider choice, greater independence and control for older people in line with changing aspirations (2003 p7).

This commitment was reiterated in 2005, in the document *Sustainable Communities: Homes for All* (Office for the Deputy Prime Minister 2005) in which the Government set out its five year plan for improving housing and pledged to:

'Meet the needs of older and disabled people, providing housing related support and improved homes to enable independent living, and ensuring new homes meet people's needs at all stages of their lives' (2005 Chapter 7)

BME extra care

At present the number of BME elders in the UK is relatively small, but is expected to increase substantially over the next twenty years. However numbers should not mask the level of need which is currently high. BME elders, like majority elders, look for housing solutions that best meet their needs, aspirations to autonomy and quality of life. As they continue to age there will be an increasing demand from BME communities for better and more flexible forms of care, including extra care housing. This was recognised in the report, *Quality and Choice for Older People's Housing - A Strategic Framework* (DETR/DH, 2001) in which it is stated that:

'...new homes should take the needs of older people into account including those from ethnic minorities (ibid p.2).'

That the BME population is ageing will have implications for a range of different service providers, and the importance of joining up services for older people at a local level was linked to the increase in the BME elder population:

'Particular emphasis needs to be given to the needs and requirements of growing numbers of frail older people and those from black and minority ethnic backgrounds.' Preparing Older People's Strategies (ODPM, 2003;6).

Despite this recognition, no policy framework exists for the provision of extra care housing for ethnic minority elders and provision as yet is piecemeal. A number of extra care housing projects have been developed, usually driven by BME voluntary organisations, and some have been funded by the Department of Health or by the Housing Corporation Approved Development Grant programme. However PRIAE's survey of Housing Commissioners and providers¹ suggests that current demand for BME extra care housing far outstrips provision, and that both policy makers and providers and social and private sector housing with care for older people need to urgently stimulate the housing provision for extra care to BME elders.

¹ See section 2.1 for more information

Section 1.2: The wider context

Ethnic minorities in the UK

There are sixty million people in the UK, and around four and a half million are from BME background, eight percent of the total population ². The umbrella term BME describes many different ethnic, religious and linguistic groups with different patterns of migration and socio-economic circumstance. They have made the UK their home coming at different times historically and currently from within Europe, Indian sub-continent, the Caribbean, South East Asia including China and Vietnam, and newer groups from the EU accession countries, Africa, Middle East and South America.

Ethnic minorities live throughout the UK, but are mainly concentrated in the large urban areas of England. Established refugee groups who are now ageing are also included in this umbrella term of 'BME' elders. BME elders have one thing in common: the experience of disadvantage and discrimination and where multiple discrimination due to age, ethnicity, gender, disability give rise to specific consequences which need addressing as part of housing and social policy.

Ageing and ethnicity

Britain is an ageing country, and one in five people currently is over state retirement age. This applies particularly to the majority population; ethnic minority groups tend to be much younger, although some groups, particularly those from Ireland, the Caribbean, have relatively large numbers of older people, reflecting earlier migration patterns. However, a substantial proportion of the BME population is now between 45 and retirement age category, and the number of BME elders is expected to increase rapidly over the next few decades³ with significant implications for older people's care. We present this data in Appendix 1 which shows the different ethnic group composition by age, gender and ethnicity.

BME elders in the UK experience high levels of deprivation and social exclusion (ODPM – SEU REPORT pp 101/2 (2006)). There are variations between ethnic groups, but nonetheless there is a substantial relationship between ethnicity and a range of indicators of deprivation. Overall BME elder groups are:

- Concentrated in large urban areas like London and the West Midlands, which have high levels of unemployment and deprivation
- In employment, concentrated in particular industries with low levels of pay and security
- Have lower pensionable income than their majority peers
- More likely to be living in low-income households in poorer quality and overcrowded accommodation
- More likely to suffer poor health and suffer from a range of debilitating conditions.

² Office for National Statistics: ONS (2003a) The Census

³ PRIAE (2003)

The future generation of BME elders already mirror some inequities from high unemployment to concentration of employment in specific sectors that are characterised as low paid. There is mobility within BME groups but social and health inequalities among non-elder BME groups are apparent. This suggests that the investment made today in BME extra care housing is not temporary for current generation of BME elders but will need to be sustainable to meet the changing housing with care needs and aspirations of future generations.

(Source: Census 2001; PRIAE (1999); PRIAE MEC Research 2005)

Self-Assessment Checklist

- Do you know how many BME elders live in your local authority area and what are the projections on the number who would benefit from extra care housing over the next 10-15 years?
- Does your existing provision of extra care housing reflect the ethnic diversity of your local population?

Race relations in care and housing

There are various access barriers experienced by BME communities in health and social care including the existence of institutional racism. In 1999 PRIAE's report to the Royal Commission on Long Term Care stated that:

'Mainstream health, housing and social care organisations need to urgently examine (and consequently act upon) why they consistently appear to have difficulties in effectively responding to BME elders and their carers' ordinary, not special needs. If they continue with the present approach of 'ad hoc patchy and piecemeal developments', they will by default have structured BME elder care into segmented long-term care solutions on marginal resources, endorsing de facto racism in a modern society as we approach the 21st century. ' p259 (Patel 1999).

The Macpherson Report also in 1999, acknowledged that racism exists within the public sector and identified serious failings in the structure of public authorities, referring to them as 'institutionally racist' where rules, procedures and the very framework discriminates minorities even though that is not the direct intention. The Race Relations (Amendment) Act 2000 was subsequently passed, giving public bodies the duty to promote racial equality in jobs, training, housing, education and the provision of goods and services.

The persistence of discrimination in housing provision was acknowledged in 2001 by the Race and Housing Inquiry; a joint initiative by the Commission for Racial Equality, the National Housing Federation, the Federation of Black Housing Organisations and the Housing Corporation. The Inquiry was established to challenge housing associations to drive improvements on race equality across governance, service delivery and employment matters. It set out the action that should be taken by Housing Associations and other bodies:

'Registered social landlords (RSLs) make a valuable contribution to community life. However, despite 20 years of guidance to the RSL sector on race equality, progress is too slow to satisfy the

aspirations of black and minority ethnic (BME) communities or meet the pace of change in society'.p1 (Challenge Report 2001)

In 2003, the Inquiry presented a Working Progress Report to the Housing Corporation's Black and Minority Ethnic National Advisory Board. The report listed the recommendations made by the Challenge Report and identified what achievements have been made and what work still needed to be done. In response to this, the Housing Corporation published its *BME Action Plan* (2005) in which the Corporation sets out its vision for race equality in housing provision, which includes a commitment to:

- Ensuring equality of choice and access in housing
- Better representation on housing providers' governing bodies
- Capacity building among BME housing associations.

In addition, under the ODPM's Supporting People arrangements, housing and housing related support agencies must meet a Quality Assessment Frameworks, and guidance set out in *Reflecting the Needs and Concerns of Black and Minority Ethnic Communities in Supporting People*.

The above guidance and recommendations provide housing commissioners and providers with a good source of reference to address investment in housing for BME elders, including extra care.

Self-Assessment Checklist

- Is there a written statement of equal opportunity policy or a documented agenda for diversity and inclusion in your organisation?
- Can you evidence that the way you assess the housing with care needs of BME elders promotes equality of opportunity?

Knowledge and understanding: facing and crossing barriers

To receive a service like housing one needs to know about it and its variety, to access it. But what if

- you do not know that such services exist
- that you may be entitled to it
- that it is complex (system of referrals, assessment, waiting lists, various agencies)
- that you need confidence to meet the conditions (form filling, interviews etc) and
- in the first instance be able to engage in the language spoken.

This is well before seeking whether housing is culturally appropriate. For BME elders this is where one of the problem lies: language and communication difficulties prohibit acquisition of knowledge let alone its processing. '*Don't know, don't hear, don't get*' is how an elder aptly summarised access issues. But even being able to speak the language is not a sufficient guarantee that housing provision will be accessed, if knowledge is missing.

Then what if in your cultural frame the concept of ‘separate living/home’ is not entertained. The idea of seeking external help when problems arise is still regarded by many elders from different ethnic backgrounds with shame and guilt and a sign of family failure or worse their own. Containment and tolerance of whatever the family circumstance becomes the reality for many elders⁴. That is not to say that BME elders all fulfill this reality. Increasingly where BME housing provision exists we can see sometimes planning by elders and families of living independently in their own home but close enough to the family, to the satisfaction of both (Patel 2005, notes for a Ch4 interview).

Let us suppose that BME elders have crossed the information and culture barriers, for some there may still be discrimination in obtaining housing provision. It is not therefore surprising that many who have secured housing see it as a remarkable achievement rather than an entitlement – and particularly if it meets their needs regarding language and culture in addition to other aspects of good housing care. Meanwhile housing providers also lack knowledge and understanding of health and social care issues including the need for and nature of BME extra care provision.

As PRIAE’s survey suggests, housing providers know that there is a demand, but they lack in-depth information on the needs and dependency levels of BME older people, and often lack the experience of working and communicating with this group. At the same time, BME elders and BME housing providers are not fully aware of what exactly constitutes extra care housing, who needs it, how it is funded and provided.⁵ Commissioners and Care providers can do much to overcome these issues, by promoting services through appropriate channels, by providing outreach and culturally appropriate care and facilities, and by having better understanding and communication of the issues. The AT HOME toolkit commissioned by the HOPDEV group at the ODPM (forthcoming), will be useful in gauging one’s understanding and skills needed for its application to support housing for BME elders including extra care.

Self-Assessment Checklist

- Have you identified necessary information to work with BME elders
- Have you consulted with BME elders and their representative organisations to establish what information they require to make informed choices on extra care housing in your area?
- Have you reviewed how accessible your existing information on extra care housing is for BME elders in your area and how it is communicated?

⁴ This is why many BME housing organisations, PRIAE and others are promoting awareness and education of housing provision among BME elders and communities. In the absence of well resourced promotion campaigns the impact of such efforts remain slow.

⁵ PRIAE has stated that there is lack of clarity among BME elders and families about housing provision; its many forms and what it means to live independently. Too often ‘home’ is conflated as a single entity, considered highly undesirable and ‘not for us’. As BME housing provision shows, this is far from true and some examples are illustrated in this report.

Section 2.1: Perspectives of Commissioners and Providers on Extra Care Housing for BME elders

The survey

To gain a better understanding of the issues faced by those actively involved in the provision of housing to BME elders, PRIAE conducted a survey of commissioners and providers of housing with care for older people. The majority of commissioners who responded were Local Authority based, whilst two thirds of providers were mainstream with no BME specific provision, and 7% were specifically BME housing providers. Two key issues emerged from the survey:

- Supply and demand for extra care housing
- Understanding and awareness of BME communities

Supply and demand

A substantial proportion of respondents thought that BME older people faced specific problems that were not necessarily experienced by majority elders. When asked to comment on how this affected different aspects of housing provision, commissioners and providers' viewed:

- Supply of appropriate housing as *worse* for BME elders: 68% of commissioners and 65% of providers respectively
- The quality of provision as *worse* for BME elders: 36% of commissioners and 29% of providers
- Informal provision as *better* for BME elders than majority elders: 13% of commissioners and 27% of providers
-

In other words, commissioners and providers both regard highly the problem faced by BME elders in the supply of appropriate provision.

BME housing needs

The majority of respondents in Table One were optimistic about housing provision in general, and thought that BME elder's housing needs were being met to some extent, both in their area and in the UK as a whole, though respondents were more optimistic about the national than the local situation.

Table One

To what extent do you feel that BME housing needs are being met...	Commissioners %	Providers %
...in your area?		
Not at all	23	7
To some extent	67	70
To a great extent	10	17
... in the UK as a whole?		
Not at all	0	5
To some extent	94	84
To a great extent	0	3

However, in Table Two, only 2% of providers thought that BME demand for extra care housing was currently being met. Nearly two thirds of respondents agreed that BME elders would benefit from extra care housing, and a half said

that this was a market that they would be interested in. A quarter of respondents thought that they had the capacity to meet current demand.

Table Two

Demand for extra care	Providers		
	Yes %	No %	Not sure %
Do you think that BME demand for extra care housing is currently being met....	2	47	48
Are you convinced that BME elders require extra care housing?	63	2	34
Is extra care housing a market that you are interested in?	53	15	29
If yes, do you have the capacity to meet current demand?	25	9	20

There were a number of suggestions for addressing this issue, including:

- More BME specific and targeted provision
- Increasing the supply of stock

The latter point concurs with the earlier view of inadequacy of supply of appropriate housing provision; increasing the supply is a logical step in satisfying unmet demand.

Understanding and communication

When looking at BME elder issues, the majority of Commissioners said that they would consult BME organisations and housing providers. However, while 85% of Commissioners felt that they were well informed on general demographic issues on BME elders, less than 40% had information on levels of available stock. Just over 27% had detailed information on the specific needs and dependency levels of BME elders in their area.

Housing Commissioners and providers experienced a range of challenges when dealing with the needs of BME elders. They faced similar challenges, but a greater proportion of Commissioners said that they experienced problems, perhaps reflecting the more ‘ground level’ work done by providers.

Most severe challenges faced

- Reaching BME elders
- Awareness of minority elders’ needs
- Understanding of issues

When asked how the housing needs of BME elders might be better met, many answers related to availability and use of knowledge. The most frequently cited suggestions included:

- Gaining a better understanding of the needs of BME communities
- Better engagement and consultation with BME communities
- Improving communication between BME elders and housing agencies

In conclusion the survey points to some gaps in information and involvement with BME elders by commissioners and providers, while there is a clear recognition that specific needs of BME elders require targeting of solutions. It is apparent that a good effective response by both would be to gain better knowledge of the market of BME elder housing – and in their area of operation- if any appropriate action is to be taken to respond to their growing demand and current unmet needs.

Section 2.2: Good practice examples in the extra care housing for BME elders

Introduction

Extra care housing is a concept rather than a fixed idea, and in describing some examples of good practice in the provision of BME extra care housing, it is also useful to give some examples that would not strictly be classed as extra care housing, but serve as a good illustration in discussing some of the challenges that are presented when providing care for black and minority ethnic elders. We present below six examples, some extra care, some not, which highlight a range of important issues. Most of the examples below are outcomes of initiatives by BME voluntary organisations, with support from a range of sources including mainstream housing associations, the Department of Health and local councils. They are compiled from information sources and interviews conducted for this report with their respective managers.

Bradley Court Extra Care Housing Scheme, Huddersfield

right people providing right care.....

Bradley Court is an extra care housing scheme near Huddersfield, West Yorkshire. It provides 46 flats with extensive communal facilities and gardens; a day centre serving further 30 local older people and provides a range of facilities for the wider community. Kirklees Black Elders Association devised the original idea for the scheme, in response to the large number of black elders in the area living in unsuitable properties. A partnership between Kirklees Black Elders Association, Methodist Homes Housing Association and Kirklees Metropolitan Council generated the project. The Housing Corporation provided a grant towards the cost of the scheme, and Supporting People provides a monthly grant. Kirklees Metropolitan Council was supportive throughout the development, and funds the care services at the scheme. The day centre was built with funds raised by Age Concern Kirklees. Methodist Homes provides the housing and facilities management at the scheme and Kirklees Black Elders Association provides 24-hour care.

Cultural sensitivity played central role in the development of the project from the start, reflecting the needs and preferences of the residents. For example, both European and West Indian food is served on a daily basis, the specific hair and skin care needs of African Caribbean people are catered for, and tenants are free to organize events and activities that suit their preferences and lifestyle. The scheme developers faced a low level of understanding about the nature and merits of extra care housing, among the different local communities and also within local health and social care services. Early engagement with the respective groups was important in overcoming this obstacle. Kirklees Black Elders Association took the lead on promotion and outreach to the local BME community. Considerable effort was invested to inform the wider local community, through workshops, leaflet distribution and meetings with a variety of local groups. Health and social care professionals were also briefed, in particular social workers, whose job it would be to refer people to the scheme. Today the scheme has a target of letting 50% of flats to BME elders. This has been achieved and maintained.

Fradel Lodge, Hackney, London

single purpose, articulation and voice.....

Fradel Lodge is a supported housing scheme in North Hackney located on Schonfeld Square where there is, in addition, general needs housing provision and residential care. The scheme is run by Agudas Israel Housing Association. It is aimed primarily at the local Charadi community. The development of Fradel Lodge into an extra care service will allow older people from the wider surrounding community access to existing and new community services. There is a strong desire to further develop bridges between the Charadi and the wider communities and it was thought that an extra care service would be an ideal catalyst. A scheme developed by the Charadi community but offering mainstream provision was considered to be more successful in meeting this agenda since a mainstream service would not be able to meet the cultural needs of the Charadi community.

Fradel Lodge was purpose built for the community as a sheltered scheme. A number of modifications to standard build were essential. Modifications were largely based on cultural and religious considerations. Sensitivities around the mixing of men and women had to be catered for, and there are particular religious strictures around the preparation of food and the use of technology. For example, during some religious festivals only certain kitchen utensils can be used, and on the Sabbath the use of technology and machine assistance is limited, making adaptations to things like door opening mechanisms essential.

The development of Schonfield Square and Fradel Lodge was driven by the initiative of the Charadi community. With a population of around ten thousand in Hackney, it is the largest such group in Europe, and represents a relatively large BME community in the area. This 'critical mass', a strong sense of social cohesion, and being relatively more prosperous, enables the community to voice and express their needs in a way that other communities are perhaps less able to do effectively.

The ability and willingness to work together and with the Local Authority, and to demonstrate through an evidence based approach the needs of the community, is highly welcomed by the Borough since it enables Commissioners to understand and quantify the needs of a community that may otherwise be not known and/or thought of.

Sonali Gardens, Tower Hamlets, London – (see Housing LIN case study no.7 - *Supporting Diversity in Tower Hamlet*)

Responding to racism, creating better engagement.....

Sonali Gardens is a specific extra-care housing complex in Tower Hamlets in London, one of the most deprived wards in the country. One third of the population is Bangladeshi, and the core population of the complex is elders from Bangladeshi and Asian backgrounds, with care needs of more than 12.5 hours per week. The centre provides thirty one-bedroom and ten two-bedroom flats, with secure entry and enclosed garden areas. The complex incorporates a community centre open to the wider community and a commercial centre for shops and a restaurant. To secure culturally appropriate provision, design of the centre involved lengthy consultation with the local community and user groups. Consequently housing incorporates a range of culturally specific facilities, including men and women's prayer rooms and ablution facilities, appropriate menus and décor, multi lingual staff, and flexibility of care so that family members can actively participate. One of the key challenges was attracting and winning the confidence of Asian elders, who are not traditionally familiar with the concept of 'stranger care'. Take up was initially low despite marketing and outreach programmes, but continues to improve. Shortly after it's opening the project received negative and misrepresentative publicity from the right wing press. This could to some extent have been avoided by better engagement with local borough staff and the wider community, and at an earlier stage. Unwarranted criticism was counteracted/negated by further extension of the centre's facilities to the wider community.

St Eugene's Court, Birmingham

Out of the old derelict building comes a good home for many.....

St Eugene's Court in Birmingham exists to provide appropriate support and accommodation to older Irish men that have been socially excluded from housing and other services across the City of Birmingham. Though not technically extra care housing, the scheme provides a unique form of care to Irish elder men, and as such gives some important pointers for those wishing to provide extra care to ethnic minorities generally. A derelict factory building was transformed as refurbished accommodation containing 44 apartments, communal areas, and facilities creating safe and secure housing environment for Irish elder men. The scheme was developed by a partnership between Focus Housing and Irish Welfare and is funded by a combination of Housing Corporation grants, private funding and Supporting People grants.

The scheme was developed in response to research which identified a substantial population of older Irish Men who are prone to illness and disability with high mortality rates and levels of suicide. Causes range from industrial injuries to alcohol misuse, and are worsened by factors such as poor mental health, poor housing, and social isolation. Many were not accessing care services because they felt alienated by deep-rooted cultural differences. It was very important that the scheme was not simply a replication of a

conventional supported housing scheme, which is more usually aimed at people who had lived independently and worked all of their lives. It was thought that such a peer group and such an environment would scare the target group away. The scheme is unique in that not only does it provide supported housing for 44 individuals who might otherwise be vulnerable and isolated, but it also houses a Drop in Centre for up to 40 additional people a day to have a hot nutritious meal, company, and activities which help to prevent loneliness and marginalisation. Indeed since opening it has become a focal point for a community, providing an environment of respect for older Irish men and women. They can access services which are culturally sensitive and friendly to their needs, i.e. housing, health and advice, hot meals, clothing, access to a chiropodist, optician, and appointments with a G.P enhancing the close community feel of the place. The scheme is located in the Irish quarter of the city, tends to attract staff from the Irish community, although there is no specific policy for this.

Tia Hua Court, Middlesbrough – (see Housing LIN case study no.11 – *Housing for Older People from the Chinese Community in Middlesbrough*)

***Quiet? No.
Prefer the life's hustle and bustle ...in old age.....***

Tia Hua Court is an extra care housing scheme for a small community of Chinese elders in Middlesbrough. Chinese elders are few in numbers in the area and as a consequence tend to be quite socially isolated. Initial concerns over low demand were assuaged by a survey showing a high demand among the Chinese community for extra care housing. Like Sonali Gardens the complex incorporates a community centre and a commercial space for the wider community, but focuses on providing culturally appropriate care for Chinese elders. The planning and consultation phase lasted ten years and involved the local Chinese Association and the Chinese community as a whole in the planning. This resulted in culturally appropriate design, including wider door frames, lots of glass to create a light ambience, no flat number 4 because of the association with bad luck in Chinese folklore, and Chinese subscription satellite television. A city centre location was chosen, partly because of the preference of Chinese elders for the hustle and bustle of city centre living. The project was funded from a range of sources, including social services and Supporting People grants, mixed tenancy with shared ownership and rental property, and substantial investment from the Tees Valley Housing Group. The project has been a success and has contributed in some sense to the ongoing urban renewal of the area. It provides active involvement and social contact for a small but isolated ethnic group and proves that small numbers do not necessarily mean low demand.

Tung Sing Housing Association, Manchester

Professionals rooted in the community to build more than a home.....

Tung Sing was founded in 1984 by a group of Chinese professionals in the Manchester area who wanted the Chinese community in obtaining good quality housing at affordable rent levels. The main objective is to help disadvantaged groups such as the elderly, families, single people and black and minority ethnic communities. Tung Sing was the first registered Chinese housing association in Britain and was supported by Manchester City Council and the Commission for Racial Equality. In 1989, the association opened its first scheme of 33 flats and now has over 500 properties throughout the North West of England. Initially a mainstream association provided development, management, maintenance and finance services, but since the early 1990's, the majority of services have been provided in-house. Tung Sing is currently exploring new markets, in particular the possible development of a frail elderly scheme for Chinese and other BME elder ethnic groups.

One objective of the association is the provision of culturally sensitive housing. This has been done in a range of ways and is often a matter of trial and error. For example, the first flats were built to conventional specifications, but it became apparent that the particular preferences of residents required certain alterations. Chinese people fry a lot of their food, and also like to steam food and prefer to hand wash clothing. These issues all impacted on the ability of extractor fans to cope - with excess levels of smoke and also humidity. Smoke alarms also had to be adjusted to allow for the smoke generated from frying food. Subsequent flats had these alterations built in from the start. Another issue when providing services to Chinese older people is the range of dialects spoken within the community, and there is an emphasis when recruiting on people who can speak several dialects. Although the schemes do not provide extra care, the association works closely with a number of Chinese organisations that do provide care, so that it can be accessed as and when is necessary.

Section 3.1: Issues to consider in the provision of extra care housing for BME elders

Introduction

In this section we bring together key points of some of the tried and tested examples illustrated above, and additional information to help commissioners and providers get a better understanding of the issues that they will need to consider in developing and managing extra care housing for BME elders. These are grouped around understanding individual identity, external and internal considerations and financial implications.

1. Cultural, ethnic and religious identity

Culture, ethnicity, faith and communication are all important elements in determining one's identity and worth, for both the majority and minority groups. With age, they become more pronounced. Everyone has culture whether one is religious or not. We attribute cultural elements as borne out of customs, traditions, practices, and not necessarily tied to a religion nor are they static. Culture is always evolving.

The idea that BME elders in some ethnic groups should live out of extended family at particular time in countries in which they were born, would have once been unheard of. With growing urbanisation in their birth countries, the separation of families from their elders are now part of normal life for many.

So too with changing family patterns and values in the UK. Hence the need for the provision for housing. Cultural context matters in all aspects of extra care home development: from its conception to engagement with BME and wider community to the very elements of location, the building design and care that constitute the internal elements of extra care home.

The Fourth National Survey on Ethnic Minorities in Britain⁶ found that different ethnic groups are affected by different cultural and religious influences, so for instance religion is central to the identity of South Asian groups, but less so to those of Caribbean or white origin. More recently a survey of 10,000 housing association tenants by the Housing Corporation⁷, found that 'nearly all' respondents from Pakistan, Bangladesh, India and Africa said that religion was important to them. Understanding of particular cultural and religious preferences can have a significant impact on the quality of care provided to BME elders, and the way in which they respond to care.

In PRIAE's submission to the Royal Commission on Long-Term Care⁸, it noted that:

'Where mainstream services have effectively engaged with 'different needs', (re; changes in communication, design, planning, assessment, staffing and delivery where the definition of culturally appropriate is broader than mere technical aspects),

⁶ Modood, Berthould, Lakey, Nazroo, Smith, Virdee, Beishon (1997)

⁷ Housing Corporation (2005) Sector Study 46

⁸ Patel, 1999

BME elders, carers and professionals express satisfaction with the choice and standard of care p.258.

This was acknowledged in 2001 by the National Service Framework for Older People (NSF):

'At the same time, all services should be culturally appropriate, reflecting the diversity of the population that they serve, and ensuring that services are accessible for those who do not have English as their first language. The needs and wishes of each individual should be recognised and taken into account as far as possible when planning their health and social care. (p3-4)'

Such recognition requires translation: much effort, investment and strategic response needs to be targeted if ethnic minorities are to receive appropriate care as they age. This includes greater consideration of how extra care housing may play a role in the continuum of housing, care and support. This is explored further in the next section.

2. External considerations:

a. The location of the scheme

The location of the scheme is very important. As people age, they would usually choose to continue living in the area that they are living, or in an area that is similar to where they have lived. There is both commonality and diversity among the needs of elders from different ethnic groups, and this is often expressed in terms of a preference of location⁹. For example, the majority of older people would choose to live in areas with others from their community, with appropriate cultural and religious facilities nearby, and this desire generally increases with age.

It should be noted that independence and privacy are often confused as one (Patel 2005): some groups like the idea of close proximity of their families while living independently and others may not. It is most likely that being independent does not imply complete privacy and their expressions will vary between groups from say African Caribbean elders who will be perceived as more independent than South East Asian elders who are seen as emphasising the importance of living with or near different generations of their family. This does not mean that the family is less important to an African Caribbean elder or that an Asian elder is less independent. What is most likely is the concept of privacy and independence are used differently and involve not just culture but one's psychological, physical and material well being, where social space may be considered more important than one's private space, without losing independence. Such issues have ramifications for location of an extra care scheme.

For example, when a suitable location was being sought for Tia Hua Court in Middlesbrough, it was noted that Chinese elders liked the 'hustle and bustle' of city life, in contrast to many majority elders, who perhaps preferred to get

⁹ Office of the Deputy Prime Minister (2001) *Quality and Choice for Older People's Housing – A Strategic Framework*, published online, ODPM

away from such an environment as they age. This understanding of Chinese elders' preference played a key part in the selection of the location of the scheme. Similarly the location for St Eugene's in Birmingham played a similarly important role. The scheme, for older Irish Men with a range of health and social problems, was situated in an old industrial area of Birmingham, away from the main residential area but within a few minutes walk from one of the main thoroughfares of the Irish Quarter of the city. This discrete setting provides both a measure of privacy and security for the residents, but also places them firmly in the heart of their own community.

Self-Assessment Checklist

- Do you know what barriers BME elders experience in accessing extra care housing in your area?

b. Engaging the BME community

Engaging local BME communities is important at all stages in the development of an extra care scheme, from initial concept development through the design, building and running of the scheme, and consultation early on is crucial if a scheme is to be culturally appropriate and truly reflect the needs and aspirations of the target communities. This was one of the key challenges faced by housing commissioners who responded to the survey, as described in section 2 of the report.

Building trust among communities is essential, particularly when forms of care do not always fit with their traditions (Sonali Gardens in Tower Hamlets). This is especially important among communities where until recently elders were looked after within the family. User involvement at every stage of the planning process can help get BME elders own the scheme, and so contribute ultimately to the success of an extra care housing scheme.

The planning and consultation process of Tia Hua Court lasted ten years and involved substantial input of the local Chinese Association and the Chinese community as a whole, which ultimately led to the success of the scheme in attracting Chinese elders from quite a dispersed community.

Outreach and floating support services are also important. The developers of Bradley Court in Huddersfield for instance employed an African Caribbean social worker to visit and speak to potential residents. On the other hand, Rochdale Council, when establishing (Ashiana House Foundation) used Pakistani councillors to provide information on housing services to their local communities. Translators and interpreters are increasingly being used, and can provide an important means of communication to BME elders who cannot speak or understand English. Housing associations with staff profiles which reflect the makeup of local populations can also help to boost awareness and understanding of services. The issue here is not just about employing staff who can communicate in the language of the elders – not just technically but in the full sense where promotion of the scheme; information about extra care is imparted. This area is not straightforward where misinformation; non-information and the very 'attack' on one's culture and lifestyle as some would see, is occurring. The staff therefore are working in a challenging area and employing a range of skills in addition to translation and interpretation.

Self-Assessment Checklist

- What consideration has been given to the location of the existing or proposed extra care housing schemes.
- How does it reflect the needs and hopes of BME elders?

c. BME voluntary organisations

There is a tradition of self-help among many communities, with BME elders in many cases, establishing BME age organisations. Some of this self-help is formal, with day centres, lunch clubs, advocacy services and social clubs tailored to specific ethnic minority communities now established in the UK.

The importance of these services cannot be overestimated as such organisations are often the only point of contact for information about health, benefits and housing for BME elders. As they have originated from within the community, they are uniquely well placed to meet the needs of their client group, and are often run by individuals from within the same community. However, there is a historical under-development of services for BME elders, and these voluntary organisations are acting as 'primary providers' (Patel, 1990;1999) substituting the role of statutory providers. This is not satisfactory as the community and voluntary organisations do not have the security of funding nor the infrastructure that they need to support the elements that have been placed within their remit by the inaccessibility and inappropriateness of mainstream services.

Despite this, such organisations not only provide a crucial link between housing commissioners/providers and local communities, but have been instrumental in the establishment of BME extra care housing schemes. The PRIAE MEC research cited earlier provides the first statistical data on the significance of this sector in the provision of care. It is clear that BME voluntary organisations could do more if supported appropriately. Hence the necessity and importance of engaging and/or co-working with such organisations when developing extra care housing developments.

This is what mainstreaming needs to be about, not their incorporation or deletion.

A recent Housing LIN case study (no.20 – *BME Older People's Joint Service Initiative – current strategies*) gives a useful summary of the approach Sheffield City Council have adopted to meet the needs of BME population.

Self-Assessment Checklist

- What mechanisms are in place for engaging with existing and prospective residents from local BME communities?

d. Engaging the wider community

Engaging the wider community is also important when establishing an extra care housing scheme. Extra care housing is quite a sophisticated concept, that many people find hard to understand, and there can be sensitive issues around the future provision of residential care, decommissioning “hard-to-let” sheltered housing etc.

A number of existing schemes have faced problems with misunderstandings and/or prejudices among the wider community, but these problems are not insurmountable. The developers of Bradley Court in Huddersfield, experienced much initial resistance from local residents who thought that a home for asylum seekers was being built. They overcame this issue by engaging with the local community and explaining to them what was being provided. They did this by running workshops, distributing leaflets, engaging local councilors and meeting with a variety of local groups including older people’s groups and church groups.

When Sonali Gardens - an early example of BME extra care - was first established, the scheme attracted coverage that charged the council with creating homes for Bangladeshi elders only, at the expense of white elders, or words to that effect. This was countered by starting up a dialogue with the local communities, which resulted in the opening up of the scheme’s facilities to the wider population. Such actions can have positive effects, and by involving different sections of the community, it can bring people of different backgrounds together and enhance mutual understanding. It can also lead to greater financial viability by attracting a larger number of people to use onsite facilities, thus providing more income for the scheme.

Self-Assessment Checklist

- What links does your organisation have with BME elders and organisations?
- What arrangements do you have in place to develop these links, maintain relations and produce tangible housing results?

3. Internal considerations to the Extra Care Home *per se*

a. The physical and social environment

BME elders come from different religious, cultural and linguistic backgrounds, and many are born in another country before coming to the UK, bringing with them a range of tastes and preferences. It is an accepted fact that as people age they become increasingly nostalgic towards their cultural and historical background, and this applies to ethnic minority elders as much as majority elders. The immediate physical environment of a scheme is therefore very important in providing culturally appropriate extra care, and issues of design and décor must be taken into account early on in the development of the scheme. This can include meeting specific religious needs to cooking provision to the signage of facilities. For example:

- Sonali Gardens in London, provides men and women’s prayer rooms for its largely Asian Muslim residents.

- Tia Hua Court, in consultation with the Chinese community, designed a centre with wide door frames and large areas of glass to create an ambience desirable to Chinese elders, and in keeping with Chinese folk lore, numbered the apartments in such a way that there was no flat number 'Four' - believed to be an unlucky number, or not used specific colours (white) associated with death or providing storage space.
- St Eugene's was developed in response to high levels of social exclusion among Irish elders, so it was important as part of the design to build large communal areas where residents could socialise with each other as well other members of the community.

Awareness of the importance of 'social ambience' is essential. This cannot always be reduced to design elements but rather to the management of the scheme, staff and resident relations within it, which help to create a sense of atmosphere of any well managed home. Providers should take care to provide an environment of trust, safety and friendliness, where the individual feels able to express themselves and their culture.

Attention to detail is also important, and basic things can enhance well-being and quality of life. Things like dress, skin and hair care, and the provision of appropriate food can have a huge impact on the overall enjoyment of daily life. Bradley Court for example, provides African Caribbean hair and skin care for its residents, and also a mix of Caribbean and Western food on a daily basis, provided by a local firm who specialises in Caribbean food.

To provide culturally accessible housing provision does mean that residents can effectively live in a home which offers, respects and exercises their cultural beliefs, though not necessarily variant preferences. Such a scheme would be flexible enough to meet individual needs since culture shared among one ethnic group will have differences, let alone say 'Asian' group which encompasses several ethnicity's, faith, language besides class, customs – and many more that we see for majority elders also.

This can be expressed in a range of ways. Having people who speak the same language as residents, be able to understand BME elders' specific needs as well as common needs in old age, where interpreters and translators can facilitate communication are all important. BME elders have diversity of backgrounds coming from Ireland, the Indian sub-continent, Caribbean, Africa, China, Vietnam, South America, within Europe . Many would regard the family meetings and connections as an important element in bridging the distance between an extra care scheme and a 'family home' where they originally resided. Often families visiting range from one or two to several, or none. Therefore the design and the management of home can reflect this. Different groups are also likely to have different preferences when it comes to social activities. Bradley Court in Huddersfield involves its largely African Caribbean residents in putting together their own activity program, which helps to increase their self esteem and feeling of ownership. Training has proved

successful in attuning staff members to these issues, and a tailor made programme would further enhance competence needed in this growing area.

Self-Assessment Checklist

- What consideration has been given to the design and management of the extra care scheme so that it reflects the needs and aspirations of residents?

b. The nature of care provision: ‘the soul of the house’

There is a common saying that ‘*a home without love, is not a home*’. Why should this be any different for BME elders in an extra care housing scheme or any housing provision for that matter? Let us assume that all the above factors that give rise to the creation of an appropriate home is in place. Physical and social features (e.g. accessibility etc) are an essential aspect but so are the constituent parts that make up a home: what some BME elders call ‘*the soul of the house*’. Care is an essential aspect of this ‘soul’ since entry into extra care housing for BME elders is determined by at least five factors:

- Levels of ill health, mobility and dependency
- Changing pattern of family care, from absence to low level
- Acceptance by the elder/family that Extra care is an appropriate option
- Supply of appropriate extra care housing and assessment
- As a lifestyle choice

Good care and/or support is not about being culturally sensitive to the exclusion of competence, quality and value of care. These are all important in framing the essentials of person-centred care: indifference and ignoring the BME elder were seen as defining features for ‘dignity’ in hospital nursing care (PRIAE 2003). In other words BME elders in that work defined ‘dignity’ as ‘*being treated like I was somebody*’. This means that staff need appropriate training to listen, think, design and deliver care support in a culturally respectful way that can be deemed as ‘dignified’. What is also important is that BME elders needing extra care housing will have range of intellectual abilities and desires to have their ‘minds nourished’. However, most attention to date in this regard has been geared to meeting diet, religious and linguistic needs – all essential and are basic to the needs of people – elders.

Common room areas that provide access to ethnic media, programs that allow for both intellectual activities beyond cards or games and physical exercise and/or outings to places of interest rather than just prayers are important in creating that ‘atmosphere’ but also in developing good staff and residents’ relationships. Some BME elders also help staff so that provision of care is not always one dimensional.

The essence of culturally sensitive care is to regard BME elders, as do majority elders, as having a culture, in which specific adjustments need to be made to meet their specific needs. They are not special needs – just ordinary but different. It is about being responsive to the needs (since they are changing) rather than assuming that BME elders all have the same needs that

fit some notion of pre-designed framework of cultural appropriateness. In this way, commissioners and providers can work to see how care planning and provision will be engaged with BME elders who are neither static nor homogeneous.

Self-Assessment Checklist

- How do you prepare for, and evidence that the care and support needs of BME elders in extra care housing are reflected in the delivery of person-centred services?

4. Funding for BME extra care

We identify here the main sources of funding for extra care and consider their implications for BME extra care developments. As with majority elders, BME extra care would be funded through the key statutory sources.

Capital

Funded through local authorities own capital finances, in partnership with a housing developer. Capital funding through the Housing Corporation National affordable housing funding programme. Main sources are:

1. Department of Health Extra Care Fund
2. Using the Private Finance initiative: private developers/RSL's
3. Private for sale developments
4. Mixed tenure and for sale provided by RSL's
5. Loan/mortgages through the developer/RSL
6. Remodelling existing sheltered schemes into extra care

Revenue

1. Rents/Housing benefit
2. Supporting People funds
3. Social Services care funds
4. Charitable funding

As previous sections have shown, BME elders are either concentrated in certain localities and/or are scattered, that local authorities often state that they have insufficient data on demand, which is then accompanied by lack of strategic leadership on BME extra care.

There are strategic implications in accessing above sources of funding. It is necessary for the commissioning bodies to develop clear strategies for BME elders and to agree to allocate scarce resources according to those in greatest need, and not by numbers. Since extra care housing of BME elders is a recent issue, as with any new developments, strategic leadership would suggest that for example, the current standard size of housing units required as being viable may not be the best yardstick for measurement by commissioners when considering extra care for BME elders and/or any other group such as people with dementia. BME elders' housing therefore cannot be treated on the same basis as the majority who have had a longer history of

developments, awareness and infrastructure, resulting in extra care being better established. This is not asking for 'special' treatment but to simply recognise the need to employ a basic investment principle for non-established groups.

Such an approach opens up funders and commissioners with greater innovations in using funding streams that do not conform to the mainstream 'fit'. Flexible funding solutions are what is needed by funders, joint commissioners and providers. The use of both capital and particularly revenue funding through partnerships and innovative service delivery models can help sustain schemes in the long term.

The provision of culturally appropriate care may necessitate greater financial and human costs than mainstream care. This is due to BME housing being a specialist market with limited suppliers. As with any investment, as the supply increases and developments costs are reduced, it is likely that in the future the unit costs may well converge with mainstream provision. BME housing providers have often raised this as an issue not considered in their funding allocation for residential care in PRIAE's Royal Commission Report (Patel 1999). Providing information in different languages, culturally appropriate food, additional training and recruitment of staff, provision of cultural and faith activities, design of rooms and facilities all demand resources for service provision while design features generate some additional capital costs up front. However these costs are far outweighed in the long term preventative savings that are accrued. Therefore in the development of care-support contracts and accompanying service expectations, cost implications need to be recognised in the sourcing and the provision of appropriate care.

Partnerships with BME organisations in modelling the development and management of a scheme are an effective way of being flexible in using any of the above streams of funding. Smaller BME organisations often have the trust, expertise and experience of providing solutions to the needs of BME elders but do not necessarily have the internal resources or fit the criteria to compete for large statutory funds. In such cases, we see that it is these agencies that can often provide innovative solutions by bringing in funding from the charitable sector and BME private sector to complement the funding mix.

The BME sector contains considerable diversity where internal resources can be tapped into delivering this type of extra care. Involvement of BME private sector agencies wishing to invest in mixed tenure extra care to BME elders is just emerging and one with substantial resources. The establishment of effective for sale models to BME elders, is yet to be developed but can prove successful in meeting needs and changing expectations. Like the majority elders, BME elder groups are not homogenous in income/asset base and family patterns. Nor all will need extra care housing. Challenging such assumptions requires research, partnering and modelling to develop a market that engages private sector and individual resources, while promoting housing options to different ethnically based BME elder groups in individual areas.

Joint commissioning of extra care to BME elders must adequately map the needs of their communities in accessing resources.

Thus BME extra care housing presents different challenges in different parts of the country. For example, in order to establish Chinese Extra Care Housing in the capital city London, where the community is dispersed and considered 'small' but with demand for extra care housing, the following conclusion was reached by the organising group: *' the dispersed nature of London's local authority structure has meant that we were compelled to undertake a series of negotiations with 15 local authorities, all of whom chosen for having a significant Chinese community within their boundaries. We envisaged a cross authority joint working arrangement, where a number of boroughs could jointly revenue fund the placing of Chinese elders into one project that was hosted by a lead borough that took responsibility to access capital funding for it. This model would ensure that scattered nature of the Chinese community was accounted for in meeting need and the allocations from a number of boroughs would adequately create enough demand for the development of one scheme in a suitable location in London. But, in spite of having the Housing Corporation's principle commitment to capital fund such a scheme, and the DH Housing LIN calling for extra care bids that meet the needs of BME communities..., the commissioning of services to a significant community like this is still inadequate'*. (Gandhi,K Hanover Housing on behalf of the organising group: Mrs Shu Pao Lim at Great Wall Housing and PRIAE 2005)

We have shown in this section a range of funding issues that necessitates strategic leadership in determining and developing BME extra care. Perhaps with greater number of commissioners, funders and providers adopting this as a necessary working method, the London scenario illustrated above may be averted soon, to benefit all new and emerging elder groups.

Further information on the capital and revenue funding of extra care housing is contained on a Housing LIN Technical Brief (no.2 – *Funding in Extra Care Housing*)

Self-Assessment Checklist

- Have you identified sources and methods to attract investment in extra care housing for BME elders in your area?
- What consideration has been given to influencing regional housing strategies and future regional allocation arrangements to maximize the housing with care needs of BME elders? To what effect is this carried out?

Section 3.2: Summary

Tomorrow may be too late - Extra Care Housing for BME elders today!

Overall conclusions

As has been shown in this report

- BME elders represent a small but growing population in the UK
- who have experienced deprivation and inequality in their younger years
- and continue to do so as they age.
- Cultural and linguistic barriers can serve as additional barriers when accessing information and expressing needs.

As said at the beginning,

- BME elders share similar aspirations as majority elders
- They would like to age with dignity and respect, if possible, in or near their own homes, surrounded by friends and family.
- That asking for housing provision that is appropriate to their needs is neither asking for special treatment nor seen as a breakdown of their culture or their family or themselves.
- Extra care housing models are not static for majority elders – there is a diversity in their design, satisfaction and usage rates where not all schemes are 'perfect' in meeting white majority elders' needs.

For BME elders the same will occur when the issue of supply is addressed, and as evidenced by the snapshot survey of commissioners and providers conducted by PRIAE in year 2005.

This report has presented a set of guidelines and various examples on good practice, as well as some general contextual information. It is produced with the expectation that commissioners and providers will help to change the current scenario of a few and inadequate developments to having extra care provision that is appropriate and that BME elders, like all elders, have choice and hope that should they need such a home, it will be there:

'I've been banging on the door for so long to set up Chinese Elder Extra Care Home that there are only two options: give up or act to make it happen'
(Mrs Shu Pao Lim, an elder and the Chair of Great Wall Housing, London, PRIAE 2004).

We hope that the commissioners and providers will help to realise the needs and aspirations of not just Mrs Lim working for the community, but BME elders who need suitable housing, in developing extra care housing by 'making it happen'.

Summary of points:

- BME elders come from different ethnic backgrounds. As they age, with ill health and family changing patterns their needs for extra care housing grows from the current base of unmet need.
- The numbers' issue should not determine the need for extra care housing; rather it is the need *per se* that should determine whether extra care housing is needed or not.
- The fact that family and BME voluntary organisations have been looking after BME elders should not disguise the fact that currently housing needs of BME elders remain unmet:

That commissioners and providers both agree on the current lack of appropriate supply of extra care housing.

- BME elders' therefore represent a section of all elders whose housing needs in extra care need specific and urgent attention.

Why specific Extra Care

- BME elders cannot just 'fit into' existing majority designed extra care – just as the reverse would not be possible. Why? Cultural considerations are important to all of us, not just BME elders. This includes communication and an ability to regard formal housing as one's own.
- Requiring cultural appropriate housing solutions is not asking for special treatment, merely different to suit different needs.

How to meet different ethnic elder group needs?

- This does not mean different BME elder extra care housing for every small and large ethnic group: already the term 'Asian' embodies several sub ethnic groups, languages, customs, faith well before other aspects like class, lifestyle preferences as any other ethnic minority or majority group would have. Housing for Asian elders shows the capacity for meeting different ethnic groups needs under one roof but catering specifically to some needs.
- Success of Extra care housing is dependent on the internal, external considerations being met (section 3).
- BME housing provision like others have emerged not out of a desire to be ethnically separate, but as a response to providing care that is appropriate to them in the absence of mainstream housing.

With what information and resources?

- Commissioners and providers in PRIAE's survey share the view that BME elders' extra care housing is unmet and that they would like to be

engaged with this area of work. But many lack information, know how and understanding of what will best provide, the housing solution.

- Like any new area, there is a need to know your 'market', and well. This report has given you some pointers. In addition further advice can be given as part of DH Housing LIN's very good ethos and structure of learning through open dialogue depositing questions, with suggestions and solutions as part of what PRIAE calls, 'continuous transparent learning' through e-communication and events.
 - Commissioners and Providers are using their competence, decision making and judgement for developing extra care for any group that requires it. BME elders are no different and require commissioners and providers to not only apply these very set of values, knowledge and skills but to extend/examine them in the context of culturally appropriate housing as part of one's professional and organisational conduct. In the process changes may well take place but it is likely this may also benefit *all* elder groups, not just BME elders.
 - BME elders are entitled to decent housing in old age as *all* elders. Culturally appropriate care is not limited to BME elders. For majority elders these are taken for granted understanding and assumptions as part of everyday work. So lack of connection, familiarity and not sharing the same value system and knowledge of issues may suggest that BME housing represents something new/different/unique when BME elders and housing are discussed. Culture and identity are as basic and fundamental as the air we breath (Patel 2005). It needs to be imbued in the conception, design, development and delivery of extra care provision for all elders, today and not at some distant future.
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Appendix 1: Demographics: age, gender and ethnicity

Figure 1: The age distribution by ethnic group: Great Britain 2001

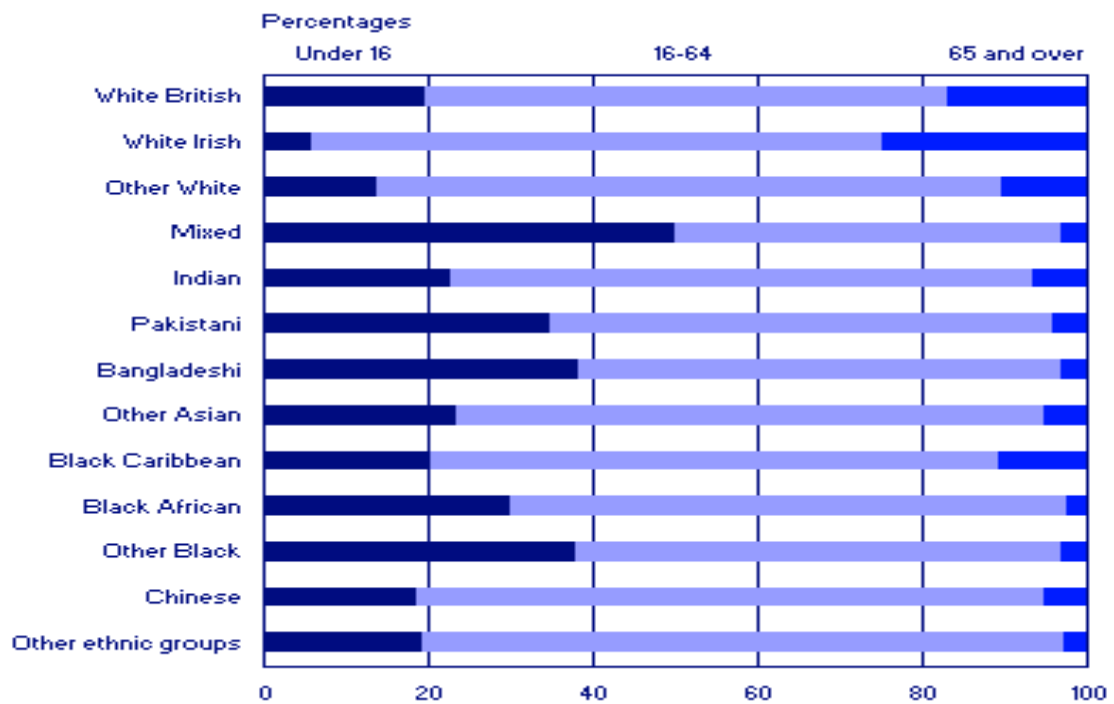


Figure 2: Sex distribution of people aged 65 and over by ethnic group: Great Britain 2001

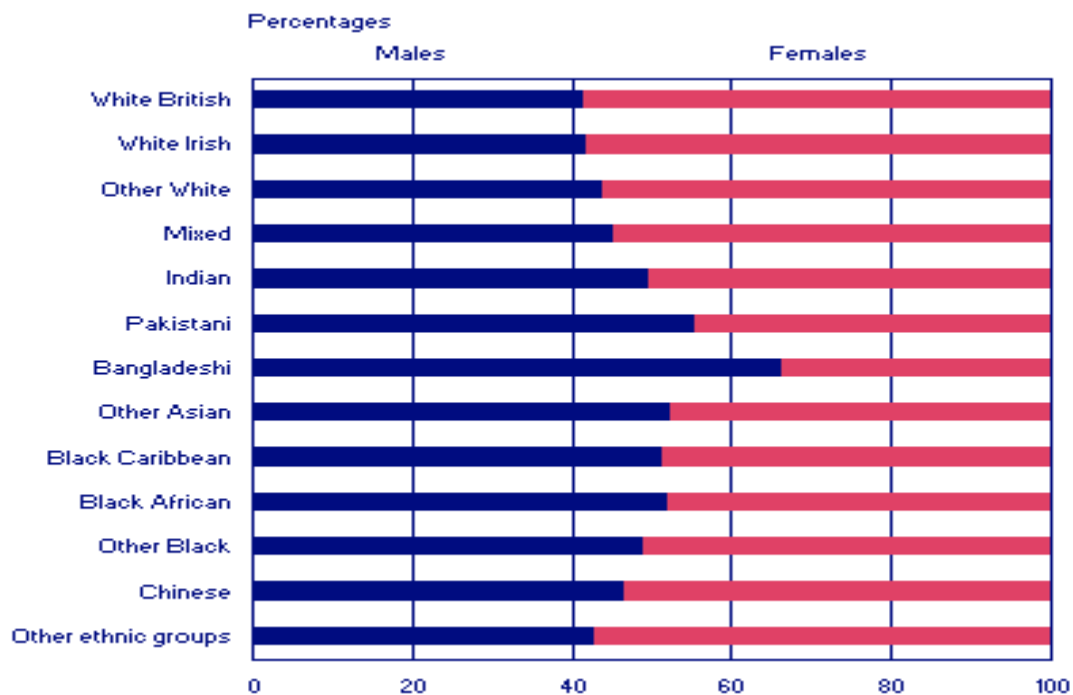


Table 1: The age distribution of ethnic minority women and men in the UK, 2001

Women											
Age	16 - 19		20-39		40-59		60-79		80 and over		Total
	absolute	%	absolute	%	absolute	%	absolute	%	absolute	%	absolute
Ethnic group											
White British	1,054,596	5.5	6,175,306	32.5	6,079,965	31.8	4,292,443	22.6	1,418,195	7.6	19,020,505
White Irish	6,524	2.0	83,170	25.9	108,368	33.8	101,553	31.7	21,176	6.6	320,791
Mixed group	27,088	15.7	96,158	55.6	35,367	20.4	11,668	6.7	2,775	1.6	173,056
Indian	35,526	8.8	187,672	46.3	129,349	31.9	47,254	11.7	5,560	1.4	405,361
Pakistani	30,230	13.1	124,024	53.9	55,088	23.9	18,638	8.1	2,139	0.9	230,119
Bangladeshi	12,653	14.7	49,731	57.8	17,793	20.7	5,464	6.3	424	0.5	86,065
Black Caribbean	15,132	6.2	110,223	44.9	74,808	30.5	41,787	17.0	3,317	1.4	245,267
Black African	16,107	9.1	107,936	61.1	43,372	24.5	8,424	4.8	946	0.5	176,785
Chinese	10,261	10.5	47,130	48.4	30,758	31.6	8,056	8.3	1,206	1.2	97,411
Other ethnic groups	6,199	6.1	56,453	55.6	32,845	32.4	5,296	5.2	685	0.7	101,478

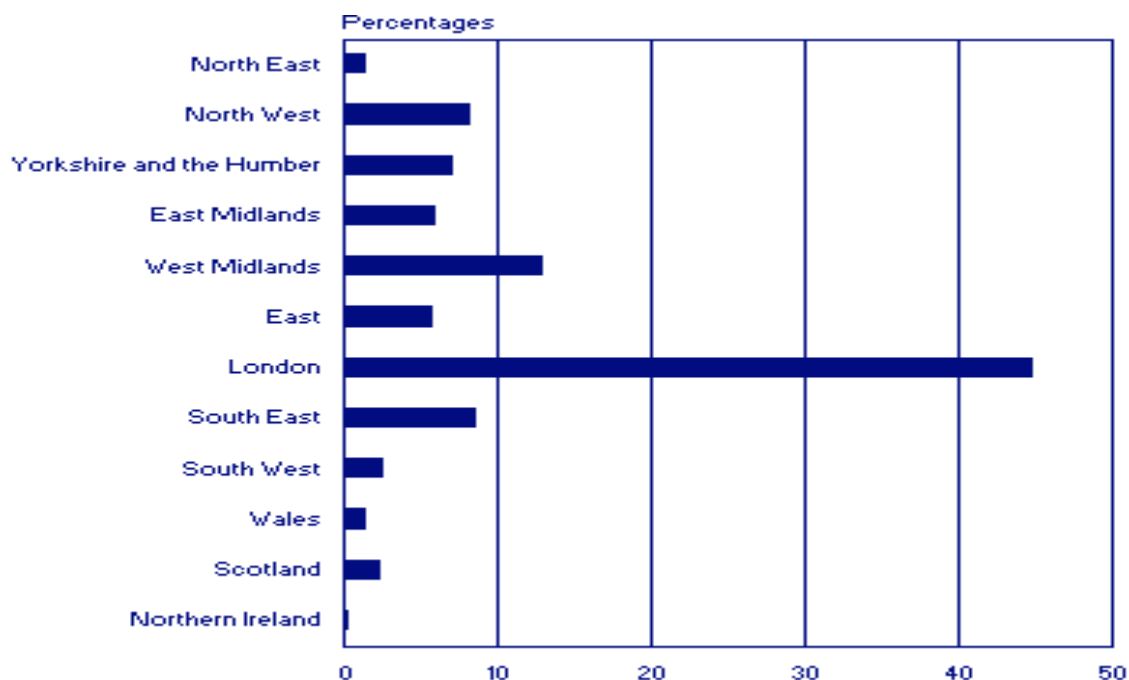
Men											
Age	16 - 19		20-39		40-59		60-79		80 and over		Total
	absolute	%	absolute	%	absolute	%	absolute	%	absolute	%	absolute
Ethnic group											
White British	1,103,689	6.3	6,086,548	34.6	6,040,403	34.3	3,699,702	21.0	679,704	3.9	17,610,046
White Irish	6,881	2.4	79,604	28.1	101,294	35.8	85,015	30.0	10,423	3.7	283,217
Mixed group	27,999	17.8	85,504	54.3	31,146	19.8	11,176	7.1	1,550	1.0	157,375
Indian	36,387	9.2	178,254	45.2	126,396	32.1	48,688	12.4	4,394	1.1	394,119
Pakistani	31,191	13.3	122,532	52.2	54,354	23.2	24,779	10.6	1,785	0.8	234,641
Bangladeshi	12,533	14.4	47,961	55.2	15,748	18.1	10,177	11.7	401	0.5	86,820
Black Caribbean	14,573	7.2	87,592	43.0	55,353	27.2	43,281	21.2	2,968	1.5	203,767
Black African	15,232	9.6	91,973	58.2	40,854	25.8	9,408	5.9	673	0.4	158,140
Chinese	10,986	12.5	43,926	49.9	24,501	27.9	7,905	9.0	630	0.7	87,948
Other ethnic groups	6,668	8.8	42,173	55.5	22,423	29.5	4,260	5.6	403	0.5	75,927

- Table derived by PRIAE (2005) from the Census 2001 (ONS 2003 p121/2)

Table2 : Age distribution by ethnic group, 2001, ONS

Aged :	50-64	65-84	85 +	All 50+
White	18.2	14.9	2.1	35.1
Mixed	4.7	2.7	0.3	7.6
All Asian or Asian British	10.3	5.0	0.3	15.5
Indian	12.8	6.2	0.3	19.4
Pakistani	7.4	3.9	0.2	11.5
Bangladeshi	6.4	3.1	0.1	9.6
All Black or Black British	9.9	6.2	0.3	16.4
Black Caribbean	13.4	10.2	0.4	24.0
Black African	6.8	2.2	0.1	9.1
Chinese	11.1	4.8	0.3	16.2
Other ethnic groups	11.0	2.7	0.2	13.9
All non-White minority ethnic population	9.4	4.8	0.3	14.5
All population	17.5	14.0	1.9	33.5

Figure 3: Regional distribution of the non-White population, April 2001



Figures 1, 2, 3 taken from Focus on Ethnicity and Identity (ONS 2005 published online at <http://www.statistics.gov.uk/focuson/ethnicity/> accessed on 12/09/2005)

Table 2: Resident population by ethnic group, 2001 by London – England/Wales

	Percentages			
	Percentage of total population		Percentage of non-White ² population	
	London	England and Wales	London	England and Wales
White	71.2	91.3	.	.
White British	59.8	87.5	.	.
White Irish	3.1	1.2	.	.
Other White	8.3	2.6	.	.
Non-White²	28.8	8.7	100.0	100.0
Mixed				
Mixed White and Black Caribbean	1.0	0.5	3.4	5.3
Mixed White and Black African	0.5	0.2	1.7	1.7
Mixed White and Asian	0.8	0.4	2.9	4.2
Other Mixed	0.9	0.3	3.0	3.4
Asian or Asian British				
Indian	6.1	2.0	21.1	22.9
Pakistani	2.0	1.4	6.9	15.8
Bangladeshi	2.1	0.5	7.4	6.2
Other Asian	1.9	0.5	6.4	5.3
Black or Black British				
Black Caribbean	4.8	1.1	16.6	12.5
Black African	5.3	0.9	18.3	10.6
Other Black	0.8	0.2	2.9	2.1
Chinese	1.1	0.4	3.9	5.0
Other	1.6	0.4	5.5	4.9

Source: Adapted from the Census 2001, in: Phillpotts, G, Cohen, D [Editors] (2005) Region in Figures: London, Winter 2004/5 No 9. London; ONS p 15

Appendix 2: The BME Elders and Extra Care Housing Self-Assessment Checklist

Ageing and ethnicity

1. Do you know how many BME elders live in your local authority area and what are the projections on the number who would benefit from extra care housing over the next 10-15 years?
2. Does your existing provision of extra care housing reflect the ethnic diversity of your local population?

Race relations, care and housing

3. Is there a written statement of equal opportunity policy or a documented agenda for diversity and inclusion in your organisation?
4. Can you evidence that the way you assess the housing with care needs of BME elders promotes equality of opportunity?

Knowledge and understanding

5. Have you identified necessary information to work with BME elders? Have you consulted with BME elders and their representative organisations to establish what information they require to make informed choices on extra care housing in your area?
6. Have you reviewed how accessible your existing information on extra care housing is for BME elders in your area and how it is communicated?

Culture, ethnicity and religious identity

7. Do you know what barriers BME elders experience in accessing extra care housing in your area?

The location of the scheme

8. What consideration has been given on the location of the existing or proposed extra care housing scheme? How does it reflect the needs and hopes of BME elders?

Engaging with the BME community

9. What mechanisms are in place for engaging with existing and prospective residents from local BME communities?

Engaging with the wider community

10. What links does your organisation have with BME elders and groups? What arrangements do you have in place to develop these links, maintain relationships and produce tangible housing solutions?

The physical and social environment

11. What consideration has been given to the design and management of the extra care scheme so that it reflects the needs and aspirations of residents?

The nature of care provision

12. How do you prepare for, and evidence that the care and support needs of BME elders in extra care housing are reflected in the delivery of person-centered services?

Funding for BME extra care

13. Have you identified sources and methods to attract investment in extra care housing for BME elders in your area?
14. What consideration has been given to influencing regional housing strategies and future funding allocation arrangements to maximise the housing with care needs of BME elders? To what effect is this carried out?

Other Housing LIN publications available in this format:

Housing LIN Reports:

- **Extra Care Housing Training & Workforce Competencies (Report and Executive Summary)**
- **Yorkshire & the Humber Region - Extra Care Housing Regional Assessment Study (Report and Executive Summary)**
- **Preventative Care: the Role of Sheltered/Retirement Housing**

<u>Factsheet no.1:</u>	Extra Care Housing - What is it?
<u>Factsheet no.2:</u>	Commissioning and Funding Extra Care Housing
<u>Factsheet no.3:</u>	New Provisions for Older People with Learning Disabilities
<u>Factsheet no.4:</u>	Models of Extra Care Housing and Retirement Communities
<u>Factsheet no.5:</u>	Assistive Technology in Extra Care Housing
<u>Factsheet no.6:</u>	Design Principles for Extra Care
<u>Factsheet no.7:</u>	Private Sector Provision of Extra Care Housing
<u>Factsheet no.8:</u>	User Involvement in Extra Care Housing
<u>Factsheet no.9:</u>	Workforce Issues in Extra Care Housing
<u>Factsheet no.10:</u>	Refurbishing or remodelling sheltered housing: a checklist for developing Extra Care
<u>Factsheet no.11:</u>	An Introduction to Extra Care Housing and Intermediate Care
<u>Factsheet no.12:</u>	An Introduction to Extra Care Housing in Rural Areas
<u>Factsheet no.13:</u>	Eco Housing: Taking Extra Care with environmentally friendly design
<u>Factsheet no 14:</u>	Supporting People with Dementia in Extra Care Housing: an introduction to the the issues
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<u>Factsheet no 16:</u>	Extra Care Housing Models and Older Homeless people
<u>Case Study Report:</u>	Achieving Success in the Development of Extra Care Schemes for Older People
<u>Technical Brief no.1</u>	Care in Extra Care Housing
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