



Care Services Improvement Partnership **CSIP**

**Housing Learning and
Improvement**
Network

Putting Older People First in the South West

Selected regional case studies

November 2008



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Introduction

This paper is one of five documents prepared for the Housing Learning and Improvement Network in the Care Services Improvement Partnership and the Housing Corporation concerned with the future accommodation needs of older people in the South West of England. The five documents comprise:

- This paper which offers a set of ten case studies demonstrating how some of these challenges are being met in the South West through strategic partnership, the reconfiguration of existing services, and the development of new services. They are intended to provide examples and ideas for commissioners and providers about the approaches that could be taken. Each study includes a description of the project itself and how it was carried out, the outcomes achieved, and the lessons learnt
- A briefing Taking the Strategy Forward in the South West
- An executive summary providing a concise introduction to the key issues and themes that concern housing for older people in the South West and the policy considerations that flow from these themes. This paper draws on the material developed in the two main papers below
- A comprehensive overview of the regional housing market for older people, and
- A glossary of useful housing, care and support terms that will help provide a common understanding of language used across the sectors.

Overview of the case studies

This section provides an overview of the case studies linking them to specific strategic challenges faced in the South West. Further details are contained within the case studies themselves.

A strategic partnership approach to Extra Care Housing

There are wide variations across the region in the level of provision of extra care housing. There are also variations in the amount of extra care housing for rent and for sale between authorities. These gaps in the provision of extra care housing indicate areas which individual authorities will wish to address depending on the population projections for their area. There are two case studies demonstrating approaches firstly to assessing need for extra care housing, and secondly to developing a partnership approach to delivering a programme of extra care housing.

Swindon Borough Council developed and applied a tool to help inform the council's strategy for housing, support and care for older people (**Case study 1**). The tool is based on an approach which examines the gap between current service supply and likely future populations of older people in different geographical areas within the Borough in order to estimate the number, location and characteristics of Extra Care Housing units that will be required by 2010.

The tool makes use of available demographic data which enables the council to understand likely changes in population profiles over the next thirty years, but also incorporates current levels of community and residential support; and discussions with older people and their carers, practitioners and elected members.

The Bristol Very Sheltered Housing Partnership was set up by the City Council to enable the development of very sheltered housing (or extra care housing) to meet the stated needs of older people for housing options which promoted independence and choice within a safe and supportive environment (**Case study 2**). The Partnership includes a range of housing providers as well as the city's Neighbourhood & Housing Services and Adult Community Care, the Primary Care Trust and the Housing Corporation. It has been successful in completing a number of VSH schemes across the city, with others in the planning and development process. It has also created a partnership which fosters shared learning and the development of best practice both in the development and management of very sheltered housing.

Modernising sheltered housing services

Many authorities and providers are looking to decommission or remodel their ordinary sheltered housing stock as they are finding difficulties in letting accommodation that is sub-standard or no longer suitable. There is widespread anecdotal evidence that much sheltered housing is no longer fit for future populations of older people, in terms of design, size and space standards. Increasing the provision of housing designed to enable care and support services to be delivered into it, including extra care, may be achieved in part through remodelling existing sheltered schemes or using the sites for new build schemes. The two cases illustrating approaches to this review look at different aspects, firstly the properties themselves, and secondly the services provided within them and how they are accounted for.

Somer Community HT (SCHT) commissioned the development of objective standards with which to measure how adequate their sheltered and older people designated housing was, given expectations of older people now and into the future (**Case study 3**). These standards were then used to assess their stock, and have provided information about the long-term viability of schemes and the measures needed to ensure they are future-proofed. SCHT are now to use this information to support the development of a strategic approach to their services for older people

Devon Community HS (DCHS) carried out a review of their sheltered housing service to enable them to provide a modernised, cost efficient and accountable service which met the needs of their tenants, and the Supporting People commissioners (**Case study 4**). The project involved reviewing the income and expenditure associated with all aspects of their sheltered housing service (thus including support as well as housing benefit eligible and non-eligible services) as well as considering the best delivery options. The project aimed to include tenants and staff fully in the process of developing this understanding, and considering options for reconfiguration.

Developing a flexible support service

A review of Supporting People strategies in the South West shows there is a growing trend towards the introduction of more flexible and person-centred models of housing-related support. This may take the form of a menu of support options being offered to individuals both in sheltered housing and the wider community. The approaches taken in Dorset and Mendip illustrate how support services can be developed in this way, one creating a menu of services, the other creating an integrated area-based service.

Signpost HA, in partnership with Dorset Supporting People, developed an Independent Living Service in North Dorset, providing a menu of support services for older people living in Signpost's own housing, and also for those living within the community, regardless of tenure (**Case study 5**). It has resulted in significantly improved satisfaction levels amongst residents, as well as meeting the assessed support needs of older people living both within Signpost's own housing and in the community.

A second approach is that taken by Mendip Housing in partnership with Somerset Supporting People (**Case study 6**). This was a pilot study exploring the potential to offer low level support services to older people in Mendip on an area rather than a service basis, combining sheltered housing, floating support, a short term "road to recovery" service, helpline and assistive technology services. The pilot was developed in close consultation with tenants and staff, and aimed to test a range of hypotheses including that this would be a more cost effective approach to providing support, and would open up the facilities within the sheltered housing schemes to the wider community of older people.

Supporting choice for older people

Most older people want to remain in their own home for as long as possible. However this does not necessarily mean that they do not want to move, and often the reason for not moving is lack of independent advice about housing options. Older peoples' preference for staying put may also reflect the limited options available to them and their perception of sheltered housing. The service developed in Bristol demonstrates how an independent advice service can be effective for older and disabled people, improving access to a range of housing and other services.

Bristol Care and Repair developed their Housing Options Service to help clients make an informed choice, and provide intensive support if they decide to move (**Case study 7**). The focus is mainly on clients' housing needs but HOS take a holistic approach to each client and their situation, maximising income, and making referrals to statutory and voluntary agencies as appropriate. If required, they support the client by dealing with estate agents, solicitors, their bank, mortgage company, the local authority, the Department of Work & Pensions etc. Through their publicity strategy they have built positive links with other agencies, which enables them to provide the best possible support to the client.

Offering a choice of tenure

The South West has relatively high levels of owner occupation: particularly among the younger old. Assuming the region follows national trends, the proportion of older owner occupiers will increase further over the coming years. Many of these owner occupiers will be asset-rich and income-poor. The provision of extra care housing for sale is patchy across the region, but the Bristol mixed tenure scheme demonstrates how properties for sale and rent can be successfully combined within one development.

As a partner in Bristol City Council's Very Sheltered Housing (VSH) Partnership¹, the St Monica Trust developed a large housing scheme for older people, Monica Wills House, on a 1.25 acre brownfield site in Bedminster in the south of Bristol (**Case study 8**). The scheme combines a mixture of tenures and dependency levels and provides a model of a mixed development for older people in a busy urban setting.

¹ Very Sheltered Housing is the term used in Bristol for their form of extra care housing

Supporting older people in rural communities

The South West region has a higher proportion of its population in rural areas than any other English region. Although in terms of absolute numbers, people aged 65 and above are predominantly found in urban areas in the South West, older people represent a greater proportion of the total population in non-urban areas, particularly in the younger old. In Gloucestershire a model of support and information has been developed which helps older people within their rural communities, as well as empowering those people employed as Village Agents within those same communities.

The Village Agent pilot project develops the concept of a locally based person who is able to provide face-to-face information and support which enables older people to make informed choices about their future needs (**Case study 9**). This concept is based on the hypothesis that older people living in rural communities prefer to approach someone they know within their community for help and advice.

Improving access to assistive technology

Most authorities are looking to increase their provision of telecare and assistive technology (AT) as a way of maintaining older people in their own home. Many services are being expanded and developed to improve accessibility and availability to a wider range of older people.

The approach taken in Cornwall is one example of moving from a disjointed and reactive development of AT to one that is sustainable countywide (**Case study 10**). All partner organisations are now using a single procurement route for the provision of equipment, with an enhanced countywide call centre provision, and with the development of a SMART house to provide a central assessment and training resource.

Lessons learnt

Each of the case studies includes a section exploring the lessons learnt by commissioners and providers through undertaking the particular project. The common themes from these are set out below.

Information and awareness raising

A number of the case studies highlight the importance of raising awareness, particularly of new services. For example, extra care housing is not well understood within the community, and resources need to be put in locally to raise awareness and increase understanding of what it can offer. This will affect a range of stakeholders from older people and their families through to professionals and service providers.

Alternatively, where services are being reconfigured, such as changes to a sheltered housing service, it is important to ensure all those actually and potentially affected are fully and appropriately consulted and informed.

Several of the services described were dependent on their relationship with professionals and other agencies. For example, the Village Agents needed to develop a good information base about local services and activities. Similarly, the Housing Options Service relied on good information about what services were available. Both these services also received referrals from professionals in other agencies who therefore needed to be aware of what support they offered older people.

Project or change management

Whether the project was introducing a large programme of extra care housing developments, or reconfiguring a relatively small existing service, the case studies have highlighted the need for good project management.

Aspects mentioned included ensuring there was a shared understanding of the outcomes sought from the project (particularly important where a number of partners were involved), ensuring the process was carefully planned including stakeholder consultations, but also maintaining the ability to react flexibly to changing circumstances (such as changing funding arrangements).

Staff Development

Both in the introduction of new services and the reconfiguration of existing services, the importance of involving and training staff was critical. This needed to be properly planned and resourced. Several projects referred to the benefits of informal staff meetings to share experiences (particularly in new services) as well as more formal training.

Swindon Borough Council – Estimating future needs for extra care housing

Summary

Recognising the changing demographic profile of its residents and with a commitment to increasing the number of Extra Care Housing schemes in the borough, Swindon Borough Council developed and applied a tool to help inform the council's strategy for housing, support and care for older people. The tool is based on an approach which examines the gap between current service supply and likely future populations of older people in different geographical areas with the borough in order to estimate the number, location and characteristics of Extra Care Housing units that will be required by 2010.

The tool makes use of available demographic data which enables the council to understand likely changes in population profiles over the next thirty years, but also incorporates current levels of community and residential support; and discussions with older people and their carers, practitioners and elected members.

Introduction

Local authorities are increasingly looking for effective tools to enable them to identify needs and develop appropriate and well-targeted services for their residents. Swindon Borough Council developed a tool to estimate the likely future need for Extra Care Housing (ECH) in partnership with Kent County Council in early 2005.

Background

Since 2002, Swindon Borough Council has been working to meet targets requiring a 20% reduction in residential care placements through a programme involving remodelling and expanding the remit for some ordinary sheltered housing (OSH) schemes to meet Extra Care Housing (ECH) standards and the development of resource centres, day services, domiciliary care and nursing care through a broad-based local partnership.

The Council's 50 Promises for Swindon included the promise to commission an additional 5 extra care schemes by 2010. Funding was successfully sought from the Department of Health for a grant to provide Extra Care Housing and resource centres through the refurbishment of existing sheltered housing schemes in 2002. Three schemes, built in the 1990s to OSH standards, which had been used as OSH schemes, were thought to provide the best opportunity for development.

Thus the first phase of the Swindon ECH programme relied mainly on refurbishing existing schemes, and decisions were made on the basis of local opportunities and constraints. With funding secured from a second round of bids to the Department of Health for a new build ECH scheme, a tool was designed to assist with planning the location, size and characteristics of the next generation of ECH schemes.

Case study 1

The Approach

The tool designed to estimate likely future need for ECH housing was developed early in 2005 in partnership with Kent County Council and is based on:

- Current numbers and distribution of older people
- Current numbers and distribution of domiciliary and residential care clients
- Population projections for Swindon.

Graphs and statistics were produced with the aid of SASPAC, which is software specifically designed for the analysis and interrogation of census small area statistics.

Current numbers and distribution of older people

In order to provide ECH to meet the needs of local communities, commissioners needed a good understanding of where older people live within the borough, as well as the geographical distribution of characteristics such as ethnicity and tenure. This can be done by examining data from the Office of National Statistics at ward level.

According to the mid-2003 population estimates there were at that time 181,500 people in Swindon, of whom 16.1 percent were of retirement age – somewhat lower than the England and Wales figure of 18.5%². The first stage in developing the model was to plot the age profile in each of the 22 wards in Swindon. This exercise identified wards with unusually high proportions of older people and others with a younger profile with larger proportions of children and young families, or other people of working age.

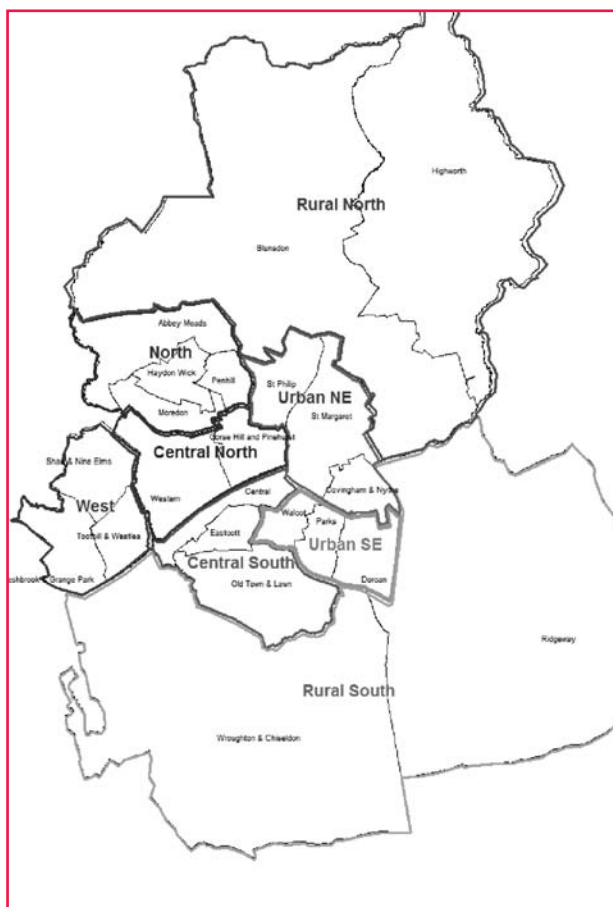
The next stage was to group together wards with similar characteristics. A number of statistical methods are available to achieve this, the standard method being cluster analysis which allows the investigator to group geographical areas on a range of different variables. However, cluster analysis would have selected pockets of wards with similar characteristics dotted about the borough. To avoid this, a pragmatic approach was taken, whereby workable boundaries were drawn around groups of wards, creating geographical entities with reasonably homogeneous populations. In the case of Swindon, the wards were divided into six sectors covering the urban areas of the borough, and two covering the rural areas (see *Figure 1 on the next page*).

Stakeholders were invited to comment on these sector boundaries, which were found to be consistent both with local knowledge and with those emerging from similar work taking place in the borough.

Plotting the population characteristics of the sectors results in a much simpler picture than does plotting wards. The two rural sectors: Rural North and Rural South, are home to older populations. Having found a way of making the age profiles (and potentially other population characteristics such as ethnicity and tenure) more manageable, the next step was to find a mechanism for relating the information to what older people actually need in terms of service provision. The solution adopted in Swindon was to use existing supply as a proxy for need.

² Source: Office of National Statistics: Swindon Neighbourhood Profile

Figure 1 Sector boundaries for Swindon 2010



Current numbers and distribution of domiciliary and residential care clients

The first element of this step was to assess the likely need for ECH among clients currently living in the community. This stage of the analysis identified where the recipients of social care in the borough currently live. The numbers of people in each sector currently supported by domiciliary care indicated that, in terms of absolute numbers, more people are supported in the urban sectors.

In using data on the supply of services as a proxy for estimating need, it was assumed that current supply is adequately and equitably meeting need in the borough.

It may be useful to check this assumption by examining the way in which the current number of clients supported relates to the actual number of older people in the sectors, to see if there is any geographical variation.

In fact, numbers of domiciliary care clients as a percentage of people aged 85+ did vary somewhat by sector of the borough, although probably not significantly. Central and Rural South sectors appeared to have fewer domiciliary care clients as a percentage of all those aged 85+ than other sectors, whilst Urban South East sector had rather more. This may be an indicator of increased need in the south east, or it might be contingent on a particular local context which is independent of actual need.

Supply data can also be broken down into the number of visits per week each client receives. Although the numbers varied in each sector, clients receiving ten or more visits per week as a proportion of all clients remained fairly similar across the sectors; ranging from 0.4 to 0.5. Once again, although this tells us something about volumes of care across the sectors, it is important to amplify the figures with qualitative data to ensure that they do not gloss over inconsistencies in access or supply across the borough.

Further analysis revealed that in Central South sector a notably lower proportion of those aged 85+ were receiving ten or more domiciliary visits a week, whilst in Urban South East Sector the reverse was true. Such anomalies may be the result of other reasons such as health inequalities, of differences in service delivery and cultural differences. They should be investigated in the light of the service experience of older people, carers and practitioners to build up a richer picture of local complexities.

Local knowledge about levels of service provision can amplify the demographic and supply figures – what do local people, service providers, older people and carers say about service availability in the different sectors?

Are there factors which result in unequal service delivery in the different sectors – for example, are some more remote than others? This a key point at which to link demographic and service data, as well as local knowledge, in order to understand how those factors might operate in Swindon.

The second element of this stage involved assessing likely need for Extra Care for clients who would otherwise access residential care. The overall distribution of residential beds in the borough was not included in the model for two reasons:

- Residents of care homes are likely to be accommodated at a distance from their original communities, so their current location gives no information about the future distribution of need.
- At this stage Swindon was primarily concerned with local authority residential care beds, not with the private sector.

Applying the target of a 20% reduction in the residential care population across all local authority residential clients between 2005 and 2010, suggests that 92 additional clients would need of alternative provision.

These clients were allocated across the sectors in the same proportion as domiciliary care is supplied, on the assumption that the distribution of need will be similar. However, it is important to have good assessment processes to ensure that those people who are diverted from residential care in order to access ECH are the people who will benefit most from what ECH has to offer.

The experience of Swindon in estimating the appropriate number of ECH places for older people in the borough illustrates the way in which careful triangulation of data from a number of sources – population age profiles, supply data and local knowledge – can help to build up a picture of need and supply. It also indicates the way these interact in the borough.

No single source is sufficient: decision-making: anomalies in the quantitative data have to be examined and understood in light of qualitative information about local communities and their expectations and local service delivery decisions.

Population Projections

The final element in the Swindon model is population forecasts. Population projections until 2011 indicate that people aged 60-69 will increase by about 1,000 per year, slowing to about 700 per year. Meanwhile, the group of people aged 70-84 will grow at about 200 per year, and those aged 85 and older at about 150 per year. These numbers represent a steep increase in the proportion of older people within the wider population. If present trends continue, the Swindon population will grow by about 10% by 2011, but during the same period the population of people aged 85 and over will grow by 111%.

Some sectors were identified as likely to have considerable growth in the population of people of retirement age while others predicted a smaller increase or even a fall in the numbers of older people.

Making the links

Incorporating the information from the three elements – along with discussions with elected members, practitioners, older people and carers – the Swindon team calculated the expected number of ECH places required in 2010 for each sector. The council has produced maps which summarise the data for each sector, and it recently developed added to the maps information about the distribution of people from BME groups, and of owner occupiers. These maps have been produced in MapInfo, using information imported from SASPAC via Excel.

Good practice guidance on ECH suggests that the community of older people within the scheme will be more vibrant if it contains a balance of less frail people who are likely to be active in promoting leisure activities and supporting tenant and owner participation. Any model for estimating the likely future number of ECH places must consider that one third of new occupants are likely to have few or no care and support needs on entering the scheme.

Resources

In 2002, Swindon Borough Council and Swindon social services jointly applied to the Department of Health (DH) for a grant to provide Extra Care Housing and resource centres through the refurbishment of three existing sheltered housing schemes. The partnership was awarded £304,000 by the DH, which was augmented with £500,000 capital funding from social services and £250,000 from the housing department. This funding was allocated to the development of the first two remodelled schemes: Newburgh House in Highworth (a borough owned sheltered scheme) and The Ridings (a Kennet Housing Society scheme). At the Ridings, which was remodelled first, Kennet Housing provided £250,000 for the project, whilst social services provided capital of £250,000 and £130,000 DH funding.

Funding of £370,000 was secured from the second round of bids to the DH, for remodelling a scheme at Harry Garrett Court in Wroughton, owned by Sanctuary. Initially, funding was to consist of the DH grant, £250,000 from social services, and £150,000 from Sanctuary: however social services later agreed an additional £80,000.

Additional resources have been obtained for a new build extra scheme being developed by Housing 21 at Lease Hill through the leasing of the site at a peppercorn rent for 125 years by the council, and corporate support of £300,000 as a capital grant. A day centre for 20 local residents will be part of the completed facilities at the scheme. A grant of £3 million was received from the Housing Corporation. The scheme will include a proportion of mixed tenure flats.

Outcomes

Future schemes will be planned and located with reference to the new model. The objective is to provide a minimum of 200 ECH tenancies by 2010. Currently 40 extra care flats have been completed; this will increase to 89 when Lease Hill is completed. Moreover, the model has prompted partners to work with planners and housing providers to identify potential sites in the appropriate locations.

Future

The stock of local information and systems for collecting it are likely to grow in the future in response to discussions with stakeholders including elected members, staff from other agencies, older people and carers.

Ideally, in the future a template for grouping wards could be developed and agreed by all service providers. Although different agencies will be interested in different characteristics when defining groups of wards, it would be helpful if this exercise could be done on the basis of an agreed set of variables so that all agencies begin to work to a single model.

Ongoing conversion of flats at the three re-modelled schemes (on a voids basis) will see a gradual increase of extra care provision at these locations. Further sites are under consideration for new build schemes.

Consultation with local people has revealed interest in shared ownership extra care, particularly among owners who bought under the Right to Buy, as a way of preserving their equity. This is therefore going to be a feature of the new Lease Hill scheme and will be considered for further new build schemes.

The council has produced an information leaflet on Extra Care and is planning a Day Centre brochure as a supplement to the scheme brochures

Lessons learned

- When assessing future need, demographic and supply data should be supplemented by local knowledge in order to understand where and how access and service inequalities operate. Local information can be used to link different elements of the demographic data: for example, how many people from BME groups are likely to be owner occupiers, and do they own high or low value properties? Would local house prices allow owner occupiers to buy into ECH with capital to spare, or would there be a shortfall?
- Part of the success of the Swindon programme is attributed to the adoption of an entrepreneurial style by commissioners in their negotiation with potential providers – for example a Project Manager post was part funded by Kennet Housing to manage the remodelling of The Ridings
- Identifying suitable land at the right price and in the right locations is always a problem.
- There is a need to continuously review and refresh demographic information in order to maintain its usefulness and effectiveness in demonstrating need to the planning authority
- Understanding of ECH in the community is limited and there is a need to raise awareness and understanding of what it can offer. Open Days have been found to be an effective tool, along with trial tenancies.

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Bristol Very Sheltered Housing Partnership

Summary

The Bristol Very Sheltered Housing Partnership was set up by the city council. It was intended to enable the development of very sheltered housing or extra care housing to meet older people's stated desire for housing options which promoted independence and choice within a safe and supportive environment. The partnership, which includes a range of housing providers as well as the city's Neighbourhood & Housing Services and Adult Community Care, the primary care trust and the Housing Corporation, has succeeded in completing a number of VSH schemes across the city. Others are in the planning and development process. It has also created a partnership which fosters shared learning and the development of best practice both in the development and management of very sheltered housing.

Introduction

In Bristol the Very Sheltered Housing (VSH) programme, involving five different housing suppliers, was set up to provide an alternative to residential care.

The main challenges for this programme were:

- High level of capital funding required
- Selling the benefits of the new service
- Maintaining consistency among providers
- Competitive sector-wide range of partners

- There were no existing outcome measures or formats to follow
- How to link Best Value vision to service change
- Delivering VSH and closing residential homes.

The programme aimed to provide a positive, innovative alternative to residential and nursing care, including promoting a preventative agenda.

Background

In 1999/2000 the Best Value Review of Services for Older People identified that Bristol had a relatively large number of people in nursing/residential care compared with other cities. The review, which included extensive consultation, highlighted that "no matter how good, residential care was not seen as a positive option". Older people wanted to be able to retain their privacy, independence and choice, within a safe and secure environment. The Best Value review recommended a reduction in the number of residential and nursing placements and the development of 600 new extra care Very Sheltered Housing (VSH) flats.

At the time of the review the main options for older people in the city were ordinary sheltered housing (mainly with a residential or non-residential scheme manager, but also schemes without support except possibly through an alarm system), or, for those with more care needs, residential and nursing homes. All of these forms of provision were provided both by the local authority and independent providers (RSLs and independent providers).

Case study 2

The VSH partnership

Partnership Structures

The project management for the new partnership is led by a VSH Project Board with key representatives from Neighbourhood & Housing Services and Adult Community Care, and which takes reports to the city council's cabinet for major decisions.

A partnership board was set up as the main vehicle for enabling the delivery of the programme. Board membership includes all partners and key stakeholders, with the city council as the lead partner holding an overview of the whole programme. The partners are four registered social landlords and one charity, with the Housing Corporation and primary care trust as the two key stakeholders.

Partnership Vision and Ethos

The success of the partnership has been described as being achieved through the open sharing of information and skills, a joint commitment to the vision, and developing a consistent approach across the whole programme.

The original vision agreed by the partners is as follows: "Our shared vision is to create 600 new VSH flats within local community hubs for older people; and to achieve a good geographical spread across the city, linked to key demographic factors".

The guiding principles of the VSH concept in Bristol was that older people should have a home for life and not have to move again if at all possible. This was reflected in design arrangements which would provide full wheelchair accessibility throughout, a commitment to ensure required care provision; and a pledge that there would be a balanced community.

VSH communal facilities would be open to use by local people to facilitate integration into the community. Residents would be able to choose how they live in the scheme and a proactive philosophy of care should operate, with an emphasis on promoting independence, empowerment and health and quality of life. The schemes would 'provide accommodation and care of the highest standard within available resources'.

The partners to the programme undertook to use their best endeavours to promote these aims and to develop schemes which facilitated effective joint working between housing providers, care providers, housing related support providers and commissioners. They agreed to be collaborative rather than competitive, to encourage local community involvement and consultation and to promote the use of local labour wherever possible.

Partnership Agreement

An agreement was developed and agreed by the partners covering a range of issues including:

- A description of the partnership's original concept of VSH
- An agreed design brief for VSH
- How sites would be chosen (location criteria)
- Eligibility criteria (including definitions of levels of need)
- The allocation process for flats between housing and care nominations
- A maximum level of rent and service charges, including a statement of what should be included in service charges
- A description of the circumstances in which people might need to move on from VSH, and the process to be followed.

Resources

Initially Bristol created a VSH team with two dedicated officer posts (covering both neighbourhood & housing and adult community care). The other partners also committed considerable time and resources into developing the programme, and this overall commitment has been key to the programme's success.

The city council was committed to the provision of capital grants and land into the programme (to the value of £7.8M) and to revenue funding for the care and housing related support services into the VSH schemes from the Adult Community Care department and Supporting People budgets. One third of the capital costs of the programme were to be met by the housing providers. At the outset the Housing Corporation committed funding on a matching basis with the total value of the whole programme being £60M.

Capital costs have increased over the life of the programme, with the latest anticipated total for capital costs being £70m. The partnership has been able to attract additional funding of approximately £4m from the Department of Health, but also from a local charity, to support the programme.

Outcomes

The key objective of the partnership was to build 600 units of very sheltered housing to improve housing options for older people in Bristol and as an alternative to residential care.

Recently, to further reduce the demand for residential and nursing beds across the city, Bristol City Council decided that all future nominations to VSH schemes will come via Adult Community Care.

As at January '08 progress was as follows:

- Eight schemes have been opened
- Two schemes are due to open in the next couple of months
- Two schemes will be going on site, hopefully by March '08
- One site is yet to be found.

The partnership also wanted to ensure the right geographical spread of schemes to reflect the needs of the older population around the city. Subject to locating the final site, this has broadly been achieved and with most sites meeting most of the location criteria set by the partnership.

The partnership sought to find effective ways of meeting the needs of excluded communities, and has dedicated flats in two schemes for Chinese elders, and for those for whom sign language is their first language. It has also developed a new scheme with a broader multi-cultural approach while another new scheme has a focus on older people with dual sensory impairments. There is also a commitment to ensure that older people with learning difficulties get access to VSH. However, the difficulty of finding appropriate sites has so far prevented the development of a scheme specifically designed to meet the needs of particular black and minority ethnic groups.

The second of St Monica Trust's VSH schemes is for 121 flats of which 50 are for rent with nominations through BCC, ten are shared ownership flats to which BCC also has nomination rights, and the remaining 61 are available for leasehold sale. None of our other current VSH schemes have a shared ownership option but the three remaining schemes planned (to complete our 600 VSH flats programme) will all include some element of mixed tenure. It is also hoped in the future to roll-out the shared ownership concept and to gradually create mixed tenure options in all schemes within the programme if possible

The partnership has been very successful as a mechanism for sharing information and skills and developing best practice in the city. In addition, it is now developing a networking forum for VSH scheme managers to enable them to share and learn in the same way. It has also developed a VSH scheme manager's handbook to promote best practice.

The partnership has developed consistent information about VSH schemes, with common approaches to marketing, design, measuring outcomes etc. It produces a regular newsletter for service users (and professionals) about the progress of the programme, and more recently produced a DVD aimed at service users and their carers/families and professionals.

Future

The VSH Project is due to finish when the 600 units are delivered and funding for the VSH Project Team is only until March 2009. There are a range of issues for the partnership to resolve over the coming months:

- Finding the final development site
- Discussing whether the programme should extend beyond the original 600 units planned, and if so, how that could be achieved
- Developing an exit strategy for the project, so support for providers can be mainstreamed (eg continuing with networks)
- Developing a refreshed shared vision
- Ensuring the continued close working between care and housing related support provision, and developing an effective joint commissioning approach
- Developing the schemes as community resources for older people from the local communities (this should be assisted by the ring-fencing of some Supporting People money specifically to fund work in this area) and linking into the development of LinkAge Centres across Bristol.

Lessons learned

Given the Beacon Status awarded to Bristol City Council for the VSH Partnership a considerable amount of work has been done by the partners looking at the detail of what works and what does not work in partnership working. This is accessible via the IDeA website.³

As expected there have been challenges to partnership working but the VSH Partnership is working to overcome them. Some of challenges for Bristol have included:

- The need to ensure that any partner doesn't take unilateral decisions or actions
- The difficulty of effectively meeting the specific needs of a multi-cultural population particularly given the problems of finding acceptable and appropriate sites
- Ensuring the outcomes for the partnership are clearly spelled out at the beginning, and are measurable and
- The potential impact of changing involvement from partners.

The Very Sheltered Housing Partnership has also delivered many positive outcomes, including:

- Award winning designs for individual schemes
- High tenant satisfaction within completed schemes
- Considerable additional capital grants coming into Bristol
- Knock-on impact of improving standards in other types of older people's housing provision
- The ability to be innovative, dynamic and responsive to changing needs and demands.

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Taking stock – reviewing Somer Community Housing Trust’s sheltered housing

Summary

In May 2007, Somer Community Housing Trust (the trust) undertook a programme of work to support the development of a strategic approach to the provision and development of services for older people.

This programme of work was undertaken by external consultants and Trust staff and included:

- The assimilation of national, regional and local research and best practice, demographic data and policy documents
- The development of a questionnaire to ascertain the ‘fitness for purpose’ of SCHAT’s current sheltered and designated elderly housing stock
- The development of a database within which all information relating to each scheme was recorded
- An assessment of each scheme against developed criteria, and
- The analysis of all information and data from which final conclusions were drawn.

Introduction

Somer Community Housing Trust had already recognised the range of drivers affecting services for older people, including:

- The anticipated growth in numbers of older people as the most notable trend affecting the provision of accommodation over the next 10-15 years
- National priorities such as the need to ensure that services meet the needs of the most vulnerable communities, and
- Nationally identified trends such as the increased demand for low level care and support services, well designed bungalows and flats and a progressive reduction in demand for traditional sheltered housing.

They wished to extend the choice of both accommodation and services provided for older people, to ensure they could better meet the continuum of care and support needs demonstrated by tenants. They therefore commissioned external consultants to support a major review of national, regional and local policy, demographic trends and best practice; while carrying out a detailed assessment of their housing stock. This case study focuses on this review of the fitness for purpose of the trust’s sheltered and designated older people housing stock.

Background

Somer Community Housing Trust was established as a new organisation to take on the ownership and management of Bath & North East Somerset Council (BANES) homes in March 1999 following a positive ballot by residents in favour of stock transfer.

They currently have just under 9,000 properties, of which three quarters are located in the three main areas of Bath, Keynsham and North Radstock.

Case study 3

The remaining homes are located in rural parishes of Bath and North East Somerset, Wiltshire and Bristol. The trust is a growing organisation, with stock in 5 other local authority areas in the South West and is the preferred partner in two further local authorities.

It provides 1702 units of sheltered or designated older people's housing, all of which is located within the Bath and North East Somerset local authority area. This equates to 101 schemes which include 97 rented schemes, two leasehold and two Extra Care. The Trust also owns and manages 49 schemes which are designated for specific use by older people.

In addition, despite providing significantly more general needs than sheltered housing stock, most of its services are to older people as 50-60% of all residents are currently aged 60 years or above. Older age, therefore, is a significant factor influencing the care and support needs of tenants across its housing stock. Furthermore, 23% of trust residents who live in accommodation specifically for older people are aged 85 years or above. As a consequence they may need greater levels of care and support to remain at home.

In 2005 the Trust's sheltered housing service moved from having resident sheltered wardens to a floating support service. The new service structure reduced staffing from 38 to 29 full time equivalent staff. In addition to this, there are five further officers who are employed specifically to provide support to two leasehold sheltered services and three extra care housing schemes. The reduction in staff was achieved through natural wastage. The annual value of the Supporting People contract is approximately £700,000. This accounts for 72% of the total cost of the sheltered service; self-funders meet the balance.

The Approach

A project board was set up to manage the process of the review, consisting of board members (including the Chair and two resident representatives) and members of the trust's management team. The existing Sheltered Housing Delivery Working Group (operational staff and sheltered housing residents), which had an ongoing remit to review and oversee the delivery of older people services, was also involved.

Between July and August 2007, a review was carried out on SCHAT's designated, sheltered and extra care housing stock using a specifically developed questionnaire. The aim of the review was to ascertain the relative 'fitness for purpose' of all schemes by assessing them against a number of criteria to achieve a final rating. The final rating would then enable the scheme to be categorised into one of the following five categories:

- Category 1:** Fit-for-purpose with good potential for further upgrade
- Category 2:** Fit-for-purpose with poor potential for further upgrade
- Category 3:** Not-fit-for purpose but good potential for future upgrade
- Category 4:** Not fit-for-purpose but situated on high value viable land
- Category 5:** Not fit-for-purpose with poor potential for future upgrade.

The final rating categories were determined by scoring individual schemes against pre-determined assessment areas.

These five assessment areas were developed by the external consultants using best practice and research of the characteristics of appropriate accommodation for older people, and are:

- **Standard and Condition:** An assessment of the current state of the building, both internally and externally, and its performance against a number of national standards
- **Accessibility:** An assessment of the ability of the scheme to support older people with both frailty, disability and impairment
- **Demand:** An assessment of the number of voids at scheme and their average length
- **Value:** An assessment of both the land value, size of plot and current density
- **Future Viability:** An assessment of the ability of the scheme to be easily adapted in order to improve standard and condition and accessibility to an acceptable level.

The questionnaires were completed by a small team of operational staff to ensure a consistent approach to gathering information and making assessments. Where the questionnaire results were felt to be counter-intuitive, members of the project board made scheme visits to check information.

The results of this exercise were then fed into a broader review of the future approach to services for older people by the trust.

Outcomes

The review of the stock highlighted some key issues for the trust to consider in its strategic review of older people's services.

These include:

- The need to align all housing stock for older people (ie both sheltered housing and designated housing) in terms of standard, condition and accessibility
- Acknowledging the care and support needs of tenants in designated housing (and general needs housing) to consider the expansion of the sheltered housing service to these people
- Establishing minimum standards for new and remodelled schemes in relation to external and internal design, assistive technology and adaptations
- The potential to upgrade some otherwise good schemes (eg through improved heating or enhanced accessibility), and for some schemes the potential to both enhance and expand to form extra care housing, and
- To consider the future for sites which were not considered adequate, including disposal and redesignation to other forms of housing.

Future

The trust's board will be meeting later in the summer to consider the report and to make some initial decisions about next steps. These are likely to include more detailed financial appraisals of the schemes highlighted as not being fit-for-purpose, and also considering the broader asset management implications of the review.

BANES has also recently produced a draft Housing Strategy for Older People which reaches similar strategic conclusions as the trust's review. A partnership approach to working with BANES and other RSL providers will be key to taking this work forward successfully.

Lessons learned

The project is still in its early stages, but there are a number of issues that have been raised so far:

- The project board had to read and assimilate a large amount of information to ensure members were fully aware of the breadth of issues affecting older people's services. This was not purely an assessment of the suitability of buildings – it required an understanding of everything from gardening services, dementia, housing advice and information through to design. For this reason the process took longer than expected but it was felt that this time was important given the nature of the strategic decisions to be made

- The trust is in the process of developing an asset management strategy looking across all of its stock, which will include a stock condition survey. This will include a detailed financial appraisal of all properties. This appraisal was not included in the original brief for the project but is an important aspect of the decision making process
- Similarly, the priority given to capital expenditure on sheltered housing can only be decided once the asset management work looking across the entire stock has been completed and there is a clearer understanding of the financial liability and the financial contributions of all of the trust's housing
- Residents have been involved in the process through the project board and the Sheltered Housing Delivery Working Group. In addition, the external consultants reviewed the wide range of research looking at what older people want now and in the future so this could be taken into account in developing objective standards. This has proved a successful level of involvement at this stage but once decisions are being made about individual schemes the trust will begin more detailed consultations with the residents affected.

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Reviewing a sheltered housing service in Devon

Summary

This was a project undertaken by Devon Community HS (DCHS) to review its sheltered housing service so the organisation could provide a modernised, cost-efficient and accountable service which met the needs of tenants, and the Supporting People commissioners.

The project involved reviewing the income and expenditure associated with all aspects of the sheltered housing service as well as considering the best delivery options. The project aimed to include tenants and staff fully in the process of developing this understanding and in considering options for reconfiguration.

As DCHS amalgamated with Guinness Care & Support (part of the Guinness Partnership) in October 2007, the project was put on hold at that point and is now being considered as part of a national review of the new organisation's sheltered housing services.

Introduction

Devon Community HS is a not-for-profit provider of housing, care and support services in Devon. It provides a range of services for older people, physically disabled, and people with learning difficulties – including sheltered housing, residential care homes, supported housing, floating support and domiciliary support.

Against a background of concerns about service charge income not covering expenditure and moves towards a clearer distinction between housing management and housing related support, in 2006 DCHS initiated a project to review how the sheltered housing service was being delivered and accounted for.

Background

DCHS has 21 sheltered housing schemes which, at that time, were providing a traditional service, with seven resident scheme managers; the other managers were non-resident. DCHS also provides a small floating support service for older people in Exeter. Scheme managers were line-managed by an office-based team who also provided the range of housing management services.

Although DCHS operated a system of variable service charges in their schemes, historically inflation-only increases had been applied to their service charges and this had resulted in deficits. In addition, at the introduction of Supporting People, DCHS had assumed a low percentage of the scheme managers' time was spent on the provision of support as opposed to housing management. They were therefore receiving a low level of Supporting People grant for their schemes. Finally, tenants were not fully involved in the management of their services, accounting for their service charges or the approach to support.

At the time this work was being undertaken there was no Older Persons Strategy within Devon, although this is now in development. This meant there was a lack of clear guidance about the approach being sought by the county to sheltered housing services.

Case study 4

Process

DCHS set up a small project team whose initial task was to develop an understanding of the real costs associated with the sheltered housing service and how that service was divided between housing management and support.

Scheme managers were asked to fill in time sheets on a sample basis and a wider review was carried out of the division of tasks between site and office-based staff. Quarterly team meetings and specific focus groups were held with sheltered scheme managers to explore in more depth and detail how their time was being spent and on what tasks.

Staff were informed and involved throughout the process and actively contributed to the development of options for changes to service delivery. They were instrumental in the development of the preferred way forward.

Tenants were consulted through scheme-based meetings, making use of an established consultation mechanism. This consultation included questions about what was important or not so important about the services they received and whether or not they wanted or needed the support service. Tenants prioritised the safety and security of the buildings and having someone there to report problems to, ie largely a housing management function. Many of the tenants said they did not want or need the support service but they could not currently opt out of it. This meant they were paying for a service they did not want or need.

Once the new model had been developed, the Devon Supporting People team, as commissioner, was consulted about its acceptability.

The new model

The new model developed through this process involved a more accountable approach to setting service charges (including support charges), and a more modern approach to the delivery of housing management and support services.

The delivery of services

It was decided to work towards a more person-centred approach to the delivery of support – with a clear separation between support and housing management functions.

The office-based team was divided into two teams, providing:

- Housing management services focusing on tenancy and building issues
- The management of the support services, including contract management and the management of the delivery of the services. Support services would focus on people and their support needs, and would include all client groups.

The scheme managers would gradually move to providing a non-resident service, although there was the potential to make this shift more quickly if necessary. The scheme managers would be line-managed by the support team, and although cost-efficiency considerations meant a proportion of their time would still be spent on housing management tasks (such as testing alarms and reporting repairs), the main focus of their work would be assessing, planning and providing support for individuals. The assessment and monitoring tools for support were also to be re-developed to better reflect individual needs and desired outcomes.

Accounting for services

The service charges for the schemes were now to be reviewed on a variable charges basis, reflecting real increases and decreases in expenditure on a scheme by scheme basis – rather than the increase for inflation that had been applied for some years previously. Tenants were to be given a quarterly update on the schemes' service charge accounts, as well as the annual review meeting. A scheme file containing all relevant invoices for that particular scheme would be available for tenants to review if they wished.

During the first two years of the new procedure the potential impact of increases for tenants was managed by phasing any rises above 10% over a two-year period. Thereafter, actual costs would always be applied. If there was a surplus the tenants would be consulted on how they wanted the surplus to be used: it could be offset against the following year's expenditure, refunded individually or used in some way for the scheme as a whole.

In addition, the information provided to tenants about their service charges was improved. The service charge schedule now consisted of three sections:

- Support – this section provides information about the Supporting People grant received for the scheme and the costs associated with the provision of that support
- Housing Benefit-eligible charges – this section reflected the costs associated with running the building and the services within it.
- Housing Benefit-ineligible charges – this set out costs associated with the scheme which were not eligible for Housing Benefit, such as heating costs.

Outcomes

Two main outcomes were sought through this project:

- Improved accountability to tenants and commissioners, about the cost of the delivery of services
- Transparency in services, with a stronger focus for both housing management and support staff on their respective roles.

Although accountability has certainly improved with increased clarity about income and expenditure, better information, and more regular consultation, there remain areas of confusion amongst tenants, particularly about the way support is contracted and funded. Accountability to commissioners has also improved, but has been hampered by the lack of clear strategic direction for the shape of future services.

While the use of variable service charges has improved the financial situation for DCHS in terms of its management of services charges support services continue to run at a deficit because of the nature of the existing contract.

The division between housing management and support has even now left some staff confused or frustrated about the split in their roles and those elements that fall within the respective eligible remit of housing management and/or support. For many staff this still feels like an arbitrary split when the focus should be on the service user and meeting their needs – however these are defined.

Future

The final stage of the project will be to look at the role of the scheme managers in more detail. It is envisaged that there will be a further division between housing management and support which would result in:

- A floating support team providing targeted support to tenants (or others in the community) on an individually assessed basis, and
- A caretaker/concierge role providing the scheme based housing management role.

This model is one of those being considered by Guinness Care & Support as part of their national review of their sheltered housing. It would also fit with the apparent direction of Devon's Older People's Strategy.

This further development of the service will depend on discussions with Devon's Supporting People team about both the level of grant funding, and the type of contract to be used.

Lessons learned

Although considerable efforts were made throughout the project to inform, involve and consult tenants, the complexity of service charge arrangements and the emotional impact of changes to scheme manager services meant that these efforts were not always successful.

Potential changes for the future include:

- Rather than consulting in existing scheme meetings where scheme specific issues tended to be raised, it would probably have been more effective and informative to use focus groups including representation from a number of schemes
- Reliance on meetings alone to provide complex information is probably insufficient – they should have been followed up with better written information

- There was potential to improve the consultation process through the use of specialists in this area of work
- Although family and friends were involved in some of the scheme meetings there was no specific activity to involve them as a separate group. This was a missed opportunity to gain extra support in explaining and strengthening information provided at meetings
- There was some involvement of the local Age Concern group but, again, it might have helped the process if local voluntary groups had been involved – or at least informed of what was being proposed.

In terms of the involvement and engagement of the staff, and the success of the new staffing model with the split between housing management and support, – and how this model is to be developed, – a number of issues will need to be considered:

- How to resolve the remaining confusion and/or frustration of staff about the split in their roles – which in their view detracts from person-centred services
- The out-of-hours services are provided by support staff but occasionally they need to respond to housing management issues and there is currently no cross charging for this
- Housing staff are of the view that if, in the future, support staff did not continue to do some housing management tasks within the building – such as testing alarms – an alternative would need to be provided and this would have a cost implication for tenants.

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Developing an Independent Living Service in Dorset

Summary

This case study describes the approach taken by Signpost HA, in partnership with Dorset Supporting People, to the development of an Independent Living Service in North Dorset. The project provides a menu of support services for older people living in Signpost's own housing, as well as for those living within the community regardless of tenure. The development of this service involved the active participation of Signpost's residents and staff. It has resulted in significantly improved satisfaction levels amongst residents, as well as meeting the assessed support needs of older people living both within Signpost's own housing and in the community. The service is a pilot within Dorset and Supporting People is now working towards its rollout across the county.

Introduction

Signpost HA is part of the Spectrum Housing Group and owns nearly 4,500 homes in the South and South West of England. Originally a stock transfer association in North Dorset, it owns the majority of the social housing provision for older people within the district. This is made up of 574 "sheltered" properties, of which 300 are traditional category II schemes (purpose built with common rooms) and 274 are dispersed flats and bungalows (usually grouped together).

Background

Before the pilot started, Signpost provided support services for its sheltered housing residents through scheme managers who were mainly resident in the schemes and were providing a "24 hour" traditional service. These scheme managers were also providing a basic service to older people living within Signpost's dispersed "sheltered" flats and bungalows in the area. Managers would on average support about 60 older people in total. Every resident paid the same for their support service, whatever level of service they actually received. They all had to receive a basic minimum service (regardless of actual need).

Both Signpost's own older people's strategy, and Dorset's Supporting People strategy, acknowledged that there was little choice for older people in terms of access to – and levels of – support services. Existing support services were failing to allocate support resources appropriately, or to make effective use of staff resources; there was no access to support for older people not living in sheltered housing and those living in it were questioning why they had to pay for a service they did not want or need.

Both Strategies supported the exploration of a service model which offered choice for older people, was cost effective, and was provided regardless of tenure. In 2005 Signpost and Dorset Supporting People agreed to develop a pilot scheme in North Dorset which addressed the issues of choice and value for money, as well as extending the service into the community. The pilot was to be developed on the basis of the same level of Supporting People funding, and protecting existing service users (both financially and in terms of maintaining existing levels of support, if desired).

Case study 5

Process

Signpost had already taken the step of moving their scheme managers to providing a support service from 9 to 5, five days a week. Increasingly, with staff turnover, this was provided by non-resident staff who now had more of a community focus. However, the key issue to address was the shift to an individualised approach to providing support.

The approach taken to developing the model required clear information about the existing service, the existing needs of residents, and the potential interest of general needs residents and older people within the community.

- a) The existing service provided about 490 support hours per week, with all residents receiving a weekly call as a minimum, as well as regular equipment checks and at least an annual support assessment.
- b) The existing level of need within sheltered housing residents had already been identified and collated from support assessments; they were graded on five levels, from independent to needing daily or more assistance or unmet needs. Mapping of this information demonstrated that older people living in the dispersed homes had lower levels of need than those living in the sheltered housing schemes. In addition, 93% of residents in these dispersed homes were assessed as needing lower levels of support than they were receiving, with only 7% needing higher levels of support. In the sheltered housing schemes, while 48% of residents were assessed as being in the lower levels, in practice these residents experienced benefits in an indirect way from the presence of support on site for those residents with higher levels of need.

They also benefited from social events and activities that those in the dispersed homes did not. These indirect benefits of living in schemes would have a bearing on the support charges for residents, which in turn would suggest that in order to sustain value for money, future lettings to these schemes would have to be made to applicants with the higher levels of support need.

- c) So as to test the level of potential interest amongst its older general needs residents, Signpost commissioned a survey from Age Concern. This survey asked residents whether they felt they would benefit from a support service at the present time, or in the future. It was sent to 400 residents who were over 55. Some 123 responses were received stating they either had an immediate interest or wanted to be contacted with more information should the service become available.
- d) In addition, Signpost carried out a survey of those residents in the dispersed “sheltered” homes to see whether they would be interested in a reduced service with a reduced cost, if it were available. A total of 242 questionnaires were sent out, and 86 responses were received, of which 61% were in favour of a reduction in service. This information enabled Signpost to take the decision to progress with the development of the new model, given clear information about the range of needs amongst existing residents and the scope to free up resources to extend the service beyond sheltered housing residents.

The new model

The new service model was to be based on four levels of support, each with an allocated average time allowance, as set out in the table below. The allocated times were averages and included capacity to allow for short term increases in support, for example following hospital discharge.

Table 1: Menu of support

Support Level	Allocated average time (mins)	Support Detail
1	13	No visits, quarterly alarm call and annual support assessment.
2	26	1 visit per week, 1 alarm call per week – support assessments as required.
3	63	Up to 3 visits or 3 morning calls per week – support assessments as required.
4	90	5 visits or 5 morning calls per week, up to 5 evening calls per week – support assessments as required.

The new service model would mean offering Level 1 and 2 support to residents of the dispersed sheltered stock, general needs residents and home owners; Levels 3 and 4 would be offered to residents of sheltered housing schemes, with a minimum charge of a level 3 applied regardless of assessed need to reflect the indirect benefits of living in such a scheme and to enable higher levels of support to be sustained. However, the levels of support currently being provided to residents in the dispersed stock would be protected if those residents wished to continue at a higher level.

Signpost calculated that through introducing a lower level of support (ie levels 1 & 2) with the associated reduction in administrative and travel costs, this would provide the capacity within the total support hours to expand the lower levels of support provision to general needs and private residents. Initial calculations suggested that there would be 21 hours per week available to support non-sheltered housing residents, equating to 252 new residents at Level 1, or 63 at Level 2.

Funding

Dorset Supporting People offered Signpost an initial one year contract to develop the pilot starting in April 2006, which was then extended to a three year contract from 2007.

The contract allowed for a fixed annual amount to be paid in equal amounts every four weeks and for the provision of 507 hours of support each week. Signpost would be responsible for accounting for the use of this grant for residents who were eligible for subsidy, with any surplus from that used for sheltered housing residents available (with agreement) for older people in general needs and private sector housing. The contract also included a 10% buffer which could be used to cover emergency additional support, to protect against changes in legislation which might impact on levels of self-funders and to provide some flexibility to make adjustments to reflect changing needs.

This contract essentially gives Signpost total responsibility to allocate subsidy payments, with the benefit that changes in eligibility could be administered immediately. As landlord, Signpost knew which residents had housing benefit sent direct and was therefore eligible for subsidy. The remaining residents were targeted to find out if they received Housing Benefit and in some cases this led to welfare advice enabling residents to successfully receive housing and other benefits. Around 20% of residents are self-funders.

As part of the implementation of the new model, self-funders were protected from large increases through the application of the following rules:

Dispersed stock:

- Level 1** – to be charged to all current and new residents
- Level 2** – to be charged to all current and new residents
- Level 3** – to be charged to all current residents but new residents would not be offered this level except as a temporary measure.

Sheltered Housing Schemes:

- Level 1** – not on offer for current or new residents
- Level 2** – not on offer for current or new residents
- Level 3** – is the new minimum service charge
- Level 4** – is charged to all existing and new residents eligible for *Supporting People* funding. But existing self-funders would be charged initially at Level 3, with phased increases over two years to Level 4. New self-funders would be charged the full rate.

An additional complication was that the provision of support to residents not in sheltered housing is liable to VAT. Although some of these residents would be VAT exempt (for example because they were disabled), others were not and this meant systems had to be set up to charge VAT either to *Supporting People* or to self-funders.

Implementation

Before the introduction of the new model in April 2006, Signpost held consultation meetings with all affected residents and their families. Transport was provided to meetings and if individuals were unable to attend, arrangements were made for one-to-one discussions. Residents were given feedback forms to provide their comments and staff also developed a “Frequently Asked Questions” booklet to hand out.

After these meetings residents were sent letters explaining what their proposed level of support would be, based on their support assessment and plan. They were invited to request a change in the proposed support level if they felt it was wrong: out of 574 residents contacted, only 12 requested a change.

Early in the contract it was recognised that the level of administration and monitoring required was more onerous than expected and a new post was created. This early monitoring revealed two issues that needed addressing:

- Including the flat rate cost of providing a community alarm was distorting the cost per minute for higher support levels, and so was accounted for separately
- The time taken for the lower support levels had initially been underestimated at five minutes and so was adjusted up to a more realistic 13 minutes.

In October 2006, Signpost launched what it called its “Peace of Mind” service, offering Level 1 and 2 support to private and general needs residents via a Lifeline Alarm system and pendant. A range of marketing events took place, including a launch event raising awareness amongst other agencies. Leaflets and posters were distributed widely. At the end of the pilot year there were 32 non-sheltered housing residents receiving a support service.

This has increased to 40 at the current time. A waiting list has now been introduced, pending staff time being freed up to provide additional support. When there is no subsidy available for someone who would otherwise be eligible, they are given a choice of waiting for subsidy to become available or paying for the service themselves.

It has been found that the main reason for non-residents purchasing this “Peace of Mind” service has been as a “stop-gap” before considering sheltered housing. Referrals for the service have mainly come from families and agencies, not from the client themselves.

Outcomes

The new model has resulted in a number of outcomes for older people and for Signpost:

- A tenant satisfaction survey of all sheltered housing residents in October 2007 has revealed 94% residents are satisfied, compared to under 50% in 2004
- Consultation groups have been established for both Signpost and external service users; one of their first proposals was to change the name of the sheltered housing service to “Independent Living” reflecting the shift away from bricks and mortar to a people-focused service
- Support is now provided on an individualised basis, reflecting assessed levels of need
- Greater accountability both to their service users and to the commissioning body, particularly in terms of understanding the costs and charges for the support service

- The involvement of non-residents with Signpost through the support service has meant a greater awareness of what “sheltered housing” is, and several have now moved into sheltered housing as their needs have increased
- Staff are now working more closely with other agencies, both in terms of co-ordinating other services for residents and accessing other sources of funding, such as charitable funding, for them.

Future

For Signpost, the immediate future is focused on the consolidation of the new service and exploring the potential to expand it further to older people living in the community. They are planning a year of celebration of Independent Living in partnership with the Marie Curie Trust, with a series of events and marketing initiatives.

Following an evaluation of the pilot, the Dorset Supporting People team has signalled to other large scale (stock transfer) providers of sheltered housing that they regard the Signpost pilot as having been successful and that they intend to incorporate the key features (though not necessarily all the details) into their future commissioning of services for older people across the whole of Dorset. Above all, providers have been asked to develop proposals for service re-modelling to incorporate:

- A menu of service options for service users as to the level of support they require/choose to pay for
- Extension of the support service to older people living in accommodation outside the sheltered housing stock.

Signpost have highlighted a number of issues which will need to be explored in the future development of support services for older people, including:

- Should support be linked to other services such as domiciliary care?
 - What about levels of support within Extra Care Housing?
 - How does or will the provision of this type of floating support service impact on demand for sheltered housing?
 - What would be the impact of decommissioning a sheltered housing scheme on the support service?
 - How can an “out of hours” response service be achieved?
 - Should all levels of support be available for all tenures?
- The implications of charging VAT should be considered early in the process, and systems set up to monitor and collect it
 - Non-residents will need invoicing
 - The amount of time and resources taken to develop new systems to monitor the support service should not be under-estimated; ideally a project manager should be employed at the start of the process to see this through
 - There will need to be close liaison between rent accounting and finance teams to ensure information is correct and up-to-date
 - It was beneficial to have 6 months of settling the systems in with existing residents before launching the Peace of Mind service to older people in the community
 - The marketing campaign, and ongoing awareness raising including with other agencies, is very important.

Lessons learned

The key lessons learned in developing this model of support service focus around the administrative systems and support needed to implement the change, and manage and monitor the service thereafter:

- It is very important to plan a shift like this very carefully, and in particular to gather as much information as possible about current and future needs
- Every minute of support must have the same value of money attached to it
- Support is not an exact science, so the buffer within the contract is essential to enable support levels to be managed

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Area based provision of low level support services in Mendip

Summary

This was a pilot study exploring the potential to offer low level support services to older people in Mendip on an area rather than a service basis. It combined sheltered housing, floating support, a short term “road to recovery” service, helpline and assistive technology services. The pilot was developed in close consultation with tenants and staff and aimed to test a range of hypotheses, including that this would be a more cost effective approach to providing support, and would open up the facilities within the sheltered housing schemes to the wider community of older people. The pilot ended in December 2007, and Mendip Housing is proposing to continue this approach to service delivery having incorporated the lessons learned.

Introduction

As a provider of a range of services for older people within the district of Mendip in Somerset, Mendip Housing had recognised the need to move away from the traditional model of sheltered housing. It wanted to provide services for older people within the community and to ensure sheltered housing could be a resource for more than those people living within it. In discussion with Somerset Supporting People they developed a pilot to look at how services could be delivered differently to meet these challenges and to provide value for money.

Background

Mendip has a population of 103,869 covering an area of 740 square kilometres. It is predominantly rural with pockets of deprivation especially in Glastonbury and Frome. It has a higher than average older population. A STATUS survey carried out in 2003 identified that 52% of tenants were aged over 65 years.

Mendip Housing has approximately 662 sheltered housing units in 21 schemes (having already decommissioned inappropriate stock and remodelled bedsits), with most supported by non-resident scheme managers. In addition, Mendip Housing provided a floating support service to about 150 people and a short term “road to recovery” service to a further 30 people. They also ran a helpline service for 1,300 customers. Staff providing these services were organised on a service basis.

The pilot took place at the same time as Somerset CC was carrying out a service review of sheltered housing to recommend a future method of service delivery for older people. This meant that the activities undertaken during the pilot period were partly steered by the Somerset review. Thus, in addition to the introduction of the new service delivery model, the following activities were carried out:

- Producing a new version of the needs assessment
- Remodelling 14 bedsit bungalows into 7 2 bed wheelchair bungalows and decommissioning all other bedsits
- Developing a service decommissioning strategy with key partners

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- Developing a banding model for service delivery depending on individual assessed need. In response to concerns from tenants, all bands provide a community alarm service, monitoring via the control centre and access to communal facilities on schemes.

Process

The pilot was developed in consultation with Somerset Supporting People, and aimed to test a range of hypotheses, including:

- Services can be delivered more cost effectively if they are delivered from local area bases
- By combining a range of low level support services and therefore having a wider group of staff working in an area, it would be easier to meet the demand for high priority services at times of staff shortages and/or increased demand
- Using teams of locally based staff enables a better match between service user need and staff skills
- Housing related support to sheltered housing tenants and floating support to non-sheltered housing tenants are essentially the same service
- Removing the boundary between these two services would allow sheltered housing communal resources to be used by the wider community
- Area teams would reduce the number of people entering an older person's home to deliver services
- Good preventative low level support is not cheap to deliver, but can deliver value for money if delivered in a creative way that maximises independence.

It was recognised at the start that the pilot could not be effective without the support and involvement of the tenants and existing staff and considerable effort was put into the consultation process. Tenants were invited to a workshop at the start of the pilot and a DVD was produced to explain the project aims to tenants. Managers visited coffee mornings and used the DVD to explain the project to tenants. The project group included the elected tenants' committee and met monthly throughout the pilot. This group produced a bi-monthly newsletter, which went to every sheltered housing tenant. The group also reviewed any suggestions or comments given by tenants via their scheme suggestion boxes.

Staff were consulted during the planning process and were involved in the project group. Their commitment to the pilot was essential to its success.

The new model

Before the pilot, staff had provided services in three main teams supported by a centrally based service manager, admin team, occupational therapist and assessment team for sheltered housing.

Sheltered Housing

- A senior scheme manager, 16 scheme managers, four support workers and two vacancies
- Based across 23 schemes
- 748 customers.

Helpline Service

- One service manager and three support workers
- Based centrally
- 1,300 customers.

Floating Support Service

- one service manager, three senior support workers, nine support workers
- 150 customers supported at home from three offices
- 30 customers supported on “road to recovery” from central office.

The new model provided services in three area-based teams, with each team including a manager, four or five senior workers, and six support workers. The overall service manager was based centrally with an admin team, an occupational therapist and the team assessing for sheltered housing. The key philosophy of this approach was that all staff would work together as a team, sharing all tasks. This means there would be integration across all services. There would be individually assessed levels of support including those in sheltered housing, with staff available between 9am – 5pm from Monday to Friday.

Tasks for the area teams included:

- Daily intercom calls as required
- Support visits as identified on support plans
- Installation of helpline units
- Road to Recovery visits
- Managing communal rooms and enabling activities
- Assessment for minor adaptations
- Organising and co-ordinating shopping trips
- Liaison with local community and other groups.

Funding

Monitoring the cost of services in the new structure was complicated as services had been funded by a number of different agencies, including *Supporting People*, social services, the primary care trust, and individual service users paying directly for services.

Supporting People agreed to continue funding the services as agreed in the individual service contracts – but at the end of the pilot each service would be re-costed to take into account the recommendations for future service provision.

So as to ensure ongoing budget monitoring as set prior to the pilot, cost centres remained the same through the pilot. However, dummy budgets were also set up by area team. This meant expenditure could be monitored both according to the traditional model and also by area team.

Staff terms and conditions remained the same for existing staff, with vacancies filled as necessary using a temporary contract so as to ensure protection for existing staff if there were job changes or reduced staffing levels at the end of the pilot.

Set up costs for the three area offices were kept to a minimum and identified separately from revenue costs.

Outcomes

The two key outcomes for the pilot were the satisfaction of tenants with the newly organised service and the impact on the cost of the service of that reorganisation.

Tenant Satisfaction

A tenant questionnaire sent out in September 2007 showed that 89.2% tenants were satisfied or very satisfied with their service, compared with 90.8% from the previous survey. However, Mendip Housing feel these results should be treated with caution as older people often show satisfaction with their services even when there are known areas of dissatisfaction. The questionnaire was followed by a tenant conference to review the pilot and their feedback was included in the evaluation report for the pilot, and the recommendations for taking the pilot forwards.

Financial Impact

Mendip HA is currently developing an understanding of the financial impact of the pilot but initial work suggests savings will have been made. Savings are particularly likely because of reduced travel costs for staff but broader landlord issues will also need to be taken into account. These include income from ex-resident manager accommodation which is now being rented out.

Future

Mendip Housing is now planning to restructure its service from April 2008, subject to some commitment from Supporting People for continued funding for this range of services. Job descriptions have now been written and evaluated for the new model and a report is going to board for decision in February.

Lessons learned

Staff skills and training

Given the tight timescale of the pilot there was not time to address the training needs identified for staff to carry out the varied range of support tasks and to carry out effective support planning and outcome monitoring. This training will be built into the new ongoing model of service delivery.

Staff identified the need to have regular meetings to share good practice and areas of concern, both to allow peer group support and identify best practice.

The size of teams

The biggest area of concern amongst tenants and staff was the original idea of rotating all staff within the area team across all of the schemes in that area.

It was identified that this left tenants feeling vulnerable, staff could not get to know large numbers of tenants, and the mileage costs were higher. At the tenants' conference in September 2007, tenants chose their preferred service delivery model where smaller teams of three to four staff were dedicated to providing services across a smaller community.

Addressing higher levels of need

Tenants identified that high levels of support could not be delivered by unskilled individual staff or a team of staff. It was agreed that where a tenant meets the criteria for two hours or more targeted support to assist with an assessed need a dedicated key worker would provide this service. This would free up other less skilled staff to carry out the low level support such as regular intercom calls or coffee morning support in communal rooms. Support plans would identify where one key staff member is required and an appropriately skilled key worker allocated.

Impact on administrative and IT support

Previously, administrative support had been provided centrally by a team which provided support to other services as well. With the move to smaller area offices this presents a challenge as to how to organise support: for example answering telephones at an area office level without increasing costs through extra staff. Mendip is currently exploring ways to resolve this issue whilst minimising costs.

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Housing Options Service

Summary

In some parts of the country a Housing Options Service (HOS) is subtitled ‘Should I stay or should I go?’ The purpose of the service is to enable the client to make an informed decision about their accommodation/care options, rather than move them to other accommodation. Historically Bristol Care & Repair’s service was referred to as ‘The Move On Service’, but it was always about helping clients to make an informed choice, once they knew what their housing options were.

The Housing Options Service is able to offer advice in people’s own homes – and provide transport to take them to viewings and relevant appointments. This is a unique service in Bristol, as other advice agencies are unable to provide such intensive one-to-one support – or to take clients in their cars.

The focus is mainly on clients’ housing needs but HOS takes an holistic approach to each client and their situation, maximising income, and making referrals to statutory and voluntary agencies as appropriate. If required, they support the client by dealing with estate agents, solicitors, their bank, mortgage company, the local authority, the Department of Work & Pensions etc. Through their publicity strategy they have built positive links with other agencies, which enables them to provide the best possible support to the client.

Introduction

Bristol Care & Repair set up its Move-on or Housing Options Services in 1998 in recognition of the fact that “living at home” for older people did not necessarily mean staying in their current home, but could include moving to a more appropriate one. The service was originally designed to support older owner occupiers through this process as the allocation of rented sheltered housing at that time was restricted for that particular group and there were therefore fewer choices for them. The service has developed and broadened since that time and now provides services for older people in private rented accommodation as well – and also for younger disabled people.

Background

Bristol Care & Repair was established in 1986 and is a charitable organisation providing services for older and disabled people throughout Bristol. Its aim is to help older, disabled and low income homeowners to live in homes that are warm, safe, secure and adapted to their needs. It provides a range of services in addition to the Housing Options Service, including caseworker support, large and small adaptations and repairs, hospital discharge and admission prevention, and healthy homes assessment training.

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The current population of Bristol is just over 400,000 – of which 54,000 are currently over the age of 65 years. This equates to approximately 15.5% of the overall population. Bristol is expecting to see an increase of 6,000 people over the age of 65 by 2025.

Bristol's Housing Strategy states:

“Poor housing conditions are most likely to affect certain groups such as older people, black and minority ethnic communities, young people, unemployed people and the children of those households. There are 6,788 unfit private homes which don't meet basic standards; a home is twice as likely to be unfit in the private rented sector.”

Typically, clients of this service are living in smaller, older terraced property where adaptations such as stair lifts are not possible, and because of the age and design of the building are cold and difficult to heat. The main options available in Bristol are sheltered housing flats for rent, with a very few bungalows. There are a small number of leasehold schemes which are often very expensive. More recently Bristol has developed Very Sheltered Housing (or Extra Care Housing) with a number of schemes already developed and more in the pipeline.

The service model

Services provided

The service aims to explore the housing options available to the older person, enable them to make informed decisions about their housing and then, if applicable, see them through the whole moving process.

Examples of support activities include:

- Discussing rented and buying options
- Reviewing the possibility for adaptations or other improvement work
- Looking at their financial concerns and the implications of moving, for example on benefit entitlements
- Supporting the housing application process – including appealing against decisions if necessary
- Enabling clients to understand their tenancies, their rights and responsibilities
- Helping clients settle in to their new home.

The support ranges from short telephone conversations to more intensive longer term support. Some clients will contact the service for advice repeatedly during what can be a lengthy decision making process for them.

Scope of service

The service started with one half time worker but is now provided by three part time staff (1.6 FTE). In 2006 it received about 130 referrals, of which 94% were older clients and the remainder young disabled people. About one third of these were self-referred, 17% were via Social Services, 12% from Health, and the remainder from family, other Bristol Care & Repair staff, etc.

The staff devote time to developing relationships with other agencies who might be sources of referrals and could also be a source of services for their clients. This could include groups of health, social care or housing professionals, community groups, or the Bristol Older People's Forum. This is seen as an important aspect of maintaining and developing the service.

Funding

The service was originally funded from a range of charitable sources but has now been successful in moving to Supporting People and other City Council funding. This funding is however currently provided only on an annual basis. The income for 2006/7 was £61,000.

Outcomes

For the individual

The specific outcomes for the 130 individuals referred in 2006 were as follows:

Table 1: Outcomes for clients in 2006

Outcome	Number	Percentage
Moved	21	16%
About to move	5	4%
Awaiting offer	3	2%
Case still open	38	29%
Decided to stay put	34	26%
Required information only	12	9%
No further assistance needed	11	8%
Inappropriate referral	6	5%

Source: Bristol Care & Repair

Feedback from clients suggests that a change in their housing can have a tremendous impact on the quality of their life and most report that they would not have been able to move without the support provided by the service. An example of the impact of the service for a particular individual is attached as an appendix to this report.

For the funding agencies

There are a range of outcomes for statutory agencies:

- Impact on the physical and mental health of the older person (prevention of falls, promoting warmth and security, being closer to amenities, accessing support)
- Impact on the condition of housing (with grants being replaced by loans and people's reluctance to live through major works and/or take on the burden of loans, often a move then enables houses in disrepair to be improved)
- Impact on provision of family housing (often older people are under-occupying family housing, which is then released when they chose to move).

Future

The key challenge facing the service is the long term security of its funding which is currently only available on an annual basis. However, there are also some strategic changes occurring within Bristol which will potentially affect the service and its clients.

Choice based lettings

The imminent introduction of choice based lettings (CBL) in Bristol introduces a number of challenges for the service.

The process of obtaining sheltered housing will possibly become more difficult for vulnerable people without support. If the service aims to provide this support, then there could be a significant increase in demand from a wider range of clients which the service is not currently resourced to meet.

In addition, as the CBL scheme only allows for a single nominated bidder (rather than an agency) for people not able to bid for properties themselves, this will create pressures for a service currently staffed by part time workers who may not be available to bid at the correct time.

Very Sheltered Housing

Previously access to the VSH schemes in the city had been via housing or social services. The recent move to referrals from social services-only will impact on those people who are not currently within that system and may mean it becomes more difficult to access this form of supported housing.

Lessons learned

Since the service started in 1998 it has evolved to meet the changing environment within which it works and the changing needs of its clients. There are some particular lessons learnt during this period.

- The service needs to be well-connected with local agencies and must be sufficiently integrated with them to know how to achieve the desired outcomes for their individual clients. For example, this may mean not only understanding the process for accessing services, but also knowing the right people to negotiate with, and how to challenge decisions effectively. Obtaining this knowledge can take time
- Maintaining the profile of the service with professionals, older people, their families and friends, etc is an integral part of the work done by staff to ensure potential clients are aware of the service either directly or via other professionals they come into contact with. It also ensures the service is able to adapt to the changing needs both of funders and clients
- As the client group has broadened beyond older people to younger disabled people, the service needed to ensure the right service could be provided to any client. Given the size of the team it was decided that rather than having a specialist worker for younger disabled people, all three members of staff were equipped to respond to both client groups

- The importance has been recognised of being able to send out information to potential clients or their family/friends to enable them to make initial choices after they first make contact. The service has developed a range of information leaflets as well as a DVD to provide information about the options available, and what support could be provided.

Bristol Care & Repair

Case study

Mr C is in his eighties. He was recently helped by Bristol Care & Repair to move into his new home in a sheltered scheme in Clifton.

Mr C had lived in a rented basement flat for years. The stone steps leading to the flat were extremely steep and open on one side. They got very wet and covered in leaves during autumn and winter. *"I knew that I would fall down those stairs one day"* says Mr C. His community nurse recognised the risk and suggested that he should look for alternative accommodation.

However, Mr C describes himself as a *"very determined man"* and, having lived in Clifton since 1948, was reluctant to move. He was forced into action some time later when his landlord decided to sell the property and gave him two months notice to move out. With a risk of being made homeless it was important for Mr C to find somewhere as soon as possible.

With only one month to go, Mr C's nurse suggested that he contact Bristol Care & Repair. His newly assigned caseworker liaised with Bristol City Council's Rehousing Department to ensure his housing application was amended and he would be made an offer as soon as possible. Within days he was offered a flat in a scheme just around the corner from his current home.

Mr C liked the flat immediately and made the decision to take it. *"I was very lucky to get this place,"* he says, *"it is so nice here, so light compared to my old flat."*

However, the work did not stop there. His caseworker worked closely with Age Concern Bristol and the Royal British Legion (RBL). The flat was completely empty but the RBL secured almost £1,300 in order to furnish the property. *"It is marvellous,"* says Mr C, *"I have a new cooker, fridge, chairs and a bed – I can't believe it's all mine."* The RBL have also secured an extra £20 a week for Mr C to make his life more comfortable.

Further, his caseworker helped Mr C apply for Housing and Council Tax Benefit which he was not aware he could claim. By not claiming when in his old flat he had accrued large debts. Age Concern Bristol have given extensive support in getting these debts sorted out, a task he does not feel he could have tackled alone.

"This is a great example of organisations working together to get the best result for the client."

Mr C is thrilled with the outcome: *"It's quite wonderful that so many people took so much trouble to help me. Everyone has been so kind and Judy (his caseworker) is at the top of the list!"*

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Mixed tenure extra care housing – St Monica Trust

Summary

The St Monica Trust is a charity providing accommodation, care and support for older people in Bristol and adjacent areas. As a partner in Bristol City Council's Very Sheltered Housing (VSH) Partnership⁴, the Trust developed a large housing scheme for older people, Monica Wills House, on a 1.25 acre brownfield site in Bedminster in the south of Bristol. The scheme combines a mixture of tenures and dependency levels and provides a model of a mixed development for older people in a busy urban setting.

Introduction

As a provider of a range of accommodation and services for older people in the Bristol area and with a commitment to the continued development of services, the St Monica Trust (the Trust) sought to develop a very sheltered housing scheme which would meet the changing needs of older people and offer a choice of tenures. The aim of housing older people with a variety of care needs was a key aspect of the scheme.

Many people prefer to 'stay put' as their care needs increase. The combination of services and support on offer at Monica Wills House was specifically designed to make this possible. The aim was to offer a programme of care and support that enables individuals to maintain their independence beyond the traditional limits of care at home.

The Trust operates two other retirement communities in north Bristol, Cote Lane and Westbury Fields. These also provide a range of services and support in an environment that is designed to promote independence, dignity and fulfilment. The Trust's services also extend beyond these locations to individuals who live in and around Bristol.

Background

The Bristol Very Sheltered Housing Partnership had identified the need for a very sheltered housing scheme to meet the needs of the older population in the Bedminster area of south Bristol. A large site was located which formerly had light industrial use and which was well-placed for access to local facilities – including the shopping centre of Bedminster itself. The Trust bought part of the site for its scheme and the remainder is being developed by a private developer to provide flats for sale on the private market.

The Trust provided the capital funding both to buy the site and build the development; there was no public funding input.

⁴ Very Sheltered Housing is the term used in Bristol for their form of extra care housing

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Monica Wills House provides 121 one and two-bedroom flats over five floors, all designed to mobility standard and able to take assistive technology devices in addition to the nurse call system, as needed. All flats have fully accessible showers and there are three assisted bathrooms. The building has a central atrium with a number of on-site facilities located on the ground floor and basement, including a fully licensed communal restaurant, residents' lounge, hairdressing salon, activities room, an IT room, a residents laundrette (as well as a commercial laundry with a sluice washing machine), a small library, a gym and small pool, an underground car park and a roof garden with views of the city on the top floor.

Each of the floors of the building has different coloured flooring, and different pictures opposite the lifts to help residents identify where they are. The building includes a number of small communal seating areas both within the atrium itself and on small outdoor terraces on each floor.

The development of the adjoining site in West Street has recently brought a range of local retail and service facilities, including a small supermarket. Residents also benefit from the proximity to the busy shopping area of Bedminster.

The Service Model

Tenure options

The 121 flats house approximately 140 people, who are either social housing tenants, leaseholders or shared owners.

All flats are identical, although some leaseholders have chosen to pay for alterations and additions. The different tenures are pepper-potted around the scheme, with guidance taken from the Trust's sales and marketing team about issues with location which might impact on sales. This has meant that all of the top floor flats are leasehold, but otherwise there are social rented, shared ownership and leasehold flats on each floor.

There are 50 socially rented flats for which Bristol City Council has nomination rights. Originally these were to be split 50:50 between VSH and ordinary sheltered housing tenants, but more recently the Council has requested a shift towards more VSH – and hence higher dependency tenants – so they will now be working towards a split of 60:40. These flats are rented at social housing rents and service charges, with increases capped at RPI, as agreed with all VSH partners.

There are also 8 shared ownership flats, with residents owning between 50%-75% equity and renting the remainder at a social housing rent. The City Council also nominates people for these flats.

The remainder of the flats are sold on long leases at a market price. Both these and the shared ownership flats must be sold back to the Trust at the original purchase price. The subsequent resale value will depend on a current market valuation at the time.

Residents who are shared owners or leaseholders are responsible for the internal maintenance of their flats, although they can buy a service from the Trust. A major repair sinking fund is being built up through the service charges.

The services available in the scheme are the same for all residents, except that leaseholders receive 30 minutes housekeeping per week funded through their service charge.

Eligibility Criteria

Prospective residents must be 55 years old or over. Those nominated through the City Council will have had their care and support needs assessed and there will be a mix of low, medium and high care needs. Prospective leaseholders must agree to have their care needs assessed and to pay for the assessed package to be provided.

The scheme is not designed or staffed to support people with medium to high levels of dementia, - although there are couples where one partner has dementia – and it is recognised that given the ambition to allow residents to age in place, numbers of people with dementia are likely to increase.

Services

There are 34 individual members of staff providing a range of services primarily for residents:

- Care and support provided by an integrated team
- Lunchtime meal (choice of three main courses with a vegetarian option, plus salads)
- Housekeeping
- 24 hour porterage and security
- Organised activities.

Care and support staff are available on a 24 hour basis, with one waking night worker supported by the porter (who has been trained to assist with lifting). The Trust has a block contract from the City Council to provide 350 hours per week for the 25 high care residents, with additional hours purchased on a spot basis or privately by residents. The Trust is also contracted to provide 104 hours of support through Supporting People.

The meal is available either in the restaurant or, for a small extra charge, it can be delivered to a resident's flat. The main courses are cooked at the Trust's central catering kitchens and then delivered to the site but vegetables and salads are prepared on site. Evening meals and breakfasts have been provided on an occasional basis, usually connected to a special communal activity. Residents are able to invite guests for meals (at a slightly increased cost) and older people living locally are able to join a luncheon club which enables them to buy lunches at the same price as residents. The club has attracted 30 members so far. Local people have also been making use of the hairdresser and the gym.

It was felt that organising activities would be an important part of developing an active and integrated community so an activity co-ordinator works 25 hours per week. Activities include keep fit, tai chi, bingo, cinema, craft classes, snooker and indoor bowls competitions and quizzes. The co-ordinator also arranges monthly trips out, as well as smaller occasional outings in the minibus. The roof garden contains 16 individual raised beds which are looked after by residents, as well as communal beds looked after by residents and staff.

Future

The development of the remainder of the site will be completed shortly and will include a large public square adjacent to Monica Wills House. It is not clear how this will affect the quality of life for residents, although clearly there will be benefits to being part of a wider community.

The Trust is funding a LinkAge worker, alongside the primary care trust community workers. He will be based in Monica Wills House and work with the local community. He is likely to work closely with the activities co-ordinator and improve access to the scheme for local older people.

The Trust is continuing to develop, with its next major development being a care village in North Somerset with a state of the art dementia care home. Although the scale of this development will be different, the same model of mixed tenure and needs will be followed as at Monica Wills House.

Lessons learned

The scheme has so far proved very successful despite suffering a serious fire only a few months after opening. Residents seem unconcerned by the tenure of their neighbours and this mix within one scheme has yet to cause any issues. There is an active community life with 75%-80% of residents taking part in some sort of activity.

The Trust's experience with a mixed community has been more successful here than at Westbury Fields.

This could be because of the design of the building with all residents living within one space (whereas in Westbury Fields the social rented accommodation is on a separate part of the site), or it could be its location within a more socially mixed community.

A key risk for the scheme would have been the failure to sell the leasehold or shared ownership flats within the scheme. Considerable effort was put into researching the local market and understanding the issues likely to affect sales. So, for example, the location of the leasehold flats within the building was seen to be an important factor and resulted in all of the top floor flats being leasehold. Equally, it was recognised that sales might fall through if leaseholders were delayed in selling their original homes.

The Trust has been able to rent flats in these circumstances until the leaseholder had sold their home and was able to proceed with the purchase. This also meant that the older person was able to move into potentially more supportive and appropriate accommodation sooner than the property market might otherwise have allowed, because of the flexible approach the Trust was able to take.

There has been limited use of the gym and pool so far, but it is felt that this is one of the future proofing design aspects of the building, as future generations may be more used to making use of such facilities.

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Village Agents in Gloucestershire

Summary

This case study describes the Village Agent pilot project in Gloucestershire which is one of eight national LinkAge plus pilot projects. The pilot develops the concept of a locally based person who is able to provide face to face information and support which enables older people to make informed choices about their future needs. This concept is based on the hypothesis that older people living in rural communities prefer to talk to someone they know within their community for help and advice. The pilot started in July 2006 and the final evaluation report is due to be completed in September 2008.

Introduction

The LinkAge Plus project focuses on people aged 50 and over and is aimed at testing and evaluating different models of joining up services for older people. This pilot project is being led by Gloucestershire County Council working in partnership with the Gloucestershire Rural Community Council.

Village Agents bridge the gap between the local community and statutory and voluntary organisations able to offer help or support.

They provide high quality information, promote access to a wide range of services, carry out a series of practical checks, and identify unmet need within their community.

Background

Gloucestershire is a rural county with a dispersed population and a higher proportion of people over 50 than the national average. The Village Agent project builds on existing initiatives in Gloucestershire which have aimed at improving access to information, advice and service delivery. These include Care Direct, which provides a county-wide telephone information and support service, and the County Council Improving Customer Access Initiative. These have demonstrated the benefits that can be achieved through providing information and referral services. The project further develops this approach through identifying the unmet needs of older people in isolated rural communities.

In addition, Gloucestershire had identified the need to address the impact of an increasing older rural population and unlocking the potential benefits to the wider community of the skills and experience of older people: *“Given that many older people are willing to work, barriers to their doing so need to be identified so that this potential is better used to the benefit of the economy, the community and the individual’s quality of life.”*⁵

⁵ *The Rural Economic Strategy for Gloucestershire 2007-2015. Gloucestershire County Council*

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Process

The pilot identified four high level criteria to be used to assess its success and developed indicators to measure progress against each of them:

- 1) Older adults in Gloucestershire villages, and particularly those who are older, frail and vulnerable, feel more secure, feel more cared for, and thus have a better quality of life.
- 2) Older adults will have easy access to a wide range of information, which will enable them to make informed choices about their own well-being.
- 3) Older adults will be in receipt of any services or assistance that can help them remain independent in their own homes and enable them to feel part of a supportive enabling community.
- 4) Older adults will be engaged to enable them to influence both development of the Village Agent role, and future service provision in their area.

The project target is to achieve between 5% and 25% improvement in satisfaction levels for older people between the initial and final surveys carried out by the Village Agents.

The initial task was to identify a total of 96 rural parishes which were placed in approximately 30 clusters within three Primary Care Trusts, with each cluster containing a 50+ population of between 331 and 1125 people. Appropriate localities for the pilot were identified through a gap analysis and mapping exercise based on the 65+ age group using the Indices of Multiple Deprivation.

A Village Agent was then appointed for each cluster of parishes, provided with training and paid a small retainer to work 10 hours per week. There were 300 expressions of interest in the new role when it was initially advertised, and there have been continuing high levels of interest when follow-up recruitment has been necessary. The recruitment process has continued in the same format as was used initially, given how successful it proved to be as a way of getting to know people. The process involves holding recruitment days during which applicants carry out communication exercises, computer tests, one-to-one interviews and provide a short presentation to the group on themselves and their interests.

An initial induction event takes places for all recruits and includes introductions from the six main agencies that Agents are likely to be involved with. Thereafter monthly meetings are held on an area basis: as well as informal information sharing, they always include an external trainer.

An initial survey was carried out to assess overall satisfaction levels for older people. Village Agents distributed questionnaires between November 2006 and April 2007 to randomly selected older people across a range of age groups of the over 50's. Each agent distributed 32 questionnaires, and overall there was a 65% response rate. The data obtained revealed a range of patterns and trends, although there was some variation between individual parishes. The Agents then completed a summary of each locality containing the results of the research and their assessment.

The next stage was to hold focus groups involving older people within each locality. Village Agents were asked to approach people to invite participation in these groups, but not all clusters were able to hold focus groups. Discussions within the groups covered a range of themes including leisure, shopping, food, social, transport, home and citizenship.

The new model

Village Agents are recruited locally and trained to provide face to face information and support which enables individuals to make informed choices about their future needs. The service is provided primarily to older people, but other disadvantaged and isolated people are also able to receive Village Agent support. Village Agents are wherever possible recruited to cover clusters close to where they live, ideally within 5 miles. This not only reduces travel but also means they will know the area.

The role of the Village Agent is to identify people within the rural communities who may be in need, carry out a needs analysis to identify their concerns or issues, and depending on the needs identified, take any or all of the following actions:

- Provide appropriate information, either at the initial point of enquiry or following research using a range of information tools.
- Make more detailed enquiries through liaison with colleagues within relevant statutory or voluntary services on behalf of the individual.
- Arrange for more detailed assessments to be carried out, or for specific services to be provided.

They are supported by training programmes, publicity material, the Adult Helpdesk (holistic telephone referral service for social care, occupational therapy and health), technology (mobile telephone, laptop with mobile internet access), and one-to-one support and community building expertise from Gloucestershire Rural County Council (GRCC). They are line-managed through GRCC.

Village Agents use a "Gateway" referral form to refer people directly to the agencies that can supply the help and support the individual needs. Agencies involved include:

- Adult Helpdesk
- Department for Work and Pensions (DWP)
- Home Improvement Agencies
- Fire and Rescue and Home Safety Checks
- Energy Efficiency schemes
- Age Concern
- GuiDE (a free and confidential health, social care and disability information service).

- Patient Advisory Liaison Service
- Volunteering Schemes
- Carer's Organisations and Groups
- DISC
- Libraries
- Lifelong Learning
- Safer Communities Teams.

Agents can also facilitate access to CAB, JobCentre Plus, local transport, grants and funding.

There is now a Village Agents website (www.villageagents.org.uk) containing useful, easily found information for the over 50's. It also has its own database with very localised information about social activities, shops, pharmacy delivery etc and other services specific to the parishes covered by Village Agents. The Gateway referral system is now web based with a view to other organisations using it.

Funding

The Pilot Project is managed by Gloucestershire County Council in Partnership with Gloucestershire Rural Community Council and is funded by LinkAge Plus in conjunction with the Department for Work and Pensions.

It has been estimated that the cost of each referral made by the agents is £120. This reflects one-off costs such as investment in IT and publicity materials, as well as routine costs which are mainly salary, transport and telephone costs.

With the success of the pilot, continuation funding has recently been confirmed and will come jointly from Gloucestershire County Council and the Primary Care Trusts.

Outcomes

In the quarter April to June 2007, the agents contacted 4,344 people, with this increasing to 6,532 people the four month period July to October 2007. Both quarters exceeded the target set of 1,500 contacts for each three month period.

After each actual visit Village Agents are required to fill in a referral or 'gateway' form. The form collects demographic data, the nature of the problem and other information relevant to any follow up visit. The gateway form is then emailed to the required agency by the Village Agent for the query to be addressed. Village Agents have now submitted 2,731 gateways since December 2006.

For the whole year 2007, the total number of gateway forms (so clients visited) was 2,086. The majority of clients seen by the Agents were female, reflecting the higher percentage of women aged 50 and above in Gloucestershire. Forty-four per cent of clients were in the 75-84 age group, and the largest proportion of these were aged 80-84 (28%). Two-thirds of clients lived alone.

The main referrals related to:

- Adult Helpdesk – occupational therapy and social care
- DWP benefits assessments
- Heating – energy efficiency – Warm and Well schemes
- Transport
- Home Improvement Agencies (HIAs) – adaptations and home maintenance
- Fire and safety
- General support.

An early example of the impact of these referrals is reflected in a six per cent increase in requests to the Fire Service for smoke alarms, since the Village Agents became operational. Investment in smoke alarms is likely to be cost effective on an invest-to-save basis and further work will examine the evidence that exists for this.

While further work will be carried out into evaluating the benefits of the project, an example of a positive outcome is shown below:

A Village Agent assisted a man with poor mental health following the death of his wife. He was on benefits, in debt and selling off his possessions. The Village Agent solved his financial problems with advice and a grant from the British Legion. A job was found that he was able to fit around caring for his school-age daughter, but training was needed. It was arranged that training be provided, financed by a further grant from the British Legion. He is now in work and acknowledges that this would not have been possible without help from the Village Agent.

Future

The success of the pilot has enabled continuation funding to be obtained. Although there are no definite plans for expanding the service to fill the few gaps remaining, it would be hoped that this would be possible in the future.

A six month pilot started in January 2008 using Community Agents based within BME and migrant communities rather than being area based. Community Agents are following in the footsteps of Village Agents in order to facilitate access to services for the over 50s, provide high quality information and test the limit of holistic working by joining up services.

Six Community Agents have been appointed:

- 1 County Agent for Chinese community
- 1 Gujarati speaking Agent for the county and Cheltenham
- 1 Bengali speaking for Cheltenham and the county
- 1 for the Polish community
- 1 African Caribbean for Cheltenham, Tewkesbury and The Forest of Dean
- 1 African Caribbean for Gloucester City, Stroud District and Cotswold District.

Lessons learned

Gloucestershire benefited from having been a Care Direct pilot as it had already built up good working relationships with partner agencies and had the tradition of providing an holistic response. It also spent time and resources developing an information base about services and activities in rural parishes, in conjunction with its partner GRCC, as a tool for both the Helpdesk and the Village Agents.

Initially it was thought that the 30 Agents could cover approximately 96 parishes, but over the period of the pilot this has been increased to reflect their capacity levels, and they now cover 162 parishes.

The Agents employed originally were mainly older retired people (not necessarily but often with a relevant area of expertise) and were almost all women. However, this has changed and there are now more men, and there are also younger women with young children employed as Agents.

The monthly training events have proved very important for the Agents, not only for the external training given, but more so for the opportunity to share ideas and experiences. This is particularly important as it is a new role, and so often it is only another Agent who will appreciate the issues they are dealing with.

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Mainstreaming assistive technology in Cornwall

Summary

This case study describes the approach taken in Cornwall to moving from a disjointed and reactive development of assistive technology to one that is a sustainable countywide system with all partner organisations using a single procurement route for the provision of equipment, with an enhanced countywide call centre provision, and with the development of a SMART house to provide a central assessment and training resource. The overarching emphasis of the service is to promote good (or manage) health at the earliest stage possible to have a positive impact on service demand within both health services, social care and housing at an acute level.

Introduction

In 2006 Cornwall published its Preventative Technology Strategy 2006-2008 setting out its approach to the improvement and development of preventative technology in the county.

Key partner organisations required to implement this strategy, for its infrastructure and for sustaining the service long term were identified as Primary Care Trusts, Adult Social Care (DASC), District Councils and Cornwall County Council (CCC). Other partners include Age Concern, Community Mental Health Team, Supporting People and district housing associations

Background

Currently in Cornwall there are 103,200 people aged 65 and over which is expected to rise to 177,400 in the next 25 years. Within this group, by 2028, 7,000 may have dementia, 17,740 will suffer from depression, and the current growth rate for the over 85's (the group most likely to use services) is at 600 per year. Around 75% of the over 75 age group also have a Long Term Condition which exacerbates their demand for services. In 2004 – 2005 the over 75 age group accounted for 26,809 admissions to Accident and Emergency. Another linked challenge is the support for carers which currently stand at 13,123 (providing 50 hours a week or more care) in Cornwall and without whom statutory services would be overwhelmed.

In addition, the geography and demography of Cornwall presents a challenge through the dispersed nature of the resident population, response times and location of and access to services. A major component within this is transport: firstly service users being able to access local services; secondly, the increased staff travelling cost (time lost and financial) and requirement for services in the home.

The Strategy identified a range of issues with the historic development of services in the county, although it also found examples of good practice and effective service provision:

- The development of services had taken place in a disjointed and district-based way, with limited partnership working
- There were different levels of provision and accessibility to services around the county

Case study 10

- A range of agencies were involved in providing services
- Information about what actually existed was poor
- Referral and eligibility for services was through a myriad of routes, and charging was dependent on the point of entry into the care/health system.

Cornwall received an initial Preventative Technology Grant from the Department of Health (DH) of £978,704 for the two-year period from April 2006 (the timeline for this Grant was subsequently extended to March 2009, but without additional funding attached). This Grant came with a range of expected outcomes including reducing hospital admissions, reducing accidents and falls in the home, and supporting hospital discharge. In addition, CSCI set performance targets for those receiving support through the grant, for Cornwall this figure was 1,957 extra people aged 65 and over.

The focus for this project is on the older population of Cornwall but it was recognised early on that where a proposed project/service could be expanded to encompass a wider range of people, it would be good practice to do so. This expansion would provide increased savings and efficiencies over the long term as people self manage, or earlier stage intervention packages introduced reduce later care and health service requirements. The main target groups included those with Long term Health Conditions, Older People, Mental Health and People with Disabilities.

A key element of the development of the project is Tremorvah Industries, a supported business operating within the Social Services Department of Cornwall County Council.

It operates in a number of commercial areas including textile design and manufacture, carpentry, the sale, installation and servicing of stairlifts, mobility equipment, daily living aids, CCTV and door entry systems. Tremorvah also operates the central Loan Store on behalf of Director of Adult Social Care (DASC). All these activities are underpinned by the support services to be found in any business such as sales, stores control, distribution, catering, customer service, administration and accountancy. Through this variety of work and training Tremorvah can help people rediscover old skills, acquire new ones, and progress both within the workshop and into open employment.

Project

There are four key but overlapping elements to the project:

- 24 hour information, advice and monitoring service through the call centre acting as a central point of contact countywide (to include managing response teams, out of hours service and an information line on services available)
- Single procurement route to ensure an economy of scale, the same organisation also to install and maintain equipment (countywide database of equipment provided for maintenance/upgrade schedules and also traceability of equipment)
- Smart House for the assessment of individuals and also for them to familiarise themselves and carers with AT (identify what equipment is appropriate for them). The House also to be a centralised training resource for all partner organisations

- Early identification of (potential) service users through the Doctor Foster/PARR system with referral onto appropriate support provision. Links built into the Single Assessment Process for referrals from both Health and Social Care. Comprehensive assessment carried out by trained assessors using common assessment tool.

In addition, it was recognised that for Assistive Technology to be a sustainable and mainstreamed service, there is a requirement for financial commitment from individual partner organisations. Issues around the complexity of charging between health, social care and Supporting People also need consideration if a single countywide service is to be implemented.

Originally the preferred option was to set up a company limited by guarantee with representatives from all partner organisations as members of a board of directors. Each partner would commit funding to provide the company with an operational budget, any savings to this would be fed back through to all partners on a yearly basis with further revenue generated through private work undertaken. However, given the potential structural changes within the County, and the effective partnerships already in place, this option has not as yet been pursued.

Process

Call Centre

The aim was to develop a countywide monitoring and response service, and the first step was to identify a local call centre with the capability to sustain an enhanced and expanded service. The centre would need to invest in upgraded software which could identify individual alarms and hence enable appropriate responses.

The other key area was to develop effective response services, with the first step being to carry out a service mapping and gap analysis exercise. This would enable a more consistent approach to commissioning response services.

Finally, staff training was to be carried out for both call centre staff and response teams.

General Infrastructure

So as to ensure a cohesive structure to the Assistive Technology service in Cornwall, it was recognised that it would be key to have a co-ordinated central approach to raising awareness and promoting the benefits of Assistive Technology as another option for individuals, carers and staff (from all agencies). This central approach would also ensure providing direction through evaluating and reviewing statistical and management information with an awareness of potential future developments. Funding for this central infrastructure would need to come from all partners to ensure sustainability.

The central team initially consisted of the Implementation Group whose members were the Sheltered Housing Manager, Lifeline Manager, Occupational Therapy (OT) lead, Mental Health OT lead, Supporting People Manager, Tremorvah Industries General Manager, Finance and the Preventative Technology Grant Project Manager. This group was responsible for the operational use of the grant recommending which projects were to be approved and what other links needed to be established. The group has now evolved into a Learning Network group consisting of the Lifeline Manager, Carer Support Manager, Sheltered Housing Manager, Mental Health OT lead, OT lead and Falls Co-ordinator. The group will meet quarterly and its function is to bring identified problems specific services have to the group.

The Assistive Technology Project Manager reported on progress to a Senior Management Board consisting of the Assistant Director DASC, Director of Service Improvement CIOSPCT, Sheltered Housing Manager, Supporting People Manager, Chairperson of RCHT (Acute Hospital trust) and Group Finance Manger DASC.⁶

As work progressed, a full time administrator was employed as was an Assistive Technology engineer, and at this time another engineer post is being advertised.

Single Procurement Route

The project aimed to create a single point of contact for the identification, pricing, suitability, purchasing, installation, maintenance and traceability of all Assistive Technology equipment provided throughout Cornwall regardless of agency.

The first issue was how to identify suitable equipment and compare prices before purchase and this was resolved through using the PASA (Purchasing and Supply Agency, NHS) e-catalogue. This allows a single database to be accessed for AT equipment and services (covering initially 15 manufacturers suppliers of related products) and also promotes best value and removes the need for tendering for products as the PASA catalogue is a contract which manufacturers sign up to guaranteeing best prices.

All referrals come through the Project Manager who then allocates them to Tremorvah Assistive Technology engineers. The engineers arrange a site visit directly with the client and complete an AT assessment form which identifies equipment and services required.

Once approval is obtained from the referring agency, the Project Manager arranges purchase or supply from a central stock and for the equipment to be installed.

Smart House

The aim was to develop a SMART house as a centralised training facility to support the awareness and understanding of how Assistive Technology can benefit individuals. It would also be available as an assessment resource for individuals and their carers to enable them (over a very short residential period less than 1 week) to identify and familiarise themselves with what Assistive Technology would be effective within their own home.

Early Identification of Potential Service Users

It was recognised that early identification of potential service users would increase the potential benefits for the service, so two approaches were taken to ensure this was more likely to happen:

- Raising awareness of staff across all agencies of the potential for an Assistive Technology service to their service users/patients through the development of a training package and organising targeted training events
- Implementing a common referral process with which to request an assessment and subsequent equipment or service, with links into e-SAP.

⁶ DASC = Department of Adult Social Care; CIOSPCT = Cornwall and Isles of Scilly Primary Care Trust; RCHT – Royal Cornwall Hospitals Trust

Outcomes

As at December 2007, progress had been made across a range of Assistive Developments as set out below:

Countywide Information and Monitoring Service.

- Both local lifeline providers upgraded to support latest Tunstall software offering a consistent approach and common processes throughout Cornwall
- Website of Telecare and Assistive Technology created with links to lifeline providers and sheltered housing providers, including online catalogue of equipment available
- Generic Assistive Technology e-mail address accessible to the team based at Tremorvah
- Supporting literature (flyers, leaflets and guidance sheets) developed.

Single Procurement Route, Install and Maintain.

- All telecare procurement via CCC undertaken through PASA framework
- Co-ordinated training events for all lifeline providers and sheltered housing staff as well as CCC assistive technology engineers ongoing.

Smart House/Assessment & Training Resource

- SMART house under construction at Tremorvah site, but this is for training only with no residential assessment on this site (detailed research revealed the level of resource required for staff to be available and also for stringent cleaning and infection control made it impractical to sustain beyond project funding)

- Smaller demonstration of Assistive Technology planned for Echo Centre (Liskeard).

Early Identification of Potential Users.

- Assistive Technology referral form built into Framework I (new Social Care Management Solution)
- Assistive Technology assessment form built into Framework I
- Telecare referral to be replaced by FACE telecare toolset in 2008 to allow electronic version to be incorporated into e-SAP
- Ongoing road shows, demonstrations and presentations to DASC, PCT, CPT, independent sector and voluntary staff
- Assistive technology incorporated into Age Concern Promoting Independence Project
- Assistive Technology co-ordinator employed by Penwith Healthy Living Association.

Over 2,400 people have been assisted so far through the Preventative Technology Grant, and recorded outcomes include:

- 24 saved admissions to residential care
- 41 prevented hospital admissions
- 16 intensive home care packages, and
- 88 people supported to manage their long term condition.

These outcomes have been identified by referring staff as the potential outcomes if assistive technology had not been provided, so cannot be considered clinical evidence. Further qualitative evidence was obtained through a participant survey, which highlighted the increase in confidence a user (or carer) experienced and the meeting of a previously unmet need.

Future

Cornwall is one of three authorities to pilot the DH Whole System Demonstrator. This project involves the implementation of Advanced Assistive Technology and Telehealth systems to 2000 people in Cornwall through a randomised clinical trial over a two year period which started in April 2008. This in itself has delayed any mainstreaming of an Assistive Technology Service as the equipment through this project is to be provided free. A mainstreaming paper has been submitted to DASC Senior Management and is awaiting approval. The central theme in this paper is that an Assistive Technology service should be joint funded between Health and DASC.

Lessons learned

The following lessons have been identified for the introduction of a mainstreamed assistive technology service:

- The need to identify appropriate people as early as possible for the working group
 - The risk of allowing projects to become talking shops, and the need to make decisions and get the work started
 - The importance of project management, and in particular the involvement of a dedicated project manager and a project plan with specified inclusion and exclusion criteria, start dates, outcomes expected, etc
 - The value to be gained from networking with other project leads or providers to avoid making the same mistakes or get another perspective on an issue or use of equipment
 - Testing the equipment before committing to any large-scale project spend and not only relying on what the supplier tells you
- Planning regular training sessions on equipment throughout any project as, particularly with telecare, equipment changes frequently
 - Referral rates or expressions of interest will increase as the service becomes known so you need to ensure capacity to manage this demand is in place and is knowledgeable
 - Information and promotion of the service needs to be continuous and both a SMART house and a web-based portal are invaluable tools. Both of these need regular updating.
 - The value of clear lines of accountabilities for support joint working across housing health and adult social care.

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