Care Services Improvement Partnership CSIP

THE EXTRA CARE HOUSING TOOLKIT

Acknowledgement

The Housing Learning and Improvement Network (LIN) would like to thank the Institute of Public Care, Oxford Brookes University, for their work in developing this toolkit. We would also like to thank members of the Housing LIN for their valuable contributions. We hope this proves to be a lasting and useful document.

Jeremy Porteus Housing Network Lead, Care Services Improvement Partnership.

About the Housing Learning and Improvement Network

The Housing Learning and Improvement Network is a learning network within the Care Services Improvement Partnership at the Department of Health. It is a unique network for promoting new ideas and supporting change in delivering housing, care and support services for older and vulnerable people. It has the lead for supporting the implementation of the Department of Health's Extra Care Housing Grant arrangements and related housing with care and support capital and revenue programmes.

The Housing Learning and Improvement Network manages both national and regional networks and has extensive online resources and learning materials at: http://www.icn.csip.org.uk/housing. **For enquiries e-mail: housing@csip.org.uk**

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CHAPTER ONE: INTRODUCTION

The development of Extra Care Housing (ECH)

In recent years a quiet revolution has begun to take place in terms of the provision of specialist housing, particularly for older people. For a long time, choice in accommodation for this population meant one of three options; remaining in their long term family home (which may have become increasingly difficult to maintain or increasingly inaccessible); moving to sheltered housing (predominately perceived as both an interim and a public sector option) or moving into some form of care home (often entailing a surrender of housing equity).

The change that has taken place has not only seen an increase in services to support people within their traditional family home, through specialist domiciliary care and assistive technology, but also the development of specialist housing which has been designed to accommodate people with a range of lifestyle, health and care needs to the extent that deteriorating general health should no longer be the sole reason for having to move home. The need to develop this type of provision has been emphasised in the recent Wanless Review, 'Securing our Future Health: Taking a Long Term View', and, for a number of years, by the government. For example, Stephen Ladyman stated in 2003:

'…most older people want services that allow them to retain control over their daily lives with support delivered as and when they need it. What they don't want are rigid and traditional models that take for granted an inevitable and progressive path from living independently to being cared for. Our increasing recognition of housing related services, and extra care housing in particular, - backed up by extra investment and new approaches to housing with care - is part of our policy to deliver this choice and control."[1]

Current figures show that extra care housing had by 2006 reached 25,000 housing units (although still small in comparison to the 500,000 care beds available). This development of extra care has been aided by support from the Government, such as the Department of Health and the Housing Corporation as well as a growing number of local authority commissioners, registered social landlords (RSL)/housing associations, private and voluntary sector providers who have all helped to fund and/or implement such provision.

This toolkit from the Housing Learning and Improvement Network (LIN) is designed to assist in the development of extra care housing in the context of the wider accommodation and service needs of older people. It offers a structured approach to developing policy and locally based initiatives and a variety of tools designed to facilitate thinking about extra care.

[1] New Designs for Older People. PRP Conference. (July 2003).

Why do we need Extra Care Housing?

ECH is based on three key principles:

- To promote independence – the provision of self contained accommodation with access to on-site care and support enables individuals to live independently in the community, promotes their well-being and helps to alleviate social isolation.
- To be empowering – primary health, care and support services should come to the individual, as and when needed, rather than the individual being required to change their accommodation in order to receive services that can and should be available in the community.
- To be accessible – where individuals live should be designed, or be capable of being adapted, to facilitate the delivery of personal social and health care services.

However, there are a wide variety of other influences and factors behind these three overriding principles that are helping to drive the development of ECH:

- The coming generation of older people have in their lifetime been more mobile, both in terms of employment and accommodation, than preceding generations. Therefore, the notion of moving to purpose built housing to meet specific needs in older age may be less alien than in the past. In addition, many older people have much greater amounts of equity (and hence choice about their property options) than in previous generations. As the numbers of older people increase then so it can already be seen that the housing market is beginning to adapt to meet the range of needs that such people present.
- For some people, living in their long term family home may become less desirable because of diminished accessibility or funds, eg, no level access to the property, a lack of space to fit adaptations such as stair lifts. In other circumstances the home may have just become too large, or worries about the current state of the property, or the need to maintain it may have begun to reduce the pleasure that the home once brought.
- Amongst the wider public, residential care is increasingly seen as a costly option, occupied by people who are either extremely frail or mentally incapacitated. Equally, communal living in care homes is not something that older people aspire towards and institutional care may also be perceived as having a deteriorating impact on an individual's quality of life.
- Whilst many people may aspire to either create or live in balanced communities where older people feel safe, are respected and can play a full role there are some older people who seek safety or even insularity from a world that feels difficult, different and sometimes hostile. Age should not be a barrier to choosing which accommodation, neighbourhoods and communities we may wish to live in.

Whatever the motivating factors for change, 40% of older adults find themselves needing or wanting to move home at least once past the age of 65 years (including into residential and nursing care)[2] and a quarter of adults over the age of 60 indicate that some form of specialist housing would be their preferred future accommodation[3]. Consequently, it is of little surprise that demand is already outstripping supply[4].

[2] Care Homes for Older People. Volume Two. Admissions needs and outcomes. Bebbington, A. Darton, R. Netten A. (1995).
[3] The Aspirations of Older People. MORI (2004).
[4] 20:20. A vision for housing and care. Jane Allardice Communication Limited. Allardice, J. (Sept 2005).

Aims of this toolkit

The development of extra care housing has been accompanied by a wide range of papers and publications outlining different models, formats and approaches by which ECH might be developed. This toolkit aims to:

- Build on the previous Housing LIN guide, 'Developing and Implementing Local Extra Care Housing Strategies'.
- Help local authorities develop their background thinking about policy prior to making a bid for funding.
- Bring the current literature and thinking on ECH together in one place.
- Provide a working document that can be used by planners, architects, elected members, local government staff, registered social landlords, policy developers etc in order to further their thinking about the volume, types and supply of extra care housing.
- Assist in fitting the development of ECH into the various commissioning strategies across housing, health, and social care and latest Government policy.
- Provide a range of papers, ideas, checklists, and diagrams designed to further thinking about how specialist accommodation can influence the quality of life for many people.

Apart from this introduction this toolkit comprises six chapters, each of which contains a paper outlining policy and practice. Each chapter is then followed by various tools, guidelines, checklists or additional information designed to help in planning specialist housing and service provision.

Although the toolkit predominantly focuses on extra care as a service provision for older people, in a number of sections it also outlines how this type of accommodation can meet the needs of adults with a physical disability, learning disability or mental health problem, especially where it requires different methods of delivery to that of ECH for older people. The toolkit also describes how well extra care may provide for specific groups of people, eg, those from ethnic minorities, or older people who are homeless.

CHAPTER TWO

WHAT IS EXTRA CARE HOUSING?

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Introduction

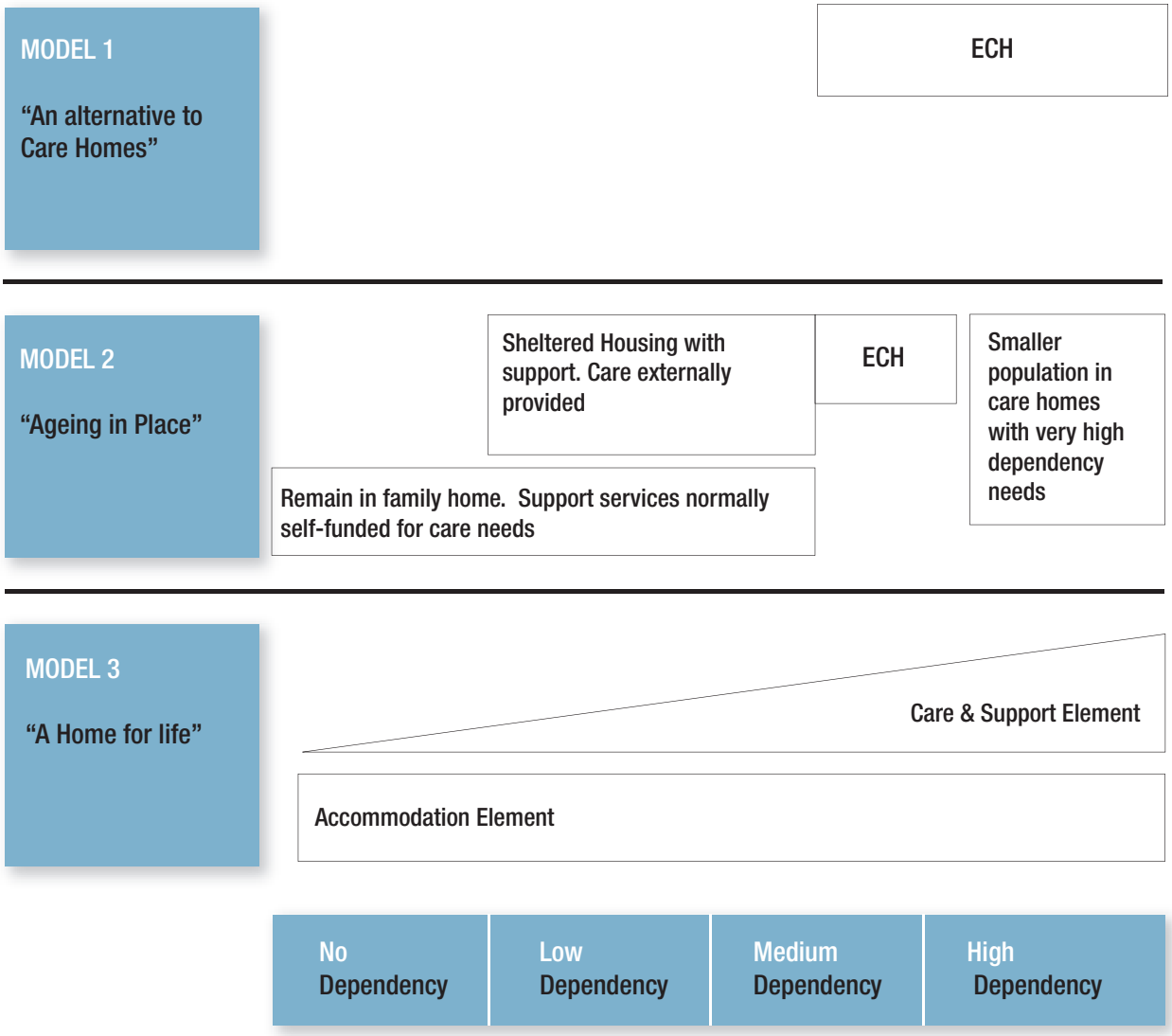
In its relatively short existence extra care housing (ECH) has gone through a number of manifestations and descriptions, from very sheltered housing, to housing with care, to extra care. Interpretations of the various different types of specialist housing for older people have not always been clear or consistent. For example, The Housing Corporation attempts to set out the difference between supported housing and housing for older people, by outlining that:

'Supported housing is "housing that is purpose designed or designated for a particular client group which enables residents to live independently". Housing for older people on the other hand is characterised as housing that "includes all or a number of special design features and access to support services as need arises which enables individuals to live in the property for the rest of their lifetime".' [5]

Put simply extra care housing is '*purpose built accommodation in which varying amounts of care and support can be offered and where some services and facilities are shared*'. However, as the principles in Chapter 1 suggest, the underlying themes behind extra care are anything but simple. For example, where to locate the approach in terms of the range of accommodation, care and support available to older people is a matter for keen discussion. In some instances extra care has been portrayed primarily as a direct alternative to residential care, in others as being at a mid point between sheltered housing and residential care or finally a model that disassociates accommodation from care and support, ie, that extra care can provide accommodation for people with a range of abilities but with differing amounts of care and support being provided dependent on need. These distinctions are displayed in the diagram overleaf.

[5] The Housing Corporation. (Released, April 2004). Regulatory Circular 03.04.

Figure 1 Locating Extra Care



Whilst it may seem as if the differences in definitions and descriptions are merely semantics, being clear about what extra care is, and is not, is important in terms of; furthering its development, being clear about its regulation and conveying a clear image to the general public, older people and the range of professionals who may be involved in its development or in the provision of services. What is gradually emerging is that whilst this form of housing may take a number of different formats and designs it does have a number of defining features:

- It is first and foremost a type of housing. It is a person's individual home. It is **not** a care home or hospital and this is reflected in the nature of its occupancy through ownership, lease or tenancy.
- It is accommodation that has been specially designed, built or adapted to facilitate the care and support needs that its owners/tenants may have.
- Access to care and support is available 24 hours per day either on site or by call.

Some of these themes were expanded by Riseborough and Fletcher in their paper 'Extra Care Housing, What is it?'

'It is a concept rather than a housing type that covers a range of specialist housing models. It incorporates particular design features and has key guiding principles. It can be referred to by several different names. Extra care housing can be owned, rented, part owned and part rented and leasehold. Some developments mix types of tenures. Most extra care in the UK is developed with public subsidy by housing associations, but a thriving commercial sector exists too. The most important fact is that extra care housing is housing first. It isn't an institution and should not look or feel like one. People who live there have their own homes.' [6]

Within these various descriptions and definitions there can be identified a number of themes which sets ECH apart from other forms of personal health and care provision. As Riseborough and Fletcher hint above, these are about characteristics or concepts that help to define the provision rather than descriptions of services or buildings. Some of these characteristics or concepts are:

- Living at home – not in a home.
- Having one's own front door.
- Flexible care delivery based on individual need – which can increase or diminish according to circumstance.
- The opportunity to preserve or rebuild independent living skills.
- The provision of accessible buildings with smart technology that make independent living possible for people with a range of abilities.
- Building a real community, including mixed tenures and mixed abilities. Extra care should be permeable to the wider community and offer the same benefits and services available to all older people.

However, whilst there may be a number of common characteristics, there is much debate about how, and when they are to be applied and to whom. For example, there have been differences of view about:

- Dementia – Can this be accommodated in ECH or does it inevitably require care home provision? If it can be accommodated within extra care is this in specialist 'dementia only' provision or in mixed communities?
- Choice – What choice should people have over who their neighbours are or who can enter schemes?
- Relationship to residential care – Is ECH a direct alternative to residential care and does this imply that ECH is solely for people with high dependency needs?
- What is the role of the local authority – Is this a provision that is mainly provided by the local authority, as was the case with much sheltered housing post war, or is the local authority mainly a facilitator of a range of provision, through the use of, for example, grant funding and planning controls?
- 'A home for life' – Many people have perceived ECH as a home for life, whereby nobody should have to leave their home because of their health or social care needs. Others have argued this is a form of provision like many others through which people may pass as their needs change. In a housing context this may be underlined by arguments about if ECH is a 'home for life', then what role should ordinary sheltered housing perform, if all accommodation should be capable of having a range of care, health and support services being delivered into it?
- How applicable is the ECH model to a range of populations with care and support needs, eg, people with learning disabilities, mental health needs or a physical disability?

[6] Housing LIN. Extra Care Factsheet Number 1. Extra Care Housing What is it? (2003). CSIP. (Updated 2004).

To resolve some of these issues this chapter attempts to draw out the key characteristics of ECH and highlights the diversity of such provision through exploring the range of different types, tenures and services. The tools at the conclusion of this section also offer materials to assist commissioners and providers in envisaging what that range of provision might look like across one local authority area, and materials to help communicate the concept of extra care to a range of stakeholders.

Types of Extra Care Housing

Table 1 Examples of Extra Care Housing Schemes

Type of Scheme	Description	Examples
Purpose built extra care scheme without community resources	• Normally around 40-50 units of accommodation in one location. • Flats or bungalows (often dependent on whether scheme is inner city or in suburbs). • Scheme for use by residents only.	Linters Court in Redhill is an example of an 'Assisted Living' scheme provided by McCarthy & Stone and Hanover Property Management Ltd. Flats are sold on a long leasehold basis (99-125yrs) with roughly equal numbers of one and two (wheelchair accessible) bed apartments. All schemes incorporate a restaurant in addition to resident lounges, guest suites, laundry facilities and lifts. Southfield Lodge in Durham is provided in partnership between the county council and Bradford and Northern care partnerships. It was built to provide a direct alternative to residential care for older people and replaced two existing care homes. Many residents had lived in residential care for many years, so skills and confidence had to be rebuilt.
Purpose built extra care scheme with community resources	• As above but with attached community facilities, eg, resource or activity centres, health, recreational and leisure facilities, which are open to local older people.	Hillside Court Is a scheme located in Bristol and provided by Housing 21. It specialises in providing accommodation for people with hearing impairments. A number of flats are equipped with technology specifically to support people with hearing impairments to remain at home. The scheme also includes a full catering restaurant which is open to both members of the scheme and the surrounding community.

Type of Scheme	Description	Examples
Core and cluster extra care scheme[7]	• Small local schemes with a core central building, eg, a scheme perhaps spread across four of five villages, in close proximity to each other, with eight to ten housing units in each location but with services based at one central building. • Shared housing, care management and staffing of all schemes. • Local housing units are often bungalows. • Schemes may be virtual, ie, the link is via services provided rather than geographical closeness.	Harp House in Barking has been developed in partnership with the London Borough of Barking and Dagenham and Hanover Housing. It is a core and cluster scheme with the core being extra care and the cluster being a number of nearby sheltered schemes and older people's properties. The sheltered tenants and older people can make use of facilities within the scheme and care is delivered out of the core scheme into individual's homes if required. Cumbria County Council has developed a virtual care village model of extra care. This is in response to the problem of developing appropriate models of ECH in rural Cumbria and in organising the care services to support tenants and older people living in the surrounding community.[8] The authority has used telecare to link and deliver remodelled services.
Remodelled extra care scheme from existing sheltered housing or residential care home	• Probably at least 30 units of accommodation if they are to achieve economic viability. • Due to the need for a minimum number of units to make a scheme viable, remodelling tends to be of newer and larger sheltered schemes or homes. • Schemes may not have all the facilities of a new build extra care scheme, eg, buggy store and charge, extensive communal facilities. • Cost in most instances will determine the appropriateness of ordinary sheltered housing for conversion.	Banlier Court is a remodelled development with 24 flats and bungalows for rent. It is owned and managed by Tintum Housing Association which specialise in providing housing and care services for black and minority ethnic groups. The design and facilities within the buildings were changed to bring them up to extra care standards

[7] More specific information on developing extra care for rural locations can be found in Housing LIN. Factsheet no. 12. An introduction to ageing in rural areas and extra care housing. CSIP. (2005).

[8] Further information on Cumbria's virtual extra care model can be found in Housing LIN. Case study no 17. A virtual care village model. CSIP. (2005).

Type of Scheme	Description	Examples
Retirement village/ continuing care communities	• 100 plus units of accommodation. • Large development spread over one large site. • Often incorporate a range of buildings including flats, houses and bungalows. • Extensive communal, health and leisure facilities. • Scheme may incorporate a residential care or nursing home on site.	St Monica's Trust is an extra care retirement village situated in North Bristol and provided by St Monica's Charitable Trust in partnership with Bristol City Council. The community consists of approximately 170 flats available for sale, shared ownership and to rent, and a 60 bed care home. All properties are laid out around a central cricket field complete with a pavilion and public house. Avonpark Village is situated on the outskirts of Bath and is one of the Care Village Group's five developments. The scheme consists of a mix of studio, 1, 2, and 3 bed properties available for leasehold purchase and both a residential and nursing home. Short and longer term rentals are also available. The village has extensive on site social facilities including restaurant, library and visiting doctors' surgery.
ECH linked to care home provision	• Small number of units – often flats. • Attached to existing care home. • Units often specifically for couples of whom one has a very high care need, or specialist need, and the other who is their carer. • Ability to access care, support and facilities of existing home.	The Ridings in Swindon Borough Council (in partnership with Kennet Housing Society), has been remodelled to provide 25 extra care flats. A large conservatory style building has been added, as well as a hairdresser and shop. The scheme incorporates a day centre and has an important role as a resource centre for residents and the wider community of older people.[9]
Extra care schemes for people with specialist needs	• Smaller than many other schemes often around 20-30 units. • Scheme specifically developed for individuals with specialist needs, eg, cognitive impairment or learning difficulty. • Scheme incorporates specific care and health facilities, and is designed to specifically meet the needs of these groups.	Yew Tree Court in Leeds is provided by Methodist Homes Association. It provides fifty, 1 and 2 bed flats for frail older people. Situated next to the scheme is Rosewood Court, a bespoke extra care scheme offering 20 flats for older people who have a dementia. Also available at the scheme is a dementia day care centre.

[9] For further information on extra care housing schemes in Swindon Borough Council, see Housing LIN Case Study no. 21 CSIP (2006).

Type of Scheme	Description	Examples
Extra care schemes for people with specialist needs *(continued)*	• Scheme may incorporate a day resource for individuals both in and outside of the scheme with similar specialist needs.	The Seven Oaks Dementia Care Unit in Northern Ireland is managed by Fold Housing Association and provides purpose built specialist extra care. It is designed specifically for people with dementia and provides 30 units, all with ensuite facilities and includes 5 two bed bungalows which enable couples to stay together.
ECH as a co-housing scheme	• A model of shared ownership provision originally developed in the Netherlands and Denmark. • The concept behind co-housing is that of independent living within private space, but alongside others within a community that promotes active engagement with others, in communal spaces and around common interests. The key features of co-housing are: • Common facilities. • Private dwellings. • Resident-structured routines. • Resident management. • Design for social contact. • Resident participation in the development process.[10] • Pragmatic social objectives.	The Peabody Trust Housing Association has developed a purpose built community in Southwark, London (Darwin Court). It offers 76 new flats for people over the age of 50, community facilities such as a health care suite and swimming pool, and provides a range of health living and educational activities for older people. The Threshold Centre in Dorset currently comprises a group of six individuals, all age 50-plus, with a common interest in all aspects of sustainable/holistic. They commonly purchased Cole Street Farm in November 2004 with the aim of creating a small, informal community, ultimately of 12-14 people, with shared values, linked to the wider community.

Tenure of Extra Care Housing

Like the rest of the population, older people wish to live in a diverse range of accommodation in a variety of neighbourhoods with different types of ownership. There is little evidence that increasing age changes this desire to choose. Given the projected levels of owner occupation as Table 2 shows then the likelihood is that most of that provision will be in the independent sector or at least in mixed tenure schemes.

[10] A Literature Review of Housing for Older People. Scottish Executive. Time to Move? (July 2006).

Table 2 Projected levels of owner occupation for 2011[11]

Age	60-64	65-70	71-74	75-80	80-84	85+
% of owner occupation	78%	79%	77%	72%	70%	66%

Given the above data, it might be expected that one task for local authorities is to try and facilitate the maintenance of such diversity in the housing market rather than just seeing their role in terms of being planners, providers or commissioners of housing provision. This approach has been mirrored by housing policy since the 1980s which has focussed on helping to create tenure diversification and 'the construction of sustainable communities where home owners and renters live alongside each other.'[12] Apart from meeting needs and demands, a range of sources identify additional benefits to mixed tenure arrangements:

- Can positively affect resident's attitudes, behaviour and the community.
- Helps create balanced communities and provides choice.
- Utilises individual's assets in the provision of their future housing and care.
- Shared ownership meets people's aspirations to own and is an option for those in low value, poor conditioned properties who need new accommodation but cannot afford to move.
- For poorer owner occupiers shared equity can mean that the proceeds from the sale of their property are reinvested in new property which does not count as an asset for the purposes of either Pensions credit or Housing Benefit thresholds. Shares risk management in terms of funding for care and support.
- Shared ownership is able to meet the demand from ex right to buy individuals and is a good way of individuals retaining an asset but still being eligible for benefits.
- Encourages providers to diversify their practice. For example, housing associations and private developers are now beginning to offer privately financed shared ownership (previously only offered by the Housing Corporation). This is helping to further develop the market without depending on Housing Corporation funding.

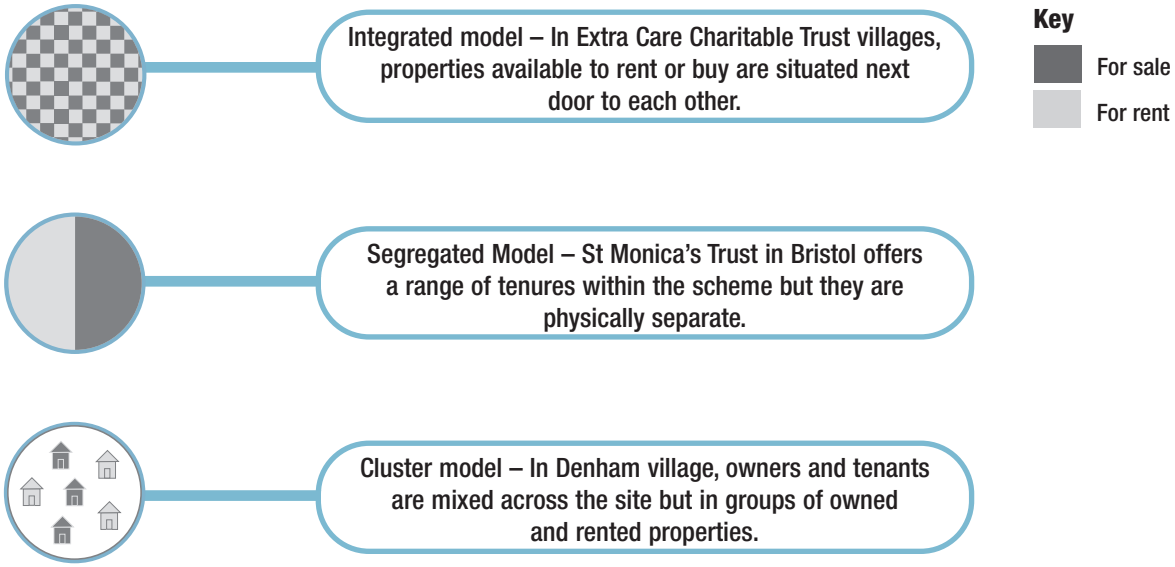
Whilst having mixed tenure developments can drive up the quality of services and offer a wider choice of provision, developing and managing such schemes may well prove challenging to providers. For example, the differing legal rights of ownership for leaseholders in comparison to tenants can be challenging to providers that are unfamiliar with these differences. As Nigel King states, these problems can be exacerbated where there is:

' ….less experience of 'extra care' mixed tenure, where there is the added ingredient of care provision, possibly by an organisation separate from the landlord and for a generally frailer and more vulnerable group of people'.[13]

[11] The needs and aspirations of older people living in general housing. Joseph Rowntree Trust. (2002).
[12] Our future homes. Opportunity, Choice and Responsibility. Housing White Paper. (1995).
[13] Housing LIN. Technical Brief no. 3. Mixed Tenures in Extra Care Housing. CSIP. King, N. (2005).

The diagram below illustrates the potential mix of tenure arrangements within any one scheme.

Figure 3 Mixing Tenure in Extra Care



However, although mixing tenure within schemes may be problematic there are examples where this has been successfully implemented; eg, Denham Garden Village, Extra Care Charitable Trust, and Hartrigg Oaks (Joseph Rowntree Housing Trust). If providers are going down this route they will need to take into account a range of issues, for example:

- Legal issues, eg, differing legal rights of leaseholders and tenants.
- Funding and payment mechanisms, eg, mixing of different funding sources to finance development.
- The differing expectations and aspirations of leaseholders from those in rented accommodation.
- Paying for care, and support, eg, ensuring that terms of tenancy and lease for properties are consistent.

Services provided within extra care

Central to the development of extra care is not just the provision of specifically designed accommodation but also the provision of a range of services designed to maintain people within the community. In some instances these may be 'on-site' services specifically for the owners or tenants of ECH schemes or they may be services which are 'off-site' and available to the wider community. However, where services are critical to individuals remaining within extra care then they need to be available in sufficient volume to meet the needs of owners or tenants. In addition, there may be a range of services which commissioners, providers and occupiers of schemes agree it makes sense to co-locate. Whether services are on or off site and/or are co-located will depend on a number of factors, eg, the urban or rural nature of the authority, the size of the scheme, and/or the level of needs of the occupants.

In planning the development of ECH (as will be discussed further in Chapter Five) the range and volume of services required needs to be estimated before any scheme is developed, particularly where it is planned that the scheme will act as an alternative for some occupants to care home provision. However, extra care does not always mean an increase in service provision. Some schemes have reported a diminution in demand for services. This may arise from some people's improved health and mobility, or from the more rehabilitative approach adopted by ECH staff or from help continuing to be provided by relatives, friends and neighbours.

There are a number of services which can be thought of as essential, if extra care is to successfully provide accommodation and potentially act as a 'home for life'.

- On-site provision or access to 24 hour personal and practical care services. Provision of personal care needs to be flexible and tailored to individual needs, so that as these change people can remain in the same place.
- Access to one or more meals every day which can help to ensure that residents receive their minimal nutritional value per day. These may be provided by onsite catering facilities or by existing providers within the authority.
- Access to domestic and housing support services particularly services which 'work with' rather than 'doing for residents'.
- The use of a range of assistive technology approaches designed to be enabling rather than disabling.
- For extra care to be successful there also needs to be access to a range of community health services. Some of these may be on site, some from nearby health facilities or agencies. In either instance their availability in sufficient volume to maintain people within the community is likely to be as critical as the care and support services. Examples of these services include; district nursing, CPN's, community dentistry, chiropody services, continence services, mobility assistance through physiotherapy or personal assistants, occupational therapy services. Such services may, of course, not be an additional requirement as they may already have been provided to ECH occupants in their former homes.

There are also a number of services, which although not essential to the delivery of an extra care environment, may be developed alongside a scheme, for example, a GP surgery, or pharmacy. However, in developing such services it is important that they are not just co-located out of expediency but are seen as being of direct benefit to residents. This may mean taking into account factors such as:

- Privacy – There will be a need to ensure that the privacy of private residents is considered, in order to maintain their sense of home and security. A number of schemes adopt 'progressive privacy' design principles to ensure adequate separation between scheme and facilities. Further detail on 'progressive privacy' can be found within the Housing LIN fact sheet no 6, 'Design Principles for Extra Care'.
- Look of premises – There will be a need to ensure that the integration of services does not make the scheme look or feel institutional in nature. Again this can be achieved by careful consideration of the layout and design of the building and landscaping.

The following table illustrates the range of services and facilities, which may be incorporated into schemes. It can be assumed that an advantage of additional services being incorporated is the economies of scale that this potentially achieves in building and staffing costs.

Further information on models of extra care can be found in the Housing LIN Factsheet 4, 'Models of Extra Care and Retirement Communities', CSIP (2004) which provides an explanation of different types of retirement communities and examples of how key decisions about the choice of a model can be made.

Table 3 Potential services that could be co-located with Extra Care Housing

Service	Advantages of incorporating into ECH	Best Practice Example
Day Services	The provision of day care within an extra care scheme may help to maintain links between residents in the scheme and the surrounding community, helping to prevent social isolation in older people. It may also reduce the need for extensive travel not just for residents but also local residents using the scheme.	Oak House, in Suffolk, is provided by Housing 21. As well as including an integrated specialist dementia wing, it provides a day and resource centre for occupants of the scheme and older people in the surrounding rural area.
Assessment Services	The provision of assessment centres within an extra care scheme enables assessment of individuals in purpose built facilities, but in surroundings likely to be similar to their own home.	A forthcoming extra care scheme in South Gloucestershire, in partnership with Housing 21 will specialise in providing accommodation for older people with dementia. It will also include a day centre and a SMART flat which will enable the assessment of older people from the surrounding community who are displaying early signs of cognitive impairment.
Community Based Care Team	The advantage of locating community care teams within extra care is that it can provide flexibility in the use of care hours. As needs within the extra care scheme change, time can be released for wider community provision or if there is an increase in dependency, resources can be moved in the opposite direction. For staff, time may be saved through reduced travel time and they can benefit from the support of colleagues within the scheme in sharing knowledge and expertise. Some facilities at an ECH scheme such as assisted bathing may be used as part of local care packages.	Harp House in Barking has been developed in partnership with the London Borough of Barking and Dagenham and Hanover Housing. It is a core and cluster scheme with the core being extra care and the cluster being a number of nearby sheltered schemes and older people's properties. The sheltered tenants and older people can make use of facilities within the scheme and care is delivered out of the core scheme into individual's homes if required.
Respite Care Services	Although there are not yet many examples of respite care being provided within extra care schemes it does offer the opportunity to provide long term respite accommodation for individuals who have partners with high dependency specialist needs.	Staunton Lodge in Swindon is run by the Methodist Homes Association. It provides apartments for couples where one person is suffering from dementia. Flats are adjoined to an existing nursing home, which enables the provision of specialist care and support which enables couples to remain together.

Service	Advantages of incorporating into ECH	Best Practice Example
Intermediate Care and rehabilitative services	ECH potentially provides a good and realistic intermediate care environment. Not only does ECH more closely replicate an individual's home, but it is also hopefully within an environment that provides a strong rehabilitative and mobility emphasis to its care and support. However, care needs to be taken in planning to use ECH for respite if the impact on long term occupants is not to be a negative one.	A scheme in Royal Windsor and Maidenhead provides short term intensive support and assistance.[14] The Extra Care Charitable Trust retirement villages are large schemes whose ethos is to rehabilitate and maximise independent functioning. Their schemes incorporate a wide range of rehabilitative facilities for use by residents and local older people including fully equipped gyms, and on-site physiotherapists.
Technology Response Centre	The locating of a technology response centre alongside an extra care scheme can enable greater use of, and access to, assistive technology both within the scheme and within the surrounding community. Being placed within a scheme provides the benefits of being able to work alongside care teams who will have detailed knowledge of the recipients of services. It may also mean a more rapid response when the technology fails.	As part of a wider telecare strategy, West Lothian have developed four purpose built extra care schemes to replace existing care homes. One of the schemes consists of 24 one bedroom cottages located around a core building which has a range of facilities which can be accessed by both residents and the wider community, and acts as a central telecare response. One of the cottages is used for assessment and respite care. The telecare component consists of a basic package with the capability to have a range of additional sensors or devices added to match individual's needs.
Health Care Services	Providing facilities within a scheme from which health care services can be delivered ensures the availability of services that are essential if individuals are to be sustained within their own home, eg, dental checks and chiropody services. For the health care provider it can provide economies of scale in the delivery of targeted preventative and health promotion services, eg, flu vaccination programmes, falls clinics, etc, to both vulnerable individuals within and in the immediate environment surrounding the scheme.	Denham Garden Village is a mixed tenure village provided by Anchor Housing. The village has a GP surgery on-site which also serves the wider community. Harry Lawson Court in East Cheshire has implemented a health promotion framework within the scheme which assists older people to improve their independence, health and wellbeing. Community Support Officers provide support to residents and older people in the surrounding community, focussing on improving a range of health outcomes, eg, numbers of falls, admissions into hospital, etc.[15] As part of the project a

[14] Further information on intermediate care in ECH and on the above scheme in particular can be found in Housing LIN. Case Study 14. Intermediate Care in Extra Care Housing. CSIP. (2005).
[15] Further information can be found in Housing LIN report Health for Life. Health Promotion in Extra Care Housing. CSIP. (2006).

Service	Advantages of incorporating into ECH	Best Practice Example
Health Care Services *(continued)*	Basing health services alongside schemes, eg, GP services or pharmaceutical services, which are open to the wider neighbourhood, can also help to ensure that the scheme is perceived as an integral part of the community.	quality of life toolkit has been developed in order to evaluate the success of the framework.
Leisure facilities, shops, etc.	The inclusion of leisure facilities alongside extra care housing not only adds to the overall attractiveness and appeal of a scheme, but also ensures that for residents the scheme offers not just housing but also a lifestyle. Through opening up facilities to the wider older population it further enables the scheme to become an integral part of the local community.	Barkway Court is an extra care scheme situated in the London Borough of Hackney and provided by Circle 33 Housing Trust. The scheme is integrated within a development which as well as offering general residential accommodation, has a number of retail units and leisure facilities. Berryhill Retirement Village is a single three storey building containing 148 rented flats, provided by the Extra Care Charitable Trust and located in the Midlands. Facilities include a gym, craft and computer rooms, village hall, restaurant, bar, shop, hairdresser, library, greenhouse and communal gardens.
Care or Nursing Home	Providing a care or nursing home alongside an extra care scheme, provides an option for residents whose needs may prove too great to be supported within their own home, but who want to remain within their own community. An example of this would be an individual who required intensive levels of nursing support, which could be better provided within a care home setting.	Hartrigg Oaks is a continuing care village operated by Joseph Rowntree Housing Trust situated in York. It consists of 152 bungalows clustered around a central complex containing communal amenities and a 42 bed care home.[16]

Extra Care Housing for People with Dementia

A number of factors have, in recent years, encouraged the consideration of extra care for people with low to moderate levels of dementia. Some of these factors have centred on the increased costs of residential care and the realisation that this environment may not always be helpful to relatives and carers. Equally, the capacity of ordinary sheltered schemes with a diminution in the use of on site wardens has also made dementia harder to manage in those schemes.

On a more positive note, the increased availability of assistive technology, the fact that much extra care is new build and hence can be specifically designed to incorporate 'dementia friendly' features and improvements in medication, have all been drivers

[16] Further information on Hartrigg Oaks can be found in a study by Croucher K, et al. (2003) entitled, Living at Hartrigg Oaks. Residents views of the UK's first continuing care retirement community.

towards the development of a number of models of extra care housing for people with dementia. These include schemes which:

- Can accommodate residents with dementia as part of the wider scheme, through incorporation of dementia friendly design principles[17] and appropriate staffing and support.
- Have purpose built wings or areas for individuals with dementia.
- Are solely for individuals with dementia.

There are a range of debates around what model of provision is best for individuals and carers with dementia and for other occupants of ECH. The ability to support an individual with dementia is greatly increased by an early move into a scheme whilst they still have some understanding of the move that has been made, have the capacity to develop relationships and are able to adapt to new surroundings, albeit with support. Equally, extra care may not be appropriate for people who on entry are in the advanced stages of dementia. However, this is not always the case, particularly if the person is already familiar with the environment through using other facilities or where a carer is moving at the same time as part of long term respite.[18]

Research recently undertaken by the University of the West of England, in collaboration with Dementia Voice, Housing 21 and the Housing Corporation,[19] assessed the outcomes for people with dementia living within extra care schemes. It found, that far from being an unsuitable housing option for individuals with dementia:

- Extra care is a resoundingly popular accommodation choice for older people who develop memory problems or dementia and need to move out of their home.
- Extra care has a key role in maintaining independence and health of people with dementia.
- With the right support, people with dementia and memory problems are able to live independently in extra care for nearly as long as people without significant cognitive impairment (around two years).
- Older people with dementia and their families choose extra care because it meets their needs and aspirations better than other accommodation options.
- Friends and relatives are more likely to remain part of an informal support network of residents living in extra care housing compared to people living in a hospital or care home.

In all schemes, regardless of whether offering specialist provision or not, there is agreement on a number of characteristics which are essential if people with dementia are to be cared for:

- Availability of care and support provision from staff who have had training in dementia.
- Good working relationships between health, housing and social care (especially in enabling early detection and diagnosis) and support from CPN services.
- Good use of assistive technology[20] and design principles.
- Enabling older people with cognitive impairments to fully utilise facilities within the scheme.
- Involving individuals with dementia, and their carers, in the provision of their care and the development and management of individual schemes.
- Awareness and understanding of the Mental Capacity Bill and Mental Health Act.

One of the main issues concerning extra care for people with dementia is the capacity of individuals to sign and understand a tenancy agreement. Having a valid tenancy is fundamental to the distinction between housing and care. There are a number

[17] For further information on designing for dementia see The Suffolk Extra Care/Dementia Design and Management Guide. Suffolk County Council. (2003). Available on CSIP website.
[18] Housing LIN viewpoint no. 4. Extra Care Housing is not the answer for everyone with dementia. CSIP. (2005).
[19] Opening Doors to Independence. A longitudinal study exploring the contribution of extra care housing to the care and support of older people with dementia. Housing Corporation, Housing 21. Vallelly, S, Evans, S, Fear, T & Means, R. (2006).
[20] For further information on the role of assistive technology within extra care refer to chapter six of this toolkit.

of guidelines which reflect the legal position with regard to mental capacity and the granting of tenancies which commissioners and providers should refer to before commencing the development of a specialist scheme. This information along with further guidance on different models and their relative advantages and disadvantages can be accessed through the Housing LIN fact sheet no 14, 'Supporting people with dementia in extra care housing, an introduction to the issues', CSIP (2005), and CDrom, 'That's My Home: Housing Needs for Older People with Dementia', CSIP (2005).

Best Practice Examples

Fernhill Care Ltd (a subsidiary of Atlantic Housing Group) has developed a scheme designed to maximise independence for older people with dementia. Rowan Court in Eastleigh is home to 21 people with dementia, each with their own flat. A central feature of the scheme is the hard wiring of the building to provide for a wide range of assisted technology. All flats have a heat sensor and a flood detector. Cabling is in place to add extra functions, on an 'as required' basis, following individual assessments of need.

Suffolk Extra Care: Dementia/Functional Mental Health Design and Management Guide – Each of these guides have been produced in partnership with District Councils, RSLs and the PCTs. They detail the additional design criteria, social activities and care/support services to be provided to older people living with dementia/functional mental health needs in very sheltered housing within Suffolk.

Extra Care for People with a Learning Disability

Extra care as a form of housing provision is also being advocated as an effective model for older people with learning disabilities, many of whom are cared for by carers at home, who may themselves be elderly, or in some form of care home or hospital provision. It is also seen as a viable way of meeting national policy objectives of supporting more people with a learning disability at home, and as such has been supported by ring fenced capital funding through the DH extra care funding process as well as the Housing Corporation funding for supported accommodation. Extra care is very much in accord with the objectives of 'Valuing People' which encourages the development of new and innovative services. Such services should 'foster independence, support and care which can be tailored to individual users and where independence, control and choice are possible.'[21] In addition, the Department of Health White Paper, 'Our health, our care, our say: a new direction for community services' (2006) makes a commitment to close all campuses for people with a learning disability by 2010. Extra care offers one of a range of solutions to meet such people's housing and care needs.

Within the field of learning disabilities, extra care is seen by practitioners and local Learning Disability Partnership Boards[22] as able to usefully focus on providing accommodation for:

- Those with a learning disability living in a residential setting or with carers who may need to move because of changing needs.
- Those with a learning disability who need specially designed or adapted dwellings including the provision of suitably enabling assistive technology.
- Those with a learning disability who need enhanced housing care and support.

Commissioners and providers also need to consider the specific needs of the learning disability community in terms of detailed design and the services available at a scheme, including those providing care and support. A detailed illustration of design and services required can be found in Housing LIN fact sheet no 3, 'New provision for Older People with Learning Disabilities', CSIP (2003). In addition, the LIN's latest report, 'New initiatives for people with learning disabilities: extra care housing models and similar provision', also includes a comprehensive list of best practice examples of innovative schemes developed across the country.

[21] Valuing People. A new strategy for Learning Disabilities for the 21st Century. Department of Health. (2001).
[22] To highlight the range of choices, at the time of writing the Housing LIN is publishing a leaflet for commissioners and an 'easy read' leaflet on housing options for people with a learning disability.

Best Practice Examples

Mildmay Park: Mildmay Park (Notting Hill Housing Group) offers accommodation to seven older people with learning disabilities who each live in their own flat. There is a dedicated team of staff who work with these individuals to help them to live independently within the extra care service. Community Support Officers attend regular training, both in house and organised by Islington Learning Disabilities partnership. This means that the staff maintains specialised skills that are directed towards addressing the particular needs of the client groups.

CHAPTER TWO
TOOLS

This chapter includes tools and guidance on:

1 Anyshire – An Illustration of the Potential Makeup and Mix of Extra Care Housing in an Average Authority

2 A Checklist to Review the Potential Tenure Mix of an Extra Care Housing Scheme

3 Extra Care Housing Leaflet

Anyshire: An Illustration of the Potential Makeup and Mix of Extra Care Housing in an Average Authority

Purpose of Tool

The intention of this tool is to provide an illustration of the range of types and tenures of extra care that might, in time, be delivered within an average authority in order to meet identified needs. Calculations have been based on a number of assumptions which are outlined below.

Population

Anyshire currently has a population of approximately 250,000 of which 36,000 residents are over the age of 65 years. This represents approximately 15% of the overall population.

Anyshire is forecast to have an increase in its older population, rising from 36,000 in 2006 to 48,000 over 65s in 2016, an increase of about 30%. The highest growth is expected to be in the 65-69 and the 80 plus age ranges.

Demand Assumptions for Anyshire

- In line with national and local objectives ECH schemes should be both mixed and single tenure.
- 75% of over 65s are owner occupiers - 75% of ECH will be purchased, however 20% will be available as shared ownership.
- The remaining 25% of accommodation will be at market or social rent.

It is anticipated that ECH in Anyshire will provide for older people with mixed dependency needs.

- High level dependency needs – 30% of the over 65 population that currently enter a care home will instead go into ECH = 648 Units.
- Vulnerable older people – there are 11,000 lone pensioners in Anyshire of which 21% also have a limiting long-term illness. ECH will provide accommodation for 30% of these households = 693 Units.
- Accommodation choice – 30% of the over 65 population, look to move to different accommodation of which 12% will look for accommodation[23] with care = 1,296 units.

Supply Assumptions for Anyshire

The development of ECH schemes will be enabled by:

- The decommissioning of 10 existing Council owned and run sheltered housing schemes. Four will be remodelled, and the remaining six will be demolished with the land used for the development of new purpose built housing schemes.
- The decommissioning of three existing Council owned and run Residential Care Homes. The homes will be demolished and the land used for the development of new purpose built extra care housing schemes.
- The development of schemes by independent sector[24] on council owned land.
- The development of schemes by the independent sector on land owned or acquired by them.
- The development of schemes on private land or land owned by other public body, eg, NHS.
- The development of schemes through section 106 requirements of new large scale developments.

[23] MORI op cit
[24] The term independent sector has been used throughout although nationally terms in use vary from private to independent sector.

- The remodelling of existing sheltered housing schemes or residential care homes by local authorities, registered social landlords, or the independent sector.

Summary of Extra Care Schemes in Anyshire

Number of Units to Buy/Share Own	1978
Number of Units at Market/Social Rent	659
Total number of Units of Extra Care Required	**2637**

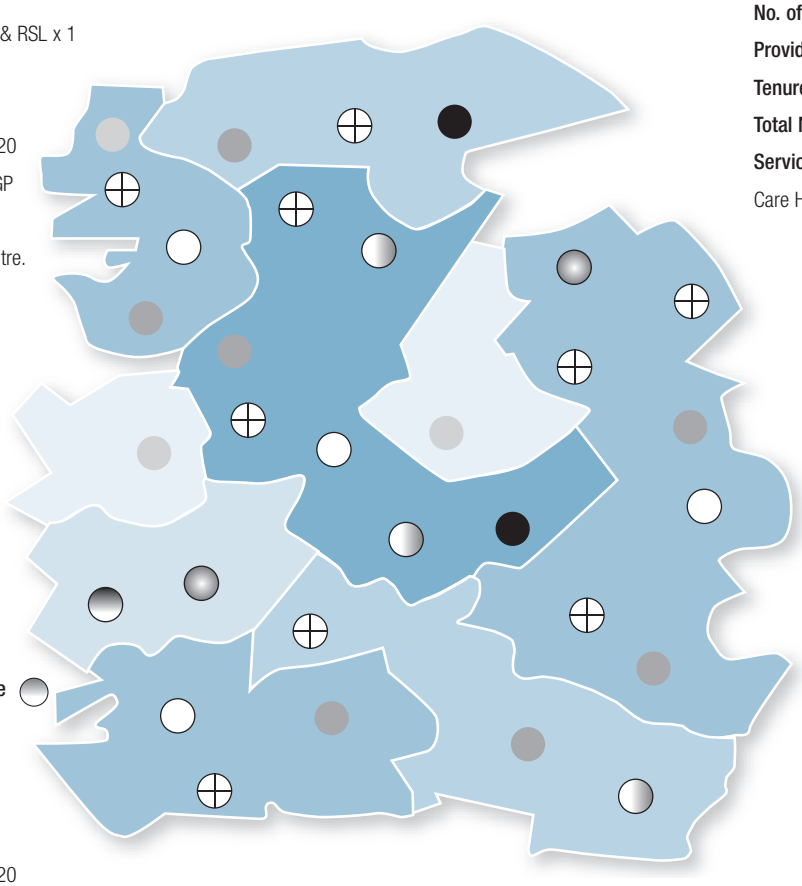
Extra Care Schemes in Anyshire

Type: Remodelled Scheme from Residential Home
No. of Schemes = 2
Provider: LA x 2
Tenure: Social Market x 2
Total No. of Units = 90
Services: Resources Centre, Intermediate Care, Rehabilitative Services

Type: Purpose Built ECH with Community Facilities
No. of Schemes = 9
Provider: RSL x 5, LA x 2, RSL & Private Sector x 2
Tenure: Mixed x 6, Rent x 2, For Sale x 1
Total No. of Units = 550
Services: Pharmacy, Health Centre, Intermediate Care, Telecare Response Centre, SMART House

Type: Core and Cluster
No. of Schemes = 3
Provider: RSL x 2, LA & RSL x 1
Tenure: Mixed x 2
, Rent x 1
Total No. of Units = 420
Services: Pharmacy, GP and Community Health Services, Resource Centre.

Type: Retirement Village
No. of Schemes = 2
Provider: Charity x 1, Private x 1
Tenure: Mixed x 1, For Sale x 1
Total No. of Units = 600
Services: Health & Leisure Facilities, Care Home, Community Facilities



Type: Purpose Built Scheme
No. of Schemes = 7
Provider: Private x 5, RSL x 2
Tenure: For Sale x 5, Mixed x 2
Total No. of Units = 350
Services: Intermediate Care, Leisure Facilities

Type: Continuing Care Retirement Village
No. of Schemes = 1
Provider: Private
Tenure: Mixed
Total No. of Units = 420
Services: Care Home, Health & Leisure Facilities, Intermediate Care

KEY
% of Population over 65 years

	19.4% - 23.8%
	15.7% - 19.4%
	14.9% - 15.7%
	9.8%- 14.4%
	0.01% - 9.7%

Type: Remodelled from Sheltered Scheme
No. of Schemes = 4
Provider: LA x 2, RSL x 2
Tenure: Social Rent x 2, Social Rent and Shared Ownership x 2
Total No. of Units = 170
Services: Intermediate Care, Resource Centre

Type: Specialist Scheme for Older People with Dementia
No. of Schemes = 3
Provider: LA x 1, Private x 1, RSL x 1
Tenure: For Sale x 1, Rent 2
Total No. of Units = 155
Services: Day Services, Long Term respite Care, Assessment and Treatment Centre

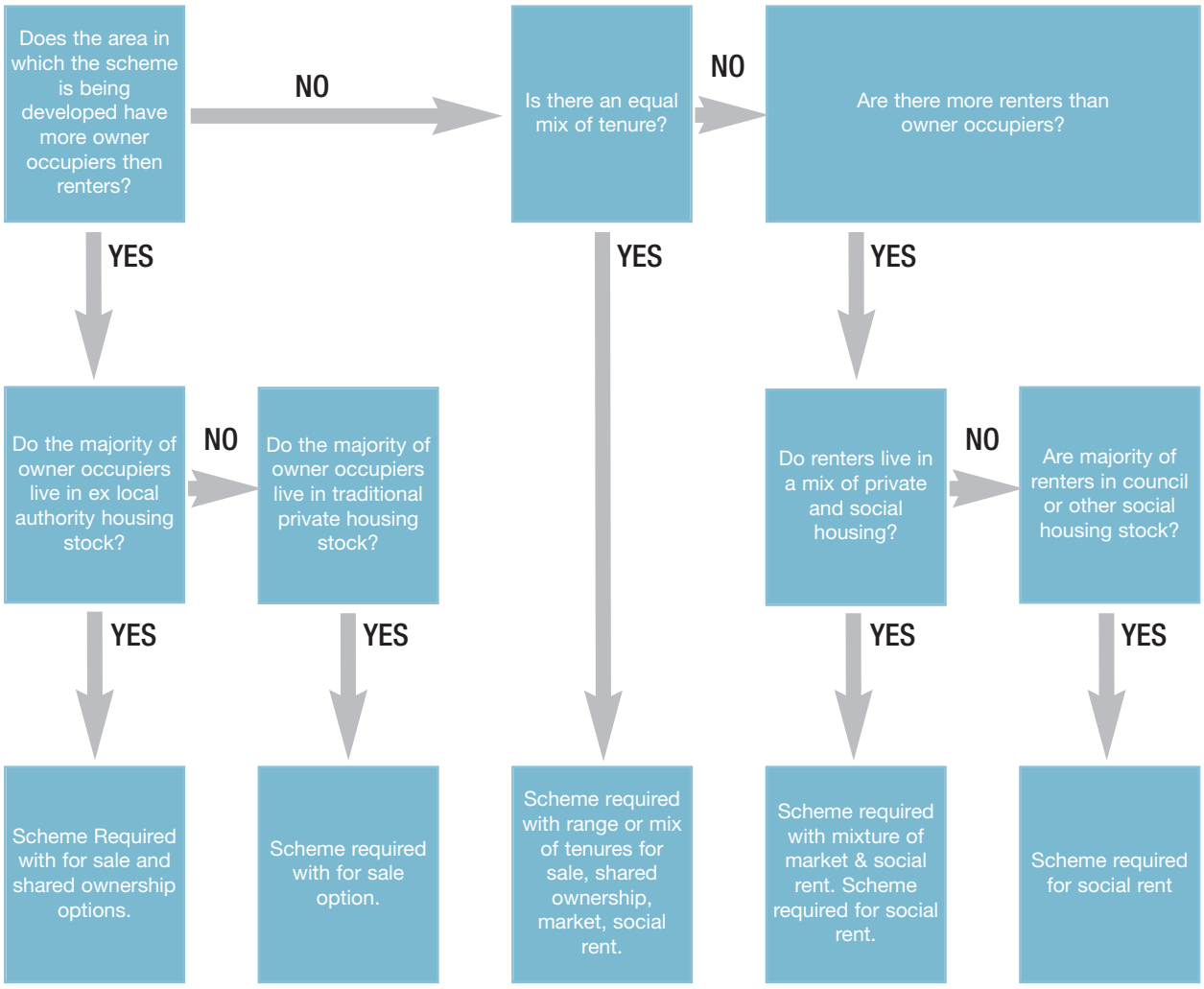
A Checklist to Review the potential Tenure Mix of an Extra Care Housing Scheme

Purpose of Tool:

The intention of this tool is to assist commissioners and providers in undertaking preliminary thinking about the market for extra care and potential tenure make up of a scheme under development. By asking questions about existing accommodation and tenure within the proposed development area it assists in helping to determine what tenure mix may be best suited to the scheme.

It is intended that this tool should not be used exclusively to determine tenure type and mix of a scheme but act more as a starting point for discussion. Results need to be considered alongside existing market intelligence, knowledge and assumptions and need to recognise that individual's preferences in certain circumstances may differ from their current situation. For example, an individual may wish to remain in the same area which has a majority of owner occupiers, but would prefer to rent and utilise capital of their house to fund their retirement rather than invest further in property.

What tenure mix?



Thinking about a move?
Think about extra care housing

"Perhaps I could have stuck it out alone in my terraced house a bit longer…it all felt a bit of a rush moving here straight after my accident in the town….but I'm content now, and I feel secure"
Anna, an extra care housing resident for 9 years.

Extra care housing is different because:

- You are living at home - not in a home
- You have your own front door – you decide who comes in
- Couples and friends can stay together
- There is a mix of able and less able older people
- 24 hour care services are available – if you need them
- You get support to keep your independence
- You can join in social activities - or you can be private
- You have control over your finances
- You have security – the aim is a home for life

Many older people end up living somewhere they are not happy to be, simply because they want to please others or not be a burden to their family. Moving after an accident or an illness can mean there is not enough time to think about what you really want. If you think through your options before you have to, you can make a positive choice for yourself.

Extra care housing offers a new way of supporting you to live independently for as long as you possibly can. It gives you the security and privacy of a home of your own, a range of facilities on the premises, with 24 hour care services available if you need them.

About this leaflet

This leaflet aims to help you decide if extra care housing would be a good choice for you and tells you where to go for further advice and information. The government is putting money into developing and expanding extra care housing; they believe it gives value for money as well as improving the quality of life for older people. The amount of extra care accommodation is therefore increasing throughout the UK.

Extra care housing is sometimes called 'very sheltered housing'. The look of the accommodation varies enormously: some are new purpose built retirement villages, others are modernised sheltered housing schemes with extra services on site. Many offer a choice of accommodation such as flats or bungalows, for sale or rent. What all residents of extra care housing have in common is the security of owning or renting your own home, control over your finances and the peace of mind that goes with having 24-hour care and support available on site.

You may be thinking of moving or having to leave your old home because of life changes or health problems. Or you may simply be unhappy with where you are living now. If you value your independence and privacy and want control and choices in your life, think about extra care housing. To find out what is available in your area see the 'Contacts' section. See the 'Money Issues' section if you are concerned about financial matters.

"Losing my home after my heart attack wasn't good, but I was very lonely and couldn't cope with the garden and housework. Here I get the help I need – my flat is cleaned and the washing done. I feel on top of things now."
Iris, an extra care resident for three years

Howard's Story
"I came into extra care housing as an emergency after I had a nervous breakdown. I'd been living in a flat on my own and never saw my neighbours. I stopped eating and got very depressed. My doctor said he'd put me in a home, but I Knew about this place because of visiting a friend here. I said it was the only place I would go. When I got here, I saw it as a new start and a chance to get back on my feet. At first I stayed in my flat, but I gradually felt better, I started eating and enjoying life more. Now I make my own breakfast and tea and join in social activities here and outside. I have made friends, and I feel a lot more confident now."

Some questions you may already be asking yourself

I am managing on my own, but my health is not good and I want to move. Would extra care housing be suitable for me?	Yes. Most extra care housing projects have a mix of more independent and able residents together with those who are very frail. Some will be getting a lot of care and support, others will be living independently. The accommodation will be accessible and it should be easy for you to manage.
I own my own home, but my friend is a council tenant. Could we both move into extra care housing?	Yes. Some schemes offer homes to buy, others offer only rented accommodation, some are a mixture of owner-occupiers and tenants.
I already live in ordinary sheltered housing – how would extra care housing be different?	The main difference is that care and support staff are on the premises 24 hours a day. There is also a restaurant for those who want it, social activities and other facilities. Different types of accommodation are available, and there is a mix of residents with different support needs. Your tenancy or ownership of your home is secure – you should not have to move if your needs change.
My husband is very unwell and we get a lot of help from our family and friends. Could we move into extra care housing together?	Yes. You and your husband can stay together and your family and friends can continue to help as before if they want to, with the added support of the extra care staff. You may make new friends too!
My doctor has said I should go into a home. What are the advantages of extra care housing over a nursing or care home?	Extra care housing shouldn't look or feel like an institution. You will have your own home, control over your finances, and privacy and choice about how much you mix with the other residents. The care staff will support you in looking after yourself for as long as possible, and you can keep up your usual routines and activities in the local area.
What happens if my health gets worse while I am living in extra care housing?	It is expected that your needs will change over time - and not always for the worse! There may be times when you need a lot of care and support, times when you need no support or a mixture of the two. The care staff should be flexible and sensitive in asking you about what you need. They cannot give you nursing care, but they will aim to support you to stay living in the same place.

My mother has early signs of Alzheimer's disease Can she move into extra care housing?

Possibly. Most people who develop dementia after moving into extra care can continue to be supported in their familiar home surroundings by staff and friends as before. Some extra care housing has a special wing for new residents with dementia; others mix residents with different needs across the whole scheme.

What facilities and services are available on-site at extra care housing?

The facilities range from restaurants and lounges to hobby rooms, shops, hairdressers and keep fit suites. Sometimes the local day centre, health services and other groups are based there, for example, a GP surgery, a district nurse or welfare benefits advice. People from the surrounding area may also come in to use the facilities and resources.

Who is in charge of extra care housing?

Most extra care housing projects are built and run by housing associations. Some are run by private companies or the local council. Usually, the care staff work under a contract from the local social services department. Extra care residents should be involved in making decisions on all aspects of the community they live in.

Can I stay until I die?

Extra care housing aims to provide you with a home for life. This may not always be possible, for example if you become a risk to yourself or others, but it is the aim.

Is there an extra care housing scheme in my area?

There are many extra care housing schemes throughout the country. They are very popular, often with waiting lists. For information on extra care housing in your area, contact your local council (you can get the number from your telephone directory), a Citizen's Advice Bureau (CAB) or Elderly Accommodation Counsel (EAC, see below). Your local Citizen's Advice Bureau can also give you general information about benefits, housing and financial matters

MONEY ISSUES

Can I afford extra care housing?

You can pay rent under a tenancy agreement, or you may be in a position to buy your home in an extra care housing scheme. Another option is to part-buy and part-rent your home (this is called 'shared ownership'). If the accommodation is provided by a housing association, the rent levels are usually regarded as 'affordable'.

Depending on your income, you may qualify for housing benefit for your rent. If you get housing benefit or income support you may also be entitled to free care and support services.

If you are thinking of moving into extra care housing it is important to find out exactly what it will cost you. You may qualify for benefits to meet all or part of the costs. Get advice and information from your citizen's advice bureau, or from the organisations listed at the end of this leaflet.

How much does extra care housing cost?

There are three elements to the cost of extra care housing:

- the cost of buying or renting your own home
- the service charges associated with your home, for maintenance and any communal facilities
- your care and support costs

The amount you pay will vary depending on your individual situation and your income. You may have to pay for all the costs, or you may be entitled to benefits to meet some or all

Whether you already live in extra care housing or are thinking about a move, you may find that your care needs fluctuate up and down. This can mean that you need different services at different times, and as a result, your care and support costs may increase or decrease. If this happens ask for a care assessment from your local social services department. Remember to keep a regular check on your entitlement to welfare benefits.

Maureens Story

"I was in a warden controlled bedsit. I liked it there and I could manage, but the council wanted to close it down, so I opted to come here. My best friend lives here too. I didn't want to come, but now I like it very much. They (the staff) don't feel they can just walk in. They wait to be invited….that's better. This is my own home, and I don't let just anyone in. If I want to see people I come down to the lounge and sit in this chair. I enjoy going across the road to the church every week. I still cook for myself some days, especially if I don't like what is on the menu. My son comes once a week with my shopping and we cook and eat together in my flat."

What do residents say about extra care housing?

"You get the extra help you need without moving" Julia

"There's plenty to do here, and good company" Enid

"Living here means peace of mind for me and my family…. and they can stay over when they come to visit" Joan

"I see people every day, and at the end of the day I can lock my door and relax" Eileen

"I have the best of both world here. The staff remind me of things – like taking my pills - but they don't do things for me". Barbara

"I like being independent and I feel very secure." Julia

Contacts

Elderly Accommodation Counsel (EAC)
3rd floor
89 Albert Embankment
London SE1 7TP
Advice Line: 020 7820 1343
www.housingcare.org
Phone EAC's advice line for free advice and information on all aspects of housing, care and support. The website has a database of housing options, including extra care accommodation, nation-wide.

For more general advice and information contact:

Age Concern England Information Line: 0800 00 99 66

AIMS: 020 8765 7465
An advice, information and mediation service for people living in sheltered and retirement housing.

Alzheimer's Society helpline: 0845 300 0336

Counsel & Care telephone advice line: 0845 300 7585

Help the Aged Seniorline: 0808 800 6565
Free Advice line for people in England, Scotland and Wales
(0808 808 7575) for Northern Ireland

Housing Learning and Improvement Network, CSIP Networks, 304 Wellington House, 133-155 Waterloo Road, London SE1 8UG Tel: 020 7820 1682. Provides factsheets and information for providers on extra care housing. www.icn.csip.org.uk/housing

CHAPTER THREE

PLANNING THE DEVELOPMENT OF EXTRA CARE HOUSING

CHAPTER THREE: PLANNING THE DEVELOPMENT OF EXTRA CARE HOUSING

Introduction

There are a number of key activities that need to be undertaken before either local authority commissioners or combined commissioning partnerships can develop extra care housing. These include:

- Developing a clear strategy: Extra care housing needs to be strategically located within the range of provision for older people and other groups of users of services for which its development is being considered.
- Putting in place strong and effective partnerships: Key partners need to be identified and appropriately involved in the development and implementation of extra care.
- Developing supportive planning arrangements: Regional and local planning policies need to reflect the needs of the ageing population and be geared towards supporting the development of extra care housing locally where required.
- Identifying capital and revenue funding: An essential requirement of any development is to secure the financial resources to develop and maintain schemes and their services.

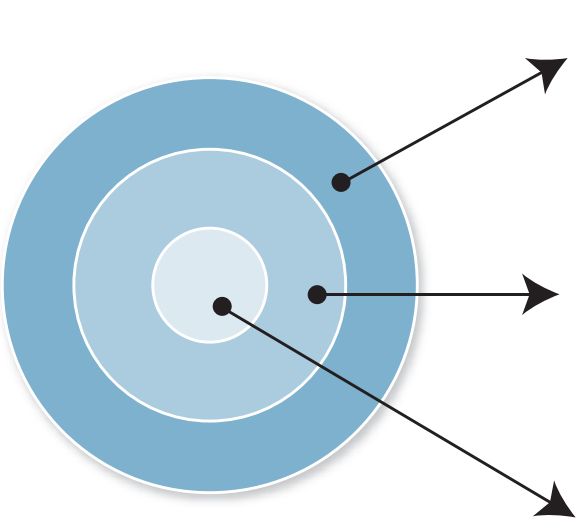
This chapter examines each of the above activities in detail and offers tools designed to help facilitate strategic planning.

Developing a Clear Strategy

If extra care housing is to meet the aspirations and diversity outlined in Chapter 2 then this requires a structured approach to its long term commissioning. Equally, planning the future role of extra care is important to providers, both of housing and current care homes. The material below, and that in the subsequent chapters, is designed to help thinking about commissioning extra care from a commissioner's and a provider's perspective.

The majority of local authorities and Primary Care Trusts (PCTs) will already have a plethora of strategies, plans and approaches concerning the commissioning and delivery of health, housing and social care. Consequently, one of the issues that commissioners will need to consider is 'Where does extra care fit'?

Figure 4 Where does Extra Care Housing strategically fit?



An interagency commissioning strategy for older people or learning disabilities or mental health.

An accommodation strategy including:

- Community based accommodation services, eg, care and repair.
- Supporting people's services.
- Sheltered Housing.
- ECH.
- Care Homes.

An Extra Care Housing Strategy.

For some commissioners[25] ECH will constitute a strategy in its own right, for others it will be a part of a number of different documents. Certainly references to extra care housing should be included within:

- Annual Service and Commissioning Plans.
- Local Area Agreements.
- The Local Older Peoples Strategy.
- Local Housing Strategy.
- Housing for Older People Strategy.
- Local Development Framework.
- Carers Strategy.
- Community Plan.
- Supporting People Plan.

However, wherever the strategy is located is not as important as making sure that commissioners, and the documentation produced, take into consideration the following factors:

- Given the long term nature of planning housing provision then the strategy needs to be over at least a ten year period.
- The strategy needs to go beyond the local authority and RSLs as providers and consider the range of accommodation needs of older people across state, voluntary and independent sector provision.
- The finished document needs to define the outcomes the commissioning strategy is attempting to achieve not just outputs and service provision.
- The relationship between ECH, residential care and maintaining people in their original family home needs to be clearly defined.
- The range of partners to be brought on board needs to be agreed at an early stage.
- The strategy needs to consider not just the provision of ECH but also the type and volume of services that will be required to sustain occupants within the community.
- The current and future housing aspirations, needs and lifestyle choices of the citizens of the local population need to be taken into account.

For some people the starting point may be greater clarity about what is commissioning and how is it distinct from contracting or procurement. The Audit Commission offers the following definition:

"Commissioning is the process of specifying, securing and monitoring services to meet people's needs at a strategic level. This applies to all services, whether they are provided by the local department or by the local authority, other public agencies or by the private or voluntary sectors." [26]

Moultrie (2006) outlines what a commissioning strategy is intended to achieve;

"A commissioning strategy then, is a very particular kind of statement. It is concerned primarily with effecting change in the overall configuration of services across a market to meet the needs of a whole population. It is also a plan specifically developed by commissioning agencies rather than providers, and is a statement of commitment about the way in which they intend to purchase services for the population in future. An effective strategy helps to establish the credibility of the commissioner as an honest and effective broker in achieving the optimum range of services to meet the needs of a particular

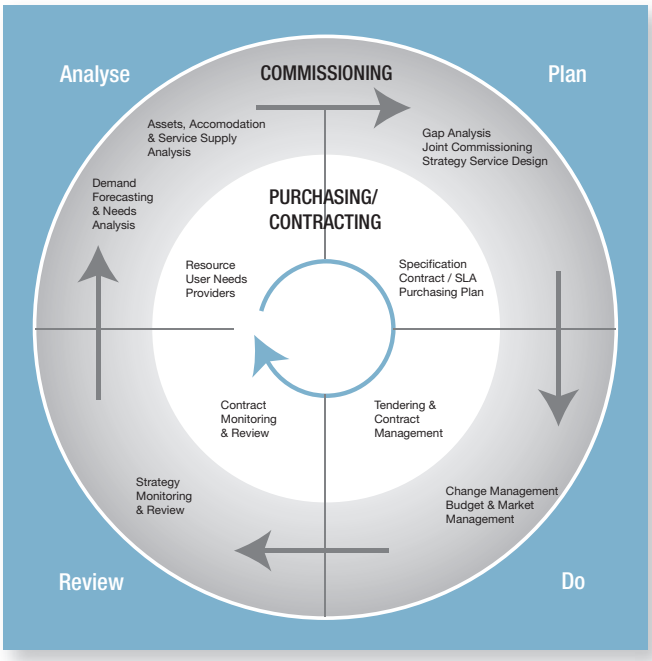
[25] Although this section refers to commissioners which may be across health, housing and social care, planning future accommodation requirements also means that providers need to consider where ECH fits into their current and future business plans
[26] Making Ends Meet. Audit Commission. (2003).
[27] Developing a Commissioning Strategy in Public Care. Better Commissioning LIN. Commissioning eBook. CSIP. Moultrie, K. (2006).

population." [27]

As the diagram below illustrates a commissioning strategy needs to embrace the following four activities:

- Analysis - of guidance/best practice, population needs, market and risks and establishing common service purpose between agencies.
- Planning - in the form of commissioning strategies for all client groups.
- Doing - through active market management or influencing.
- Reviewing - the success of the strategy in meeting the needs of the population.

Figure 5 IPC framework for joint commissioning and purchasing of public care services



In using the diagram to think about the range of activities involved in commissioning and contracting the following assumptions are also made:

- All four of the activities it outlines are equally important.
- The activities follow sequentially.
- The commissioning strategy must drive contracting.
- The contracting experience must inform the ongoing development of the commissioning strategy.

Several of the themes described in the diagram above are taken forward within this toolkit. In particular analyse and plan (understanding demand in chapter four and understanding supply in chapter five) doing (in terms of planning the management and delivery of schemes in chapter six) and reviewing (monitoring in chapter seven).

Best Practice Examples

There are a number of good examples of strategies that have been developed across England and Wales. All of which can be accessed through the Department of Health Housing LIN website.

North Tyneside Social Services: In 2005 they developed a joint strategy with partners in health and housing which considers the future pattern of housing, care and support services for everyone over the age of 50 years.

Derbyshire Council: They have developed a strategic plan specifically for extra care, which outlines their plans for delivering ECH across Derbyshire. It is a sub document of the Derbyshire Older Peoples Housing and Care Strategy.

In addition, there is a useful workbook on strategic commissioning and accompanying CD Rom, 'Strategic Moves: thinking, planning and delivering differently'. CSIP (2005)

Putting in place strong and effective partnerships

The development and delivery of extra care will require partnership arrangements across a range of agencies. The full range is often taken to mean health, social services and housing authorities. However, in planning and implementing extra care, discussions need to be had, and partnerships built, with other local authority departments such as planning, community leisure, transport and adult education as well as independent sector providers (both building and care providers), architects, voluntary agencies, current and potential users and their carers.

It is important that partnerships reflect the service provision that will be required to deliver the objectives for the scheme. Therefore, if some or all occupants are expected to have a medium or high level of health and/or care dependency needs it is important to make sure that this is reflected in different agencies 'sign up'. The capacity to deliver chiropody, continence, physio' and occupational therapy, dental and pharmacy services may be the decisive factor in whether, and how long, a person can remain in extra care. Therefore, the partnership may need health care to understand their centrality to, what may look, at first sight, like a housing or social care initiative, and for them to make long term commitments about, service availability.

This section offers help to commissioners on how to ensure strong and effective partnerships, and outlines the range of partners that will be key in part of the development of an extra care scheme, and the nature of their involvement.

The lead agency, in most instances will be the local authority, although within the authority it will be important to balance the housing and social care perspectives. The lead agency will be expected to identify, develop and coordinate partnership arrangements in order to facilitate the development of a local strategy. Specific responsibilities should include:

- Identifying what partnerships are required and how they might best be managed.
- Ensuring the involvement of key partners at the correct time. The involvement of individual agencies or groups will vary and some will need to play a less continuous role. However, this does not mean that their role in the development of schemes should be ignored. A template for a consultation and engagement plan can be found in the tools section of this chapter.
- Providing assistance to those partners who need support in order to participate, eg, some voluntary agencies may be valuable partners to any new developments but may not be able to resource attendance at a large number of planning meetings.
- Ensuring that all partners are signed up to common outcomes and objectives, have an agreed rationale as to why they are being pursued and a common understanding of their involvement in the process.
- Ensuring that partnerships continue post implementation of schemes to enable inter-agency monitoring of outcomes.

The table below is designed to illustrate which key partners may need to be involved in the development and implementation of extra care housing locally, and makes suggestions about the nature of the involvement that might be expected from each partner.

Table 4 Partnerships for Planning Extra Care

Partners	Role/Contribution
Providers and Housing Operators	
Housing Associations	• Joint working with LAs to develop strategic direction for ECH. • The provision of expertise and knowledge to LAs in the development of ECH. • Experience in responding to identified need in providing ECH, especially for those in the socially rented sector, but also for other forms of tenure. • To provide access to social housing grants and other forms of funding for ECH.
Independent Sector/Charities	• Ensuring engagement in the local ECH agenda. • Helping to inform the demand side agenda. • Responding to identified need in providing ECH and to ensure a choice of a wide range of accommodation options for older people.
Local Authorities, eg, Social Care and Housing Departments	• Ensuring utilisation of existing resources and stock to provide ECH.
Capital Financing	
Housing Association/ Commercial Lenders	• The provision of funding advice and financing of developments.
Housing Corporation (Local Representative)	• Ensuring that they are aware of local developments and future potential bids for HC funding. • The provision of guidance on financing, and bidding for funding.
Elected Members	• Ensuring that where the local authority is to be in total, or in part, a provider of ECH that suitable financial planning is put in place within the authority. This is particularly important in terms of transferred land values where ordinary sheltered housing is de-commissioned.
Health, Care and Supporting People Provision	
Social Care/PCTs, GP Commissioners, NHS Trusts, Strategic Health Authorities	• Planning that appropriate health, care and support services are available or can be commissioned. • Helping to inform and develop the ethos behind individual schemes. • Ensuring that ECH is seen as a core service in meeting the health and social care needs of the population.

Partners	Role/Contribution
Health, Care and Supporting People Provision	
Social Services/PCTs, GP Commissioners, NHS Trusts, Strategic Health Authorities *(continued)*	• Ensuring incorporation or integration of other services into the schemes where appropriate. [28]
Voluntary Sector Agencies/Independent Sector/Support Services	• Enabling providers to be part of the solution in the provision of services in ECH.
Commissioning	
Health, Social Care, and Housing Departments	• Developing strategic direction for ECH – and to ensure sign up by key stakeholders. • Ensuring/facilitating the development of a market which is sustainable and based on locally identified need. • Ensuring agencies are working in partnership.
Service Users and Carers/Older Peoples Forums etc	• The provision of ongoing input to help shape the development of the strategy and future services. • Ensuring the consideration of older people's needs and aspirations.
Elected Members	• Ensuring members are champions of ECH for the authority.
Development and Implementation [28]	
Planning (Local Authority and Regional)	• Assistance with identifying and designating possible sites for development. • Ensuring that plans submitted to the authority adhere to the LA's ethos of ECH, meet minimum standards, and respond to locally identified need. • Ensuring that key individuals are aware of impending applications. • Assist/guide key individuals through the planning process.
Local People	• The provision of input into the design and nature of the scheme. • Ensuring the support of the community in the development of the scheme.[29]
Service Users and Carers	• Shaping the nature of the scheme and services to be developed.[30]
Specialist Interest Groups	• Ensuring input from key groups to shape nature of scheme if developed for minority community. This may be BME groups, faith communities or groups with a specialist interest in older people, eg, co-housing movement.

[28] An example project plan for the implementation of an extra care housing scheme can be found in the tools section of this chapter.
[29] Brighton and Hove District Council brought together a local community and involved them in the planning of an extra care scheme which was being developed to replace an existing residential care home. Housing LIN. Case study no. 18. Community involvement in planning Extra Care in Brighton and Hove. (2005). CSIP.
[30] Housing LIN. Fact sheet no 8. User involvement in Extra Care. This paper sets out the role of users in the development and management of extra care schemes. (2004). CSIP.

Partners	Role/Contribution
Health, Care and Supporting People Provision	
Elected Members	• Ensuring elected members are 'brought on board' early in the development of thinking about ECH and the implications for other services and accommodation, eg, sheltered housing. • The prioritisation of the need for the development of ECH in the authority. • The provision of support to individual schemes being built in individual wards.
Media	• Promoting the development of ECH schemes. • The advertising of individual schemes. • The reporting of the success of schemes.
Architects/Surveyors/Development staff	• Ensuring that the concepts and ethos surrounding ECH are reflected in the design and build. • Providing architectural expertise in the design of schemes; both in creating environments that are sustainable, provide homes for life and address the specialist needs of older people. • The development of workable relationships with building contractors to ensure that the finished building mirrors original plans.

Best Practice Examples

South Gloucestershire: Developed its Joint Accommodation and Care for Older People Strategy in partnership with the Primary Care Trust and two housing associations, Housing 21 and Hanover. This was to ensure that the strategy reflected the whole needs of older people in terms of housing and social/health care as well as ensuring that the solutions were viable and deliverable by housing providers. The housing association partners were selected through a formal process that tested capacity, experience and commitment to development of a joint strategy. The partnership has ensured that those involved in developing homes for the future share a vision for maintaining independence in later life. The early involvement of the housing associations has also enabled a quick transition from developing the strategy to delivering the recommendations.

East Sussex: East Sussex has employed a partnership approach at both strategic and operational level in the development of ECH across the country. Housing LIN, case study no. 2, 'Extra Care Strategic Developments in East Sussex', CSIP (2003) outlines the key issues identified by the authority, and the challenges presented whilst working in partnership to plan and develop ECH locally.

Developing supportive planning arrangements

Mainstream housing and planning policy in England, both at national and regional level, makes limited reference to the housing needs of older people. Where they are mentioned it is in most instances in relation to broader concepts such as 'whole communities' or 'social inclusion' or linked to provision for affordable housing for disabled people. For example, the consultation document on Planning Policy: Statement three (ODPM, December 05) sets out proposed changes to planning

policy. These will mean that in drawing up development plans, regional and local planning bodies will need to take greater accountability of affordability and pressures within the local housing market. However, there is no direct reference to older people's specific housing needs in this statement and hence the potentiality that they get ignored within wider planning considerations. As a recent report by HOPDEV stated:

'the broader housing aspirations and needs of older people remain undiscovered and unheard – in contrast to those of younger adults, whose housing lifestyle are to be understood, encouraged and supported.'[31]

Limited understanding and lack of reference will often mean that older people's needs are not considered in Local Development frameworks or prioritised when planning applications or new housing developments are considered. If this situation continues then long term it may result in:

- The creation of built environments which do not meet the needs or aspirations of older people.
- A lack of good quality accessible housing which can adequately meet the needs of older people.
- The inability of individuals to remain at home.
- A greater demand on the local care economy; care homes and domiciliary care.

This section suggests that the successful long term development of a diverse range of accommodation approaches is dependent on:

- Planning policy and practice at a regional and local level adequately reflecting housing needs and accessibility standards such as lifetime home standards.[32]
- All planning decisions being set within the context of current and future demographics.
- Planners working in partnership with colleagues in health, housing and social care to achieve a planning approach that reflects current and future demand.

It is difficult to influence change at a national level but there are a number of activities that local authorities can do to address the problems outlined above and to help ensure that the needs and aspirations of older people are adequately reflected in planning policy. The table below outlines how planning practice can be improved and makes a number of suggestions as to how commissioners, planners and providers can achieve change.

Table 5 Bringing planning into the ECH strategic approach

Improved Planning Practice	Examples
Ensure integration of the ageing population into regional, and local planning policy	• Under the new planning system, regions will be expected to produce Statutory Regional Spatial Strategies. These will give detailed guidance on the future housing needs of the region and set out factors that must be considered before making a planning decision. All Regional Housing Strategies are expected to be completed and launched between 2007-08. LAs need to apply influence on regional bodies to ensure that older people are no longer seen as a minority group, but instead as a key population with specific needs in such strategies.

[31] Older Peoples Housing Strategies. Key policy drivers. HOPDEV. (2005).
[32] Major of London, London Development Plan: Spatial Development Strategy, February 2004.

Improved Planning Practice	Examples
Ensure integration of the ageing population into regional, and local planning policy (continued)	• LAs also need to ensure that the needs of older people are integrated into the Local Development framework, either through inclusion in the development plan, or through producing a Supplementary Planning Document (SPD).
Improve quality of demographic context and analysis when devising or reviewing planning policy documents	• Better consideration of local factors and data rather than just relying on national and regional figures including a better understanding of the local demographics and their potential impact on existing services in the future. • More detailed analysis of the age structure of the older people population in order to recognise the potentially different requirements of different cohorts within the broad age group of 65 plus. • Ensure that the data captured for housing needs surveys does not just look at the housing needs of vulnerable groups, but addresses the housing, care and support needs and aspirations of older people from all socio-economic groups. • Consider the development of a separate housing needs strategy for older people.
Using Supplementary Planning Documents, or control briefs or guidance to reflect the needs of the ageing population	• Supplementary Planning Documents have significant weight in a planning decision process. They take the form of more detailed guidance and are explicitly linked to the Local Development Framework. The development of a SPD locally is the most appropriate mechanism for building information, provision and guidance about the ageing population into the planning system.
Mainstream provision for an ageing population as recommended practice with regard to gender, ethnicity and disability	• Ensure that all planning policies and provision are assessed in terms of their suitability for older people, eg, sustainability appraisal.
Improve the role of planners and partnerships with housing, health and social care	• Planners need to be properly informed about the ageing population, and the implications of this trend. • There needs to be a close involvement of planners in the work around extra care and perhaps briefing sheets on extra care and older people's housing developed to act as a point of reference when required. • Planning involvement is particularly important in terms of monitoring trends in proposed developments by the independent and voluntary sectors that social care, housing and health may not be informed about. It is also important in terms of assessing the appropriateness of land and sites for ECH development.
Effective joint working between the public and independent sector in the development of older people's accommodation	• Development of pre planning guidance for independent sector developers which outlined the local authority's vision for ECH and older people's housing and minimum requirements would assist in ensuring that any potential developers had an understanding of expectations prior to application.

Best Practice Examples

The Joseph Rowntree Trust: Has published a document entitled, 'Continuing Care Retirement Villages: A guide to planning'. It offers information and advice on the main planning and development issues that may arise.[33]

HOPDEV: Have produced two useful documents:[34]

1) Older People's Housing Strategies: Key Policy Drivers, June 2006: This report explores aspects of the relationship between the housing agenda and the agenda for older age and looks at the ways in which gaps at the national level are affecting and influencing regional strategies and local policies and implementation.

2) Delivering Housing for an Ageing Population: Informing Housing Strategies and Housing Policies: Oct 2005: This report sets out key issues facing all those involved in planning housing supply and in planning for communities, for an ageing Britain over the next decade and beyond. It is intended for use by planners, commissioners and providers.

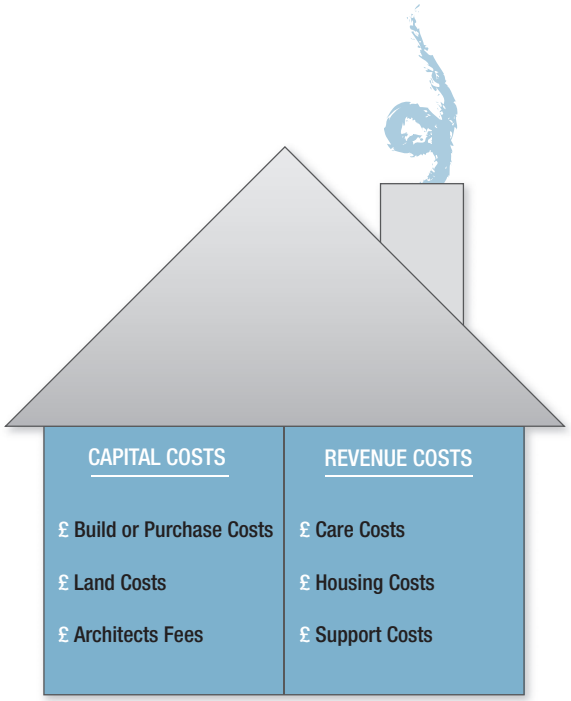
Gloucestershire County Council: Has undertaken an exercise to consider the housing needs of older people including vulnerable groups. It showed that trends in housing, aspirations and needs did not match existing housing options or assumed needs.

Coventry/Southampton City Council: Both these authorities have developed housing strategies specifically for older people. Coventry's focuses on older people with needs whilst Southampton's addresses the housing aspirations of all older people. Both strategies include detailed analysis of housing need, and incorporate implementation plans. More information on both strategies can be accessed through the Department of Health, Housing LIN website.

Funding Extra Care Housing

As with most developments the traditional divide in developing extra care is between capital and revenue costs. This chapter considers each of these areas in turn, outlining the main funding sources available and highlighting the potential issues or advantages associated with each. The diagram below outlines the main sources of expenditure that need to be considered in relation to any proposed scheme.

Figure 6 Distinguishing between Capital and Revenue Costs



[33] Continuing Care Retirement Villages. A quick guide to planning. Robin Telow. JRF. (2006).
[34] The housing and older people's development group, HOPDEV, was established by OPDM with DH to help government deliver on the strategic framework quality and choice for older peoples housing.

Capital Funding

The following outlines the main sources of capital funding that can be considered by commissioners as ways of ensuring the development of extra care housing schemes. The majority of local authorities will find that the range of funding options accessed will be just as broad as the range of models delivered locally.

Capital programme funded by commissioners in the Local Authority

Local authorities can invest their own capital from borrowing, capital receipts from sale of land and buildings, and commuted sums from planning agreements on affordable housing, including extra care. In some cases there may be an opportunity to secure the development of new extra care schemes as part of the negotiations for transferring the Council's housing stock to a Housing Association.

Capital programme funded by Housing Corporation Funding

The Housing Corporation is a non-departmental Government body, which funds and regulates Housing Associations. RSLs submit bids for the Social Housing Grant to the Housing Corporation Regional Offices in a competitive bidding round. The Corporation approves schemes that meet local housing needs at affordable rents and that offer good value for money in terms of the public subsidy required and the quality of homes delivered. Bids have to be endorsed by the local authority, and in line with the Regional Housing Body's strategic objectives. Additional funds can be secured through private borrowing, and bids are more likely to be successful in cases where the local authority has demonstrated its commitment by contributing funds. The Housing Corporation[35] also manages a reconfiguration pot of money which can be bid for to reconfigure or re-model existing sheltered housing schemes.

Capital programme funded in partnership

Developing a scheme through a funding partnership may take place between any combination of: Local Authorities, RSLs, charitable organisations and independent sector providers:

Partnership with an RSL

An RSL is a housing association or a not for profit company registered by the Housing Corporation to provide social housing. RSLs run as a business but do not trade for profit. To meet capital costs of a build they can raise private finance, access grants, or use receipts from sale of units. Since 1974 the Housing Corporation has been the major provider of capital finance for RSLs, using the Approved Development Programme (ADP). In seeking to fund the cost of a build RSLs will also look to other methods of financing, including capital contributions from partners in the local authority and PCT. The most common contribution from LAs is land at nil value or at marginal cost.

Partnership with an RSL and the independent sector

Partnerships between RSLs and the independent sector are becoming more common in mixed tenure extra care developments. It is possible that there may also be a growth in three way partnerships, particularly across capital and revenue costs.

Capital programme funded by independent developers

A number of extra care housing schemes have been funded solely by independent sector developers.[36] In such instances capital costs are met by the developer (often through borrowing) and are then recouped by the passing of costs on to private purchasers of extra care through the sale of property and the cost of care and support. It needs to be recognised that sole developments in this manner are potentially both costly and risky to developers in that the whole scheme will often need to be completed before there can be any return on investment unlike standard housing estate developments where houses are built as demand increases. Obviously, this risk is reflected in demand initially being satisfied at the higher cost end of the older persons' housing market. Schemes with lower purchase prices are more likely to require partnership arrangements where the

[35] The Housing Corporation Capital Funding Guide. (2004). Can be found on the Housing Corporation's website.

[36] Developers can come in a variety of guises from specialist independent sector housing providers with a long history of work with older people or people with a learning disability, through to care home providers who are diversifying, to local builders.

risks and costs are shared.

Where independent sector developers are building schemes that have an element of social rented accommodation or shared ownership they are eligible to apply to the Housing Corporation for Social Housing Grants for that element of housing.

Capital programme funded through Private Finance Initiative (PFI)

Typically, a PFI involves the Council entering into a long-term (25-30 years) service contract with an independent sector provider.[37] The Council defines the standards of extra care and the outcomes it wishes to achieve. It may retain certain powers of control, eg, retaining nomination rights over property to let or allocation and sale policies.

To ensure value for money, potential contractors compete for the work and raise the necessary funds. The Council pays for the service on an annual basis over the course of the contract, retaining ownership of the stock. Tenants remain secure tenants with all their usual rights. The Government helps meet the costs of the capital element of the contract by providing PFI credits. Projects will only be approved if the Council can demonstrate that it offers good value for money compared with direct investment, and that all stakeholders – including potential tenants or leaseholders – have contributed to the plans. Some authorities have been put off by expensive legal and contractual issues.

Best Practice Examples:

Tameside Resources and Community Services: Scrutiny Panel have produced a review of Private Finance Initiatives and Public Private Partnerships (also available through the IDeA knowledge website). They recommend the formation of strategic partnerships, subject to proper safeguards, to ensure that staff pension rights and terms and conditions are protected and maintained. The Council found that a partnership with the independent sector can provide investment and also commercial expertise to help councils improve and extend local services. They acknowledge that complex contract issues are involved in the development of strategic partnerships, and suggest the setting up of a team of people with the necessary expertise and experience to deal with these issues. The Panel noted that expert advice, though expensive, was crucial throughout the contracting process to close the gap in council officers' skills, and appreciated that the successful conclusion of this process in order to protect the council's interests could be lengthy and time consuming.

Kent County Council and its partners, the Primary Care Trusts, will provide specialist residential, recuperative and rehabilitative care to people at two new Social and Health Care Centres in Tenterden and Margate. A consortium called Integrated Care Solutions, led by the company Costain, has been selected to design, build, finance and operate the centres, which are designed to help older people in the transition between leaving hospital and returning home. Information is available from Kent County Council's website.

Department of Health Funding Bids

In 2003 the Department of Health announced £87 million for the development of extra care by 2006. They have since made available, via a further funding round, another £60 million by 2008. Funds are allocated according to bids which meet established criteria, and applications are open to local authorities in partnership with PCTs, and private and independent sector developers. It is possible to combine DH funding with Housing Corporation social grant and/or other funding streams to fund the development of an ECH scheme.

[37] The Easy Guide to Delivering Decent Homes. Housemark. It has a useful section on PFIs. This document can be found at the IDeA website. Harries, I. (2002).

Additional Sources of Capital Funding

Charitable funding

A few of the major village developments have attracted significant charitable funding either from established charities already involved in provision for older people, or from individual wealthy benefactors. Lottery funding occasionally contributes to the build costs of individual schemes.

Section 106

If older people's housing is recognised as a need within the local authority strategic development framework, then ECH can be incorporated as part of Local Authorities Section 106 requirements[38] from private developers on any large new housing development. These agreements require the developer to make available a proportion of a site or dwellings for affordable housing as a condition of planning. Agreements reached may either be in the form of a scheme built by the developer and then handed over to a provider to run, a handover of land at subsidised or nil cost to a specialist provider, the local authority to build a scheme, or a monetary contribution which can be put towards future developments. As the Joseph Rowntree Trust reported, there is not always understanding across local authorities as to how Section 106 agreements work.

"The affordable housing policy has been in place for more than a decade and, although it is continually evolving, there are still problems with the clarity of the policy framework. Many authorities are still unsure about the extent of their powers, including the ability to set site thresholds and targets and to demand specific tenures." [39]

At the time of writing, the Housing LIN and the Royal Town Planning Institute are developing planning notes to help inform the potential development of local authority Supplementary Planning Guidance.

Primary Care Trusts

PCTs, in principle, could enter into partnership with a provider of a scheme, and could fund health related facilities such as consultation/treatment room, intermediate care facility, a GP surgery or Minor Injury Unit.

Insurance Model

An approach where occupants pay into a separate fund through an annual fee. Care is then available at no additional cost as and when required.

Co-housing

Co-housing being a new approach offers few funding models yet. Some of the funding mechanism that has been used in the Dutch and Danish context are not available in England and this seems to have hampered the few schemes that have been attempted. However, in the long term it would be expected that properties may be purchased via a normal lease or freehold although in bigger schemes more collective arrangements may be made with the local authority if care is required.

[38] Section 106. Town and Country Planning Act 1990.
[39] Research Findings. Planning Gain and affordable Housing. Ref 042. Joseph Rowntree Trust. (2002).

Best Practice Examples

Cole Street Farm, Dorset: an example of a co-housing development.

A Limited Company was set up to purchase this property. Most of the finance was structured as loans from the prospective residents. Loan facilities were also available from the Co-operative Bank to top this up as necessary. Once planning permission is received and conversion work completed, the company will sell long leases on residential units, repaying the loans, and will retain ownership of the shared facilities. The company will be controlled by the residents. There are already group agreements both for the purchase/development and the residency phases. Owners of individual units will be free to sell their dwelling. However, it will also be essential that purchasers are acceptable to the rest of the group and accept the group's shared values and commitments.

Hartrigg Oaks in York (Joseph Rowntree Housing Trust) is financed through an insurance based model. Residents pay into a communal financial pool through an annual fee and the care and support services are then financed from this pool. Through using this approach, residents can be offered the option of paying an annual fee that will not increase according to their use of care services. This model does depend on most of Hartrigg Oaks' residents not being extensive users of its care and support services. However, this does mean the scheme needs to be seen as an attractive housing option for older people who may live there independently for many years.

Extra Care Charitable Trust: St Crispins Retirement Village consists of 258 flats and 12 bungalows that have been created in a partnership between the Extra Care Charitable Trust and the Midland Heart Housing Association. Half of the properties at St Crispin are rented to tenants who are nominated for social housing by their local authority. The remainder are either owner-occupied, with prices starting at £129,950, or sold under an equity scheme whereby residents own between 25% to 75% of the property and pay rent on the rest. Residents are guaranteed the original purchase price of their property if they decide to leave, or the money goes to their estate if they die. When a property becomes empty, it is sold at the market value, with any profit being reinvested in the village. As part of the deal, residents are promised that they will never have to sell their home to meet their care needs.

Revenue Funding

This section outlines the ongoing revenue costs that will need to be considered prior to development of a scheme. The key to ensuring a viable scheme is making sure there are identifiable revenue streams available to meet the costs of providing the housing related support and care services. In general, ongoing revenue funding is required for:

- Care Costs (including start up).
- Housing and Support Costs (including provision of meals).

Care Costs

In the social housing sector it is usual for social services to pay for the provision of domiciliary care with service users being means tested. Self funders would be responsible for the costs of their care.[40]

The Housing LIN, technical brief no 1, Care in Extra Care Housing, looks at various aspects of this provision in detail, including types of contracts, direct payments and individual budgets, charging for care etc. The PCT would need to meet the costs of specialist health care provision offered 'on site' and may be involved in revenue funding for any units that are used for intermediate care.

[40] For further information on how to implement a charging policy in a fair and consistent way for ECH tenants, see Housing LIN case study 16. (2005). CSIP

Housing costs (including rent and service charges, meals and maintenance and repairs)

Housing benefit will cover the rent for those eligible and some services. If not, residents themselves will be responsible for rent, accommodation service, and support charges. Supporting People may cover some of the housing support service costs, eg, alarm service, or scheme manager. Attendance allowance and disability premiums will also help cover the cost of domestic assistance for those eligible. If a meal is provided as part of the tenancy agreement and of reasonable costs, it can in most instances be covered by Housing Benefit. The responsibility of maintaining the properties will usually fall to the landlord who will cover such costs, normally through the accommodation service charge.

Cost Effectiveness of Extra Care

The cost effectiveness of extra care in relation to residential care or care in the home is perhaps one of the most frequently asked questions of local authorities considering extra care developments. It is a complex calculation not just due to local variations in costs and charges, but because of the implications of financial resources available to individuals, differences in calculating unit costs and the impact of differing environments on carers continuing to be able to offer care. No costing models take into account the more intangible gains such as the quality of life offered and the potential long term impact that may have on demand for other forms of care provision. Oldman provides a useful critique of cost models and highlights that:

'One of the shortcomings of some costing models has been to calculate cost transfers rather than economic costs. For example, Housing benefit may be paying the bricks and mortar element of extra care, and social services paying for the care, whereas in residential care, social services will be paying the total costs of the placement.' [41]

It is important to recognise that although extra care eases pressure on already strained social services budgets, transfer of costs does not equate to cost saving overall. The preferred model of calculating the cost effectiveness of extra care is that adopted by the Royal Commission on Long Term Care for the Elderly (1998). It concludes that:

'For a given level of need, the costs of care in very sheltered housing are less than they are in ordinary housing.'

Despite the absence of effective costing comparisons what does appear to be evident is that for those older people living in extra care with a low income, they are left with considerable more personal allowance after meeting housing and care costs. This is evidenced by a recent Joseph Rowntree study,[42] which compared the financial circumstances of people who were similar in terms of their care needs but some of whom lived in residential care and some in very sheltered housing (extra care). It found that disposable income, (after accommodation, living, care and support costs had been paid for) was higher for the very sheltered housing tenants and that for social services it can be a very favourable cost option due to economies of scale and the role of housing benefit.

Overall, it is self-evident that cost effectiveness can be greatly improved, by careful financial modelling at the outset of a development which can ensure that a scheme consists of the right number of units, mix of tenures, and facilities to make it economically viable. Detailed guidance on the modelling of a scheme's economic viability can be accessed through Housing LIN's Technical brief no. 2, 'Funding Extra Care'. It also provides a further overview of the principle ways that extra care housing developments are financed, and reviews sources of capital and revenue funding.

[41] Blurring the Boundaries. A fresh look at housing and care provision for older people. Oldman, C. (2000).
[42] Is enhanced sheltered housing an effective replacement for residential care for older people? JRF. (2002).

CHAPTER THREE
TOOLS

This chapter includes tools and guidance on:

1 Layout and Content of an Accommodation Commissioning Strategy
2 A Checklist for the Accommodation Strategy Planning Exercise
3 An Example of a Stakeholder Engagement and Involvement Plan
4 An Example of an Extra Care Housing Implementation Plan

Layout and Content of an Accommodation Commissioning Strategy

Purpose of Tool

The intention of this tool is to provide commissioners with an example template for an Accommodation Commissioning Strategy, and to clearly set out the key stages and processes involved, and provide detail about proposed content.

Summary

This section should give a summary of the overall strategy and the agreed approach over the given time period, including the investment/disinvestment to be made over that period. This can be produced as a separate, short document, or as an 'executive summary' at the front of the strategy.

Introduction

The introduction states the purpose of the strategy and shared values and vision. It provides a brief picture of the range of accommodation and services under consideration and identifies the priorities and the outcomes that the strategy is trying to achieve. It may also contain a definition of commissioning. Often, there will be a brief description of how the strategy was developed, ie, the process or methodology undertaken and the partners who have agreed its content.

Legislation, National and Local Guidance

This section should bring together requirements that are either advised or mandatory on the organisations developing the strategy together with statements about organisational goals and values where they have a bearing on the strategy's development.

Demand Forecasting

This section should contain the analysis from a broad based review of demographics, research, surveys (both national and local) of relevant populations, surveys of user, carer and patient needs and the key aspects of conditional demand to be addressed, ie, known unresolved needs of the population. It should conclude by identifying the target audiences for each type of accommodation provision and the needs this will fulfil.

Supply Analysis

This section has a number of components, which build to present a picture of existing services and their use as well as a wider picture of the market and an assessment of current gaps in service availability or performance.

- **A map of accommodation** – Where is specialist accommodation currently located, what is its value and state of repair? With regard to sheltered housing and care homes it should estimate its future fitness for purpose in terms of future suitability as ECH provision, as its capacity to meet regulatory requirements in the case of care homes and in terms of current and likely future demand.

- **A map of relevant services** – including the full range of services being provided, showing where services relevant to extra care are located and the organisation providing them.

- **Service quantity** – is there known under or over supply of services? This section may include information on referral and assessment mechanisms, take-up of services, occupancy/vacancy levels, effectiveness/outcomes of services and waiting times.

- **Service performance** – whether services are meeting needs fully or partially. To be gained from; inspection reports, performance indicators, service user and carer views relating to the relevance and quality of care through the analysis of complaints and information derived from user/carer forums and feedback from the contract monitoring process.

- **Contracting** – the contractual arrangement in place and any strengths/ weaknesses in these arrangements.

- **Finance and funding** – a picture of the financial resources available now and potentially over the period of the strategy. Some strategies include a survey of costs and charges and show comparisons with neighbouring or equivalent authorities.

- **The market** – what are the current and future trends in provision? The analysis could also include an assessment of land or house prices and their impact on the market, as well as an assessment of the robustness and capacity of the independent and voluntary sector. This section may include known plans of service providers and any local consultation that has taken place.

Gap Analysis and the Design of Future Provision

This section is the hub of the strategy. It brings the demand and supply material together, analyses obvious shortfalls in provision now and in the future and how such gaps may be met, together with a view of the resources required. It should then spell out the shape of future services and the strategic priorities necessary to achieve them within the timeframe of the strategy and appraises the options available, including risks.

Proposals for the future content and configuration of resources should be seen to emerge from the information and analyses of the preceding sections. Therefore, the evidenced route, by which shifts in provision will be made, must identify the rationale for year-on-year priorities for change. This may include identifying service or accommodation provision which will continue, any new accommodation or services from new money, decommissioning services and major or small incremental shifts in provision as well as shifts in the balance of internal and external provision. It should state the preferred contracting options for future commissioning and conclude with clear statements as to the way forward, including objectives and funding.

Monitoring arrangements

This section has two purposes:

- To make clear how the strategy will be monitored in the future to determine whether the strategy is shaping services in the way intended.
- To guide the development of monitoring of accommodation provision and services in the future.

In terms of the latter, it may be appropriate to include an assessment of the effectiveness of current monitoring and performance management arrangements, if changes to the systems are necessary. It is important to recognise that monitoring and the collection and analysis of data has a cost consequence for both commissioners and providers and this should be carefully considered in designing new systems.

An Action Plan

- A brief, snappy, review of the agreed next steps and whose responsibility it is to take these forward.
- A statement which identifies who is responsible for taking forward which elements of the strategy, in the medium and longer term.

Appendices

These may include:

- The full demand and supply analysis.
- Results of consultation exercises.
- Overview of relevant housing, social care and health guidance.
- A glossary of terms used in the strategy.

A Checklist for the Accommodation Strategy Planning Exercise

Purpose of Tool

The purpose of this tool is to provide commissioners with a checklist to complete before commencing the development of the commissioning strategy. Completion of the template, by the lead agency, together with partners will assist in both bringing clarity to the process through establishing its scope and boundaries, and also in giving structure by clearly setting out roles and responsibilities.

Boundaries
1) Whose strategy is it, and what type of document will it be, eg, a short statement of strategic intent or a detailed analysis and plan?
2) Who is (are) the audience(s) for the written strategy?
3) What are the boundaries of the population or definition to be used, eg, geographical area, age range?
4) What is the timeframe for the strategy, eg, 10 years?
5) What existing partnerships or forums are there for multi-agency planning/commissioning?
6) Which partners are to be involved in developing the strategy?
Logistics
7) When does the strategy need to be completed by?
8) Who will lead the development of the strategy?
9) Who will gather the data?
10) Who will steer and advise?

Logistics
11) Who will write the strategy?
12) Who will need to agree the strategy?
Developing the content
13) What research/best practice and guidance/legislation do you know about, and where might further sources be found?
14) What population/demographic data is currently available and/or what arrangements need to be put in place to produce a demand analysis?
15) What relevant and recent consultations or feedback exist?
16) What existing service mapping data is available and/or what arrangements need put in place to produce an analysis of the level and costs of the existing service provision?
17) How will major gaps in service provision, quality and potential improvements with providers, service users and other stakeholders, be identified tested and reviewed?

An Example of a Stakeholder Engagement and Involvement Plan

Purpose of the Tool

The following template is offered as an example to local authorities as a method for managing the process of engagement and involvement required both in the development of an Extra Care Housing Strategy, and in the implementation of individual schemes. The template is designed so that completion will provide local authorities and all stakeholders with:

- A clear understanding of the purpose and nature of the strategy.
- Common objectives.
- A clear understanding of stakeholder's roles and responsibility in the process and why their involvement is required.
- A document which can be shared and used to manage the process of engagement and involvement throughout.

To assist with completion, examples are provided throughout. Local authorities may find it necessary to have an overall engagement and involvement strategy, and then make reference to further documents which consider individual projects/tasks in more detail. Local authorities or providers may find, for example, that in the case of the development of individual schemes, a more detailed implementation plan would be appropriate which may specifically identify stages and tasks in detail, and then identify who will undertake them and at what time. Suffolk County Council have produced such a template, which is available for use by others and follows the stakeholder and engagement plan.

BORCHESTER

EXTRA CARE HOUSING STRATEGY

Stakeholder Engagement and Involvement Plan

Activity	Example
Name of the change programme:	Borchestershire Extra Care Housing Strategy
1. Nature of the change:	The overall goals of the strategy. How the change will be positioned in relation to existing strategies/plans. How will it contribute to achieving goals set out in wider strategies plans etc?
2. Purpose and Objectives of the Stakeholder Plan	**Purpose** For example: • To consider how stakeholders will be involved in the development of the strategic nature of extra care. • To think through how stakeholders are going to be informed and involved in the design and development of extra care. • To facilitate the change management process and to mitigate against the risk of stakeholders not engaging in or being committed to the changes.

Activity	Example
2. Purpose and Objectives of the Stakeholder Plan (continued)	It is not a plan for consulting stakeholders about whether the changes should or should not take place. The business case for change has been accepted and the plan is about providing detailed design to the development of schemes locally. Stakeholders are being engaged to inform them of the changes and to seek their involvement in working with the project to shape and deliver the best solution to meet the needs of the people of Borchestershire. This strategy/plan is targeted at the following stakeholders: • Housing and Care Providers. • Patients/Service Users and Carers. • Commissioning Partners. **Objectives** For example the objectives of the plan are: • To achieve a shared understanding of what we are doing. • To explain why we are taking this action. • To maximise the opportunity for feedback and input into the project. • To work with stakeholders, in particular service providers and service users, to understand the demand for extra care locally. • To develop partnerships with providers to facilitate the implementation of extra care housing. • To ensure all stakeholders know what is happening, when it will happen and how it will affect them. In addition we will: • Address the needs of individual stakeholders in both 'what' and 'how'? • Use existing channels of communication and tried and tested methods that work. • Communicate even when we don't know the answers.
3. Core Messages	**Fundamental messages that will be communicated to all audiences: (Examples outlined below)** • Case and urgency for change. • Nature of change – what it may look like. • Role of all providers in whole systems approach to provider accommodation and care for older people. • Scope, objectives and implications of project. • Terminology – jargon busting. • Opportunity for feedback and input. • Individual accountability for project delivery.

Activity	Example
3. Core Messages (continued)	• Any boundaries and/or restrictions, eg, what cannot be changed and why – what is not up for grabs. • Project timeline: When? How? • "What's in it for me?"
4. Boundaries and Restrictions	**What cannot be influenced: (examples below)** • The goals of the project. • The administering authority's statutory responsibilities to contract with providers and partner organisations. • The administering authority's statutory responsibilities to achieve value for money and review all services. **What stakeholders can influence/contribute to:** • The principles upon which a model will be based in order to improve services for users, ie, using their experience and feedback. • Practicalities of how the model can be delivered so that it works effectively in practice. • The design of a new model for Borchestershire.
5. Audiences	**The main groups of people we need to engage with:** **Internal to organisation** — For Example: Planning Department; Elected Members; Housing Department; Supporting People's Team **External to organisation** — For Example: Independent Providers; Architects; Domiciliary Care Providers

An Example of an Extra Care Housing Implementation Plan (courtesy of Suffolk County Council and the Housing LIN)

Purpose of Tool:

The purpose of this tool is to provide an example of a comprehensive implementation template for an extra care scheme, which can either be used as provided or adapted to reflect local circumstances.

Suffolk County Council

Extra Care Housing Scheme

Detailed Implementation Housing Checklist

PARTNERS

Housing Purchaser

Housing Provider

Care Purchaser

Care Provider

Other

SCHEME INFORMATION

Scheme Name

Client Group

Type of Property

New Build	❑
Rehab	❑
No. of Tenants	❑
Access Standard	❑

Address

Telephone Number

Fax Number

E mail Address

FUNDING ARRANGEMENTS

CAPITAL _____ SOURCE

AMOUNT £_____

Total Scheme Cost

Land/Property Purchase Cost

Build Cost

Development Cost

Furniture and Equipment Cost

Time Limitations on Funding?

Other

REVENUE

Housing Benefit (HB)

Income Support (Residential Care Allowance)

Supported Housing Management Grant (SHMG)

Social Services

Health

Unit Cost Per Person Per Week

Other

LEGALS	DRAFT	COMPLETED
TENANCY AGREEMENT (To be agreed by Project Team, produced by Tenant Rep and Housing Provider)	❑	❑
MANAGEMENT AGREEMENT (To be agreed by Project Team, produced by Housing Provider and Care Provider)	❑	❑
SERVICE LEVEL AGREEMENT (To be agreed by Project Team, produced by Care Purchaser and Care Provider)	❑	❑
OPERATIONAL POLICY (Produced and agreed by Project Team)	❑	❑
ALLOCATIONS POLICY (Standard document customised to scheme)	❑	❑
Timescales		

PROJECT TEAM INFORMATION (Names, Addresses, Telephone, Mobile, Fax Numbers, E-Mail Addresses)

List of:

<u>Key Stakeholders</u>

Housing Purchaser

(LA/HA)

Housing Provider

Care Purchaser/s

Care Provider

<u>Technical</u>

Architect

Quantity Surveyors

Structural Engineers

Mechanical & Electrical Engineers

Building Contractor

<u>Management</u>

Site

Tenant Representatives

Carers/Advocates

Operational Manager/Representative

Housing Provider/Management Representative

Community Health

Occupational Therapist

Interpreters

Other

Copies:

Service Manager

Housing Association Regional/Divisional Office

Care Provider Regional/Divisional Office

<u>Outline Programme</u>

Land/property purchase date:	
Completion date:	
Letting date:	

Action Plan Development Process		Lead Responsibility
1	ESTABLISHING NEED Identification of need in three year programme Agreement of Priorities Select Housing Association Bid to Housing Corporation Funding Agreed	
2	PROJECT TEAM Project Team Convened Agree Location Agree Care Provider Care Provider Seeks Accreditation (where necessary) Agree Architect/QS/Other Specialists	
3	BRIEFING Project Brief/Preliminary Specification/Outline Brief Outline Proposals Scheme Design Draft Costings Consult Planners Adjustments Update Costing Check Room Layouts Design Frozen	
4	PLANNING Planning Application Contact Members Consult with Neighbours Detail Specification	
5	DETAIL DESIGN & TENDERING Design and Build or Traditional route Agree specification/detailed design of kitchens, bathrooms, etc Agree electrical design	

Action Plan Development Process		Lead Responsibility
	Agree landscaping design Agree Building Regulation Application Prepare Tender Documentation Tender Process Selection of Contractor	
6	BUILDING Dates for Project Team meetings to monitor progress Inspection of building operation throughout build programme Arrange sod turning outlining ceremony Agreement on circulation of site meeting notes Dates for site visits Request timetables for finishes including all client choice items Arrange opening ceremony Arrange commissioning of building/staff induction, heating systems, etc Construction works checked Building Completed Building handed over to client	
7	CARE MANAGEMENT Invite nominations of prospective Tenants Begin detailed assessment of Nominees needs Create long list of nominees Work with Families and Carers Further assessment and compatibility Create short list and select Work with Tenants on their choices Select colours for floor and wall coverings, kitchen units, tiles, Sanitary ware. Select and order furniture and equipment Agree Care Specification Agree QA and monitoring arrangements for care Agree scheme reviews Decide detail of aids required Tenants move in 3, 6 and 12 months reviews	

Action Plan Development Process		Lead Responsibility
8	OTHER MANAGEMENT ACTIVITIES	
	Production of newsletters & information leaflets	
	Agree draft specification for Service	
	Agree rents and service charges	
	Agree draft budgets and start up costs	
	Operational Policy for scheme	
	Agree job descriptions	
	Start staff recruitment	
	Agree Legals	

CHAPTER FOUR

UNDERTAKING A NEEDS ANALYSIS AND FORECASTING THE DEMAND FOR EXTRA CARE HOUSING

CHAPTER FOUR: UNDERTAKING A NEEDS ANALYSIS AND FORECASTING THE DEMAND FOR EXTRA CARE HOUSING

Introduction

The rational planning of future provision based on identified needs by local authorities has not always had a distinguished history. Reasons suggested for this include:

- Demand is unpredictable and contains too many variables to accurately calculate.
- Planning in the past has tended to only take account of provision that the local authority provides rather than the range of provision a local authority area might need.
- Future planning is seen as a commitment to delivery and only fuels demand from both providers and those who use services.
- There is little need to plan as central government finance, legislation and guidance prescribes what services can be provided.

Nonetheless, given demographic changes, both in terms of the growth in the older persons population and in terms of increased longevity of people with a learning disability,[43] then the need to plan ahead becomes increasingly important.

Table 6 Projected population by age 2006-2031 in 000s[44]

	2006	2011	2016	2021	2026	2031
60-74	8,298	9,307	9,864	10,448	11,038	11,779
75 and over	4,656	4,938	5,385	6,129	7,180	7,795

This chapter proposes a structured process to try and estimate future demand and hence demonstrate need for and positioning of, extra care housing provision across the state, voluntary and independent sectors.

Undertaking the needs and demand analysis

The process described below attempts to show what data may be collected and analysed in order to define possible populations for extra care. Ideally, the output from these activities should help commissioners to divide the population into three groups:

Potential populations. The overall potential population for extra care housing. This is based on the existence of a set of pre-disposing characteristics that may be derived from national census data together with information about prevalence rates within the population and supplemented by both national and local research. Given that any older person may decide that extra care accommodation is where they would like to live, regardless of their current needs, then this is obviously a fairly inexact science. Nonetheless, it is still valuable to have some benchmark of overall potential demand particularly in terms of helping to geographically position where accommodation may be most needed.

Vulnerable or target populations. Sub-populations within the potential population may have specific needs or demands, eg, an older person caring for another person of similar age in poor housing circumstances, where it is clear that ECH would considerably improve their quality of life now or in the future. Targeting such populations would only be appropriate on the basis that offering specialist accommodation and services now would prevent a poorer outcome in the near future.

[43] See Demand for Residential Provision for People with Learning Disabilities by Parrott, Emerson, Hatton & Wolstenholme, Hester Adrian Research Centre, 1997 for a more detailed estimate

[44] Population Trends 12. Government Actuarial Department. (2006).

Known populations. Analysing data about current service users and sheltered housing tenants in order to identify those who may be better served by ECH provision. For example:

a Those moving on from sheltered housing because needs are too great to be met within current surroundings.

b Those who move on from retirement housing because accommodation does not meet home for life standard.

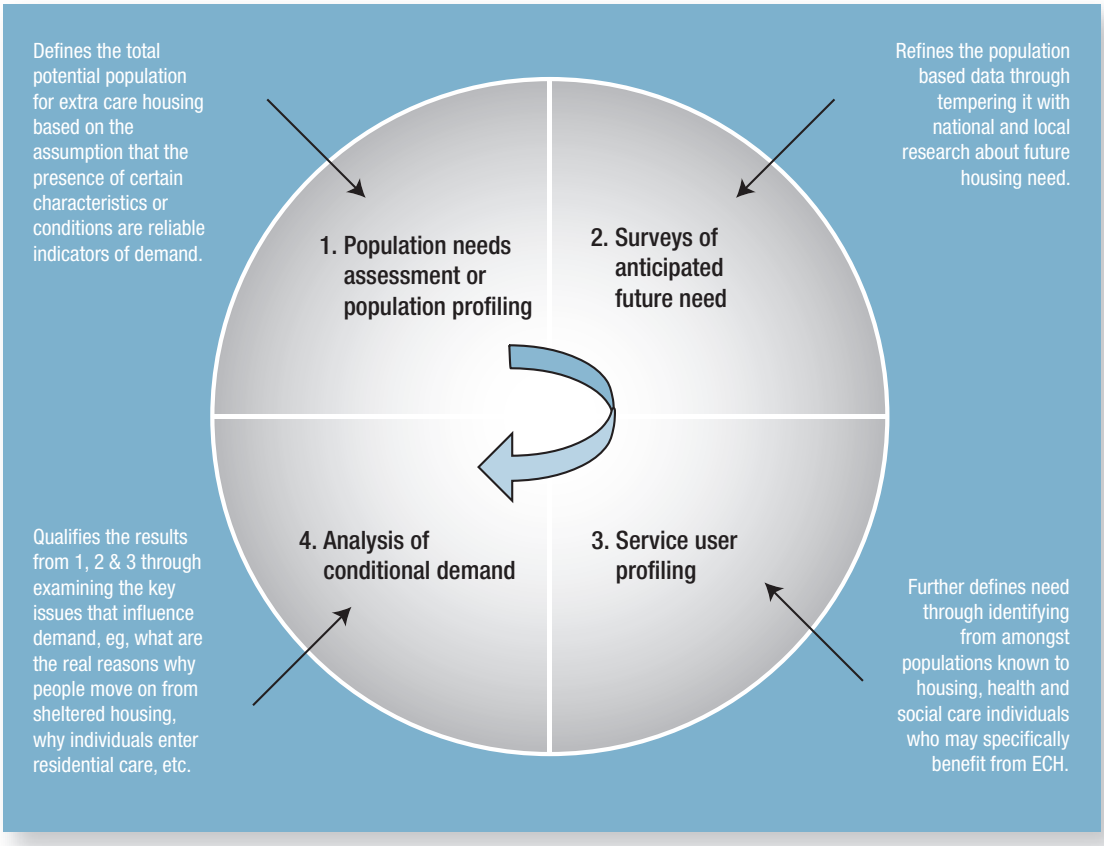
c Independent funders in care homes whose ability to fund may be coming to an end or who want to invest personal equity in a form of accommodation.

d Those in care homes funded by local authorities who could have improved quality of life within an extra care scheme.

e Those who are 'frequent flyers' in admissions or readmissions into hospital or out-of-hours home care services.

Figure 7, plus the subsequent table, identifies what information should be reviewed and the process by which it can be analysed in order to discover the three populations described above.

Figure 7 Forecasting Demand for Extra Care Housing



Examples	Purpose	Issues
Population needs assessment or population profiling		
Broad based population characteristics now and in the future, eg, defined by age, gender, locality, tenure and ethnicity. Prevalence of particular populations, eg, older carers of older people, older people in poor housing conditions, older people with a long term condition etc. Incidence of particular populations, eg, numbers of people predicted to have dementia over the next five, ten and fifteen years. Changes to a community's demographic profile, eg, a local area may currently have few older people from BME populations. This may change substantially over the next ten to fifteen years.	This type of population needs assessment provides a broad backdrop of demographic characteristics against which other data can be set. At its best it is useful where it illustrates: • Where older people live, in what kinds of accommodation and provided by whom. • The prevalence of a condition which may now or in the future predict a potential demand for ECH. • Changing patterns of prevalence within a known population eg, adults with a learning disability living longer and being subject to early onset of certain old age conditions, such as dementia. • What is the local mix of housing tenure among older people, and what proportion of older people are owner-occupiers? How do local house prices compare with the price of an extra care unit?	As the 'Purpose' suggests population data generally provides context rather than answers. Used on its own as the sole means of demand forecasting it tends to steer LAs towards measuring the prevalence of poverty and/or the incidence of conditions amongst given populations. It does not necessarily tell organisations who may or may not come through their front door. Some LAs find it hard to deliver this information as it requires some specialist skill to accurately extract material from the census data. Some authorities interpret the data incorrectly, eg, not always understanding the difference between prevalence and incidence. In terms of older people there is a wide variation in interpreting when old age starts. From a social care perspective there is little point in considering under 70's as they are unlikely to possess characteristics that would be indicative of likely service demand. Population based data may be analysed and understood in different ways between agencies which may make it difficult to make comparisons. Public Health bodies may have some population based data that can help further analyse cross over between health, housing and social care.
Surveys of anticipated future need		
General estimates of future demand, eg, Housing Needs Surveys.	The intention is to predict the kinds of accommodation and services people may want or need in the future through understanding from groups of actual, and pre, old age populations their expectations for the future.	In predicting future demand it is likely that the best results may be obtained either from people entering old age or those who have cared for an older person. Fifty year olds are not always capable of perceiving what life may be like for them in twenty years time. It is equally difficult to anticipate future demand for extra care housing if people do not understand what it means.

Examples	Purpose	Issues
Surveys of anticipated future need		
MORI polls and similar surveys that explore attitudes towards health and social care. Specific research, either local or national, which looks at older people's attitude to housing now and in the future. Monitoring take up of independent sector housing developments. Independent or voluntary sector market surveys at either a national or local level.	National research may be built on locally by devising complementary questionnaires, focus groups or interviews. Whilst it may be difficult for people to envisage particular forms of housing that are yet to exist it is possible to talk to people about what they think their requirements might be and what experience this is based upon. The approach is designed to build a picture of what options in the future people may or may not find acceptable and to identify the range of choices people might wish to exercise.	Those planning future provision may at least consider what forms of accommodation they would find acceptable for them or their relatives, eg, when social care managers are asked, 'who has seen the care home they would like to live in? Few people respond positively. Many surveys tend to concentrate on assessing future demand for particular services rather than genuinely measuring potential need or on people's incapacities rather than their abilities. The problem with this approach is that it tends to 'cut to the chase' of service provision too quickly rather than really understanding need. Often potential service users will interpret the question as being about whether they do or do not want a service even if it is framed in terms of needs and abilities. One approach to looking at future need is to conduct focus groups using a range of scenarios for old age and look at what resources people would wish to use to tackle those issues and problems and what choices they might wish to exercise. Incidence of particular conditions within such scenarios can be based on the prevalence data from section 1. Done well, the kinds of surveys and research suggested here is both expensive and time consuming, yet despite this authorities often replicate existing work with their own studies, justifying such actions on the basis of 'local factors'. There may be scope to combine LA surveys with those of the independent or voluntary sectors.
Service user profiling		
Local reporting of tenant, service user and carer data.	To understand: • What is known about the relationship between current	There are a plethora of reasons why tenant and service user consultation tends not to be well conducted and data is poorly analysed:

Examples	Purpose	Issues
Service user profiling		
PAF and RAP data. Specialist client and patient surveys in health and social care. Surveys of users and carers for joint review. Admission and exit data for sheltered housing and care homes. Occupancy rates of existing ordinary sheltered housing.	demand and the provision of accommodation and services? • What do people expect when they ask for a service or move into specialist accommodation and are these expectations met? • What happens when accommodation or service supply is restricted or when services are not delivered or are delayed, eg, aids and adaptations? • Where did people live before taking up sheltered housing tenancies and where do they move onto?	• No real history in social care or housing of examining or monitoring the actual impact of services as compared to the anticipated impact. • Data not captured in a way that lends itself to analysis, eg, most SSDs cannot tell you which of their clients have dementia or have had a stroke. Housing bodies may not know why people leave sheltered housing. • A tendency to drag out the 'usual suspects' in terms of organisations and individuals when it comes to consultations. • Not much history of genuine participative consultation 'people get services which they should be grateful for.' This is in contrast say, to the independent sector where leaseholders in properties may be much more vociferous about their accommodation expectations. • Users and carers are often aware of what services are around and consequently tailor their responses to what they suspect may be available rather than what they really need. • People are anxious that if they are critical of service provision it may influence the way in which that service is delivered to them or limit its availability. • When older people suffer falls or strokes they may limit their own expectations of making a full recovery and consequently lower their perceptions of the volume or type of service required. Overall, there is a need to move beyond likes and dislikes and look at the quality of life that people anticipate or would wish to enjoy. For example asking users and carers; "What did you used to do, what do you do now and why did you make the change?" may be more fruitful than asking "What do you need?" However, this approach may then require

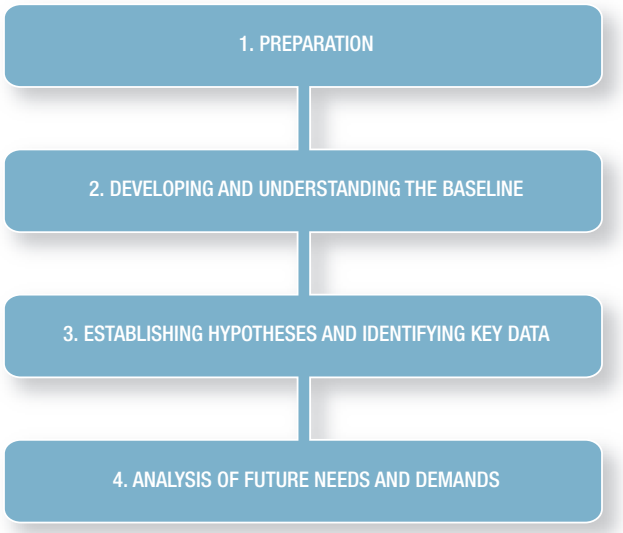
Examples	Purpose	Issues
Service user profiling		
		commissioners to be deductive about the types of accommodation and services required to ensure that these quality of life outcomes can be delivered. Profiling and defining care pathways can be particularly powerful when health, housing and social care data can be brought together. However, this rarely seems to occur not least because of the way data is stored, eg, factors such as different age banding may mitigate against this.
Analysis of conditional demand		
Research which looks at key questions in service provision, such as: • Are there needs being presented where targeted interventions could avoid poorer outcomes but where this is not occurring? • Is the intensity of the service provided sufficient to achieve the outcomes desired, eg, continence services, falls prevention, carer support? • Is the success of the service measured by outputs or outcomes, eg, the recent Sentinel Audit on Stroke almost entirely measures success through the proxy indicator of provision, such as more consultants and more stroke units rather than how many people achieved what level of improvement. • Is the intervention occurring at the most appropriate time, eg, are	Essentially this analysis is about: • Discovering unintended consequences, eg, is the provision of mobility aids actually exacerbating immobility? • Challenging some of the known 'knotty problems' that may have been around for a long period of time, eg, does this alleged preventive service actually prevent, delay or encourage dependency? • Analysing whether the volume, nature, type and timing of a service is achieving the outcomes which the service user might desire or expect. • Is a lack of demand being disguised by inappropriate use of the service, eg, take up of ordinary sheltered housing may look to be high but the accommodation is being used for purposes for which it was not intended? Reducing conditional demand may be measured by services users and carers reporting that service interventions delivered better outcomes than were anticipated.	This is potentially the most important topic in terms of demand forecasting and strategic commissioning because it attempts to analyse current demand and supply. For managers and researchers, it may present difficulties because of the number of variables that people have to control in order to achieve clear answers and because it directly challenges pre-conceptions about the need for particular types and configurations of accommodation and services. Discovering unintended consequences may not be easy where it perhaps means challenging ostensibly beneficial policies, eg, the development of direct payments and increased numbers of older people paying for their own services may have a perverse impact on demand through people underestimating or misinterpreting their needs or being persuaded into services which either do not meet or only temporarily satisfy demand, eg, housing schemes where people are required to depart if they become excessively frail or demented.

Examples	Purpose	Issues
Analysis of conditional demand		
eligibility criteria effective rationing devices or do they debar people from provision at a time when it may have the greatest preventative impact?		

Process

The preceding figure and table identified the four activities involved in demand forecasting and explored the range of data to be collected and the rationale behind its collection. This section begins to look at how that information once assembled may be pieced together and analysed in order to identify the three target populations. The intention here is to try and avoid collecting vast amounts of data which has little relevance to the planning of extra care housing.

Figure 8 Understanding, Interpreting and Analysing Demand Data



1. Prepare to undertake demand forecasting

- Identifying sources.
- Assembling the known data about populations, prevalence and incidence rates. Agreeing baseline data collections with partner agencies.
- Agreeing what additional survey work and/or research may need to be completed.
- Making sure the skill base to complete the work, and the time and resources, is available.

2. Develop and understand the baseline

- Discovering and reporting on the core population data by its relevant characteristics, location, future prevalence, and incidence data (the intention here is that this is a quick broad sweep within which a second round of more detailed data may be captured in order to answer the hypotheses established below).
- Recording the key findings from national and local studies and drawing up a list of preferences.
- Conducting or commissioning a review of relevant literature.
- Bringing together results of consultation activities with services users and carers.
- Bringing together indicator material relevant to the target populations.
- Analysing government legislation, guidance and directions in order to identify required interpretations and boundaries of need.

3. Establish hypotheses and identify key data

- Analyse and identify key characteristics and questions from the population based data above. Bring this material together with that from national and local surveys, analysis of service user/carer data and national guidance.
- Determine key hypotheses (this may be about why take up of service provision is low/high, patterns of population now and in the future, known growth within given populations in the future that are likely to have high level dependency needs, what people's future preference are in what sort of numbers, strategic direction for policy from the research). Examples of hypotheses might be:

    - 30% of individuals currently in residential care would be better provided for in extra care schemes.
    - Ordinary sheltered housing does not delay admission into care homes.
    - Disproportionate numbers of falls are experienced by older people in this particular type of housing.
    - Existing extra care schemes show a diminution in the demand for care services as compared to prior to admission to the scheme.

- Test the hypotheses by a further round of data capture (the aim here is not to find new baseline data but to find explanations for the trends that the first round of data analysis reveals).

4. Analyse future needs and demands

- From the result of the second round of data capture it should then be possible to make statements about the nature, type and volume of future demand for both accommodation and services.
- Bring the demand material together with the supply data into the commissioning strategy in order to determine the gap analysis and potential service developments.

Best Practice Example

Swindon Borough Council: in partnership with Kent County Council have developed a tool to help inform the development of a strategy for housing support and care for older people. The tool helps to examine the gap between current service supply and likely future populations of older people in geographic areas within the borough in order to estimate the number of extra care housing units that will be required by 2010.[45]

[45] Housing LIN case study no. 21. Estimating future requirements for extra care housing in Swindon. CSIP. (2006).

CHAPTER FOUR
TOOLS

This chapter includes:

1. Demand Forecasting Template for Older People's Accommodation
2. Data Sources for Undertaking Demand Forecasting

Demand Forecasting Template for Older People's Accommodation

Purpose of Tool

The purpose of this tool is to provide commissioners with a template for completion, to be used whilst undertaking demand forecasting locally. It aims to provide prompts as to what data needs to be gathered and what questions need to be asked of the information.

Topic and example activities	What have we done and/ or what do we know?	What do we need to do?
Population needs assessment or population profiling Example: 1. What are the broad based characteristics now and in the future by age, gender, location and ethnicity? 2. What is the local mix of housing tenure among older people, and what proportion of older people are owner-occupiers? How do local house prices compare with the price of an extra care unit? 3. What is the local prevalence, calculated from national rates, of: a. Physical or sensory impairment; b. Dementia; c. Mental ill health; d. Learning Disabilities; e. What other estimates are available of local incidence and prevalence of these conditions? 4. What are the numbers of older people who live alone, older carers of older people, older people in poor housing etc. Do local older people feel isolated, vulnerable, unsafe, and what are the current levels of deprivation?		

Topic and example activities	What have we done and/ or what do we know?	What do we need to do?
5. What is the quality of the housing stock in which older owner-occupiers are living? How many lack amenities? **Surveys of anticipated future need** Examples: Review of national studies. Review of recent local studies. Housing needs assessment. **Service user profiling** Examples: 1. How many older people currently live in Ordinary Sheltered Housing (OSH) and extra care housing? What are their reasons for entry to that form of housing, length of tenure and reasons for departure? What data is available on void levels and ease of lettings for particular schemes? 2. To what extent do local OSH and extra care schemes currently support people who are physically frail or who suffer from dementia, mental ill health or cognitive impairment? Do wardens and scheme managers expect to offer continued support to frailer tenants, or are they encouraged to move into care homes? 3. What are the estimated numbers and proportion of residents currently in care homes, whom the experience of extra care would have enabled to renew or prolong their independent living skills?		

Topic and example activities	What have we done and/ or what do we know?	What do we need to do?
4. What is the volume of intermediate care and delayed discharge where housing is the only or predominant factor in inhibiting a return home? **Analysis of conditional demand** 1. Are there needs being presented where targeted interventions could avoid poorer outcomes but where this is not occurring? 2. Is the intensity of the service provided sufficient to achieve the outcomes desired? 3. Is the service's success being monitored through outputs rather than outcomes? 4. Is the intervention occurring at the most appropriate time?		

Data Sources for Undertaking Demand Forecasting

Purpose of Tool

This tool provides examples of data sources and methods of collecting information which local authorities may find useful when undertaking a needs analysis exercise.

Forming Information Partnerships

It is quite likely that much of the information required may already be available locally, if not necessarily accessible. There may also be people available to compile demographic data who can help or advise on the data capture part of the work. It may be helpful to form local information partnerships bringing together information managers from social care, housing, acute and primary care trusts so that agencies can pool data and look at how capture can be better standardised.

Census Data

For help with mapping absolute numbers, Census 2001 data is readily available from the Office of National Statistics website. The Census Output Prospectus is downloadable and describes how and when the results are being released, and has links to those already available. Standard tables include numbers living alone, and those with limiting long-standing illness or in poor health by age and ethnicity, car ownership, and numbers providing unpaid care – including those providing over 50 hours unpaid care a week. Census 2001 also gives tenure by age, as well as number of houses lacking amenities by tenure and ethnic origin of head of household.

More detailed tables, which cross-tabulate a larger number of variables, can be found on DVD supplied by the Office of National Statistics. A master index is also supplied allowing researchers to download specific tables into Excel format. This DVD is supplied free on application.

For more specific cross-tabulations it is possible to commission output from Census Customer Services. Census 'extension tables', giving more detail on particular topics than the standard area statistics, but usually not at the most local levels, are being produced for the Multi-source Topics Reports which are currently being produced. These are being made available free from the website, and a list is due to be added to the Prospectus shortly with estimated dates of availability.

Attendance Allowance

Information on Disability Living Allowance and Attendance Allowance claimants by ward (though not by age) is available at the Office of National Statistics in the Health and Care section.

Information from local statutory documents

Local Housing Needs Surveys, Housing Stock Condition Surveys, and Private Sector Housing Renewal Strategies.

Housing Needs Surveys will be particularly helpful in looking at the proportion of older people who are in unsuitable housing and could not afford to buy in the open market. The reporting of Housing Needs Surveys does not always produce the analysis that would be needed for planning older people's services, but the information may well be there in the database, and some local authorities are now arranging for additional analysis to be done to answer some of the outstanding questions. For example, they may give information on the kinds of reasons that older respondents give for needing to move. Often, older people cite an inability to fund repairs or to maintain the garden as a reason for moving. The discussion paper 'Quality of Life for Older People: From welfare to well-being',[46] discusses equity release schemes for older people. Housing stock condition

[46] Quality of Life for Older People. From welfare to well-being. Joseph Rowntree Trust. (2003).

surveys will help in pinpointing areas of poor housing. The Decent Homes Standard is the new minimum standard set for all social housing, and local authorities and housing associations have been set a target to bring all their housing up to the decent standard by 2010. The majority of homes below the standard are owned by local authorities, and work being done locally to meet the standard will help to pinpoint areas of substandard social housing.

From July 2003 local authorities have been required to produce Private Sector Housing Renewal Strategies which should give information on private sector housing stock condition.

Community Safety Strategies/Partnerships

Information on fear of crime among older people can be supplied by the local Community Safety Partnership: numbers living alone by age from Census 2001.

Hospital Admission and Discharge

Hospital discharge teams will have good information about factors preventing people no longer in need of medical care from returning home, including housing related factors. Avoidable hospital admissions may include falls. Moreover, people left lying on the floor for long periods of time suffer adverse health effects over and above injuries sustained in the fall, and are likely to need hospital treatment which might not have been necessary had they been helped up straight away.

Information from Local Research and Consultation

Mapping and analysing current service user needs relies on some information which is probably not routinely collected. Before setting up special projects, it will be important to refer to Supporting People and Service Reviews to see what is being learnt about local service provision and the people it serves.

Surveying Current Sheltered Housing

Commissioning partnerships may find it difficult to collate information about local sheltered housing populations, although individual sheltered housing managers will know age and dependency levels of their tenants. In the absence of routinely collected data, conversations with local housing providers and scheme managers should start to give a picture of the way in which tenants move in and out of schemes. Is it policies, building, staffing, access to leisure facilities - or simply personalities? Group discussions with tenants will give information about the experience of living in OSH, but it is important that these should be run by skilled and independent facilitators.

Collecting information about individual schemes in this way begins to give a more local picture. Conversations with older people and their families, including people from BME groups, should help to indicate the preference of potential users for:

- Type and design of property including number of bedrooms.
- Location of premises, eg, on level ground, in a relatively crime free area, close to shops and services, and close to target communities.
- Where choice would be important concerning services and facilities, ethnic mix, coping with disability.

Surveying Residential Care

Few authorities currently profile their residential care population. Questions to be addressed include:

- What proportion of this – probably quite frail – residential care population is likely to wish to move to extra care, or to be able to recover independent living skills?
- At what stage, and for whom, would it have been appropriate to offer extra care places as an alternative to residential care?
- What is the proportion of people moving to residential care who were known to social services for longer than three months beforehand?
- What numbers of private fee payers in residential care may run short of funds and require local authority provision and funding?
- How many providers are interested in diversifying into extra care housing?

Understanding these issues might require the authority to commission a number of small pieces of research to gain an accurate picture. Authorities may use file searches, interviews with residents, care home managers, relatives, etc. Profiling admissions to residential care and reviewing the cases made to allocation panels could also be beneficial. As noted above, some of the work may have already been done for Supporting People or Best Value Reviews.

National Sources

Using Prevalence Rates

Melzer and Byrne[47] quote the following prevalence of cognitive impairment among older people:

2.3% of those aged 65-75

7.2% of those aged 75-84

21.9% of those aged 85 and older

This data could be applied to a local population as shown in the following example:

	Local Population	National Prevalence of Cognitive Impairment	Local Prevalence Applying National Rates
Aged 65-75	28,244	2.3%	650
Aged 75-84	17,348	7.2%	1,249
Aged 85+	5,251	21.9%	1,150

This will help to estimate likely numbers of older people with cognitive impairment, and policy makers also need to be aware that the numbers of oldest old are increasing, and the prevalence of cognitive impairment rises steeply with age – which will add to these numbers.

The document 'Preparing Older People's Strategies' (Housing Corporation, DH, ODPM, 2003) gives a number of sources of data and information relevant to needs and supply mapping. It also identifies a number of statutory documents and services which are potential sources of demographic data, including:

- The Local Delivery Plan for Older People.
- The National Service Framework Local Implementation Team.

[47] Cognitive Impairment in elderly people: population-based estimate of the future in England, Scotland and Wales. British Medical Journal. 315:462. Melzer D, Ely M, Brayne C. (1997).

- Local poverty and economic development studies.

For information about national and regional prevalence of health conditions the National Service Frameworks and several Audit Commission reports contain general prevalence rates for a range of conditions. For specifics see:

- 1985/86 Office of Population and Census Studies survey of disability in adults, specifically the assessment of cognitive functioning.
- According to epidemiological research reported in the Forget Me Not report, 2000, and National Service Framework for Older People, 2001, between 10% and 15% of people aged 65 and over are likely to have depression and between 5% and 6% are likely to have severe depression.
- Wittenberg R, Pickard L, Comas-Herrera A, Davies B, & Darton R, (1998) Demand for long term care: projections of long term care finance for elderly people. Personal Social Services Research Unit.

Commissioning partners will need to be careful of double counting, as some older people will have both cognitive and physical impairments.

Local information on the incidence and prevalence of these conditions is likely to be available via the Strategic Health Authority.

CHAPTER FIVE

ANALYSING THE CURRENT AND POTENTIAL SUPPLY OF ACCOMMODATION AND SERVICES

CHAPTER FIVE: ANALYSING THE CURRENT AND POTENTIAL SUPPLY OF ACCOMMODATION AND SERVICES

Introduction

Chapter 4 explored how the local authority can build a good understanding of the demand for extra care housing in particular and the range of specialist accommodation in general. This chapter looks at the other side of the development equation in terms of how to analyse the supply of accommodation and relevant services. This requires undertaking the following activities:

1. Agreeing the scope of any accommodation and service review with partner agencies. Defining the current and future balance between commissioners and providers in terms of both accommodation and services.
2. Mapping and reviewing (both quantitatively and qualitatively) the range of specialist accommodation provided by the local authority, RSLs, the voluntary sector and the independent sector.
3. Where sheltered accommodation is directly under the LA's control or influence; prioritising which schemes can be adapted for extra care housing, which have value either in terms of land or premises but which it is either not possible or cost effective to adapt, and which may need to be de-commissioned.
4. Mapping and reviewing (both quantitatively and qualitatively) the service provision relevant to extra care housing and in particular establishing its availability in the volumes that may be required now and in the future.
5. Developing a picture of what future potential accommodation and service configuration may look like.
6. Matching the accommodation and service conclusions with the data gained from chapter four in terms of developing a gap analysis and future plan/commissioning strategy.

The Local Authority role in managing the market

There are already wide variations around the country in the way local authorities interpret their role with regard to extra care housing. This ranges from authorities with a single scheme that is predominately social care driven through to authorities that have wide ranging partnerships and see their role both as developing schemes and as stimulating the market through independent and voluntary sector provision.

In relation to commissioning generally much is made of the local authority role in terms of managing the market, often to limited effect if there is little choice of specialist providers. However, in relation to the development of extra care housing and older people; given the growth in the numbers, the existence of substantial amounts of equity and changing expectations amongst older people about accommodation and the quality of service provision, then the role of the local authority in promoting the development of a diverse market seems highly significant. That diversity may be reflected in the range of roles for the voluntary and independent sectors to perform, from builders, to developers of schemes, to service providers. Consequently, there genuinely seems to be a case for local authorities to, if not exactly manage the market, then at least stimulate, encourage and influence the range of provision available. This role can perhaps best be summed up by the following definition of the local authority's function:

'The local authority should ensure that there is appropriate provision available at the right price to meet needs and deliver effective outcomes both now and in the future.' [48]

The following interpretation explores the meaning behind this definition in more detail:

'should ensure'

This begins to reflect the local authority move from provider to facilitator. In this instance the task is to make sure the right range of accommodation and services is available, and not necessarily that the public sector delivers or even commissions all that is required. However, there is an underpinning guarantee that implies if one particular service is necessary and not available then all efforts should be made by the local authority to find acceptable alternatives.

[48] Developing Joint Commissioning. Better Commissioning LIN. CSIP. IPC. (2006, Forthcoming).

'appropriate provision'

Appropriate provision can be judged in a number of ways. At the very least it can mean compliance with minimum standards or care pathways. However, 'appropriate' may be interpreted in terms of whether the service meets its outcomes, offers flexibility or is in the right location. For example, it may not be 'appropriate' to continue providing large amounts of sheltered accommodation that is inaccessible to wheelchair users. However, appropriateness may not automatically mean choice for the service user or patient. For example, in a rural area or in providing a highly specialist service, quality and the delivery of agreed outcomes may be of greater importance than choice.

'right price'

The first assessment of right price (and one which most organisations stick at) is right in terms of cheapest and/or on the best terms and conditions. However, the lowest price may also mean the lowest quality of service or a tight and restrictive service specification which does not encourage variation, experimentation or high quality. Too low a price and the provider may not be able to sustain the service or deliver the accommodation to a future proof standard. Internally provided services, or those where there is a sole supplier, may not automatically mean best price.

'meeting needs and delivering effective outcomes'

Judgement of what constitutes success is beginning to change. Traditionally, much social care provision has been judged in terms of the quantity, or more lately the quality, of supply. However, it is still possible to have a service that meets both quantity and quality tests and yet does still not deliver the best outcomes for those who use it. An outcome-based approach almost certainly requires much closer working between commissioner and providers than one based solely on service supply.

'now and in the future'

Providers, service users and commissioners all have the potential to change over time. Part of market management is not only looking at current provision but also at what provision needs to be developed for the future. This may mean subsidising the market whilst new provision is developed. In a diminishing labour market it may mean sharing the recruitment and training of skilled and qualified staff.

The role of the independent sector

Whereas partnerships between local authorities and registered social landlords have been widespread, similar relationships have been less common with independent sector developers and providers. However, the independent sector in general and care home providers in particular are potentially valuable partners with considerable experience, a good sense of how to promote and market schemes, and possession of equity and resources, including land. Working with such partners may lessen the need to rely on the use of public grants and subsidy, thereby enabling faster development. Recent consultation[49] with providers has shown that although there is considerable scope for partnership, there are a number of obstacles not least of which is a mutual suspicion of motives. Local authorities can help to stimulate independent sector involvement by:

- Purposefully sharing with a wide range of independent sector developers, from builders to specialist providers, the local authorities' future commissioning intentions.
- Involving independent providers in the development of service models and local concepts of extra care.
- Communication of key information including demographic projections and analysis of need.
- Helping to enable relationships with key stakeholders, including planners, Primary Care Trusts and the community.
- Helping to publicise schemes once developed.
- Sharing workforce competencies and training.

[49] 20:20 project.

There are also dangers to authorities in not working with the independent sector. It is possible to end up with the wrong type of developments (not developed to fully accessible standards) in the wrong location (not within strong local communities of older people) for the wrong audience (for example solely at the most affluent end of the older person's housing market).

Overall, working in partnership can potentially deliver three clear benefits:

Extends choice: Development of extra care schemes by the independent sector can help to meet the hopes and aspirations of the majority of older people who are and want to remain owner occupiers.[50] On their own local authorities are unlikely to be able to fund and deliver the range of provision that people are likely to demand in the future. Central government is keen to see the development of public/private partnerships to increase the supply of extra care housing.

Improves diversity and quality: It is clear from the Joseph Rowntree Trust research (cited below) that choice and home ownership are seen to be closely related. In addition, it is likely that property developed for sale is going to be more responsive to the market and hence more diverse. This in turn should drive up standards of accommodation. If the local authority is 'piggy backing' social rented accommodation onto schemes for sale or lease then the likelihood is that this will provide a higher standard of accommodation than that which may be provided for rent alone.

Improve viability: In some more sparsely populated areas it may not be cost effective for either the local authority or the independent sector to develop schemes on their own although in partnership they may be viable.

For local authorities who wish to pursue new development relationships, the Elderly Accommodation Council, in partnership with the Housing LIN, have put together a list of contact details of private organisations that have shown an interest in developing and/or managing extra care in partnership with a local authority or housing association. Further information on the role of the private sector in developing extra care housing can be found in the Housing LIN fact sheet no 17, 'The potential for independent care home providers to develop extra care housing'. This paper provides essential information for care and nursing home owners interested in developing extra care housing. It also provides information for local authorities and health commissioners who wish to stimulate the care home sector to develop extra care housing models in their area.

Preparing to conduct a review

Local authorities or planning partnerships that wish to review their existing accommodation and relevant services need to engage in detailed thinking before such an exercise begins. There will almost certainly be a need to consult with staff and elected members from within the local authority if unnecessary anxieties are not to be raised about the nature and outcome of the exercise. It will mean assembling data about the location, funding, value, quality and quantity of current accommodation and service provision. Finally, it will take internal staff resources if the work is to be conducted effectively. The intention here is to review not only what the local authority provides but also accommodation and services provided by the voluntary and independent sectors.

Reviewing and mapping current accommodation provision

The information needed, and the reasons for its collection and analysis, is summarised below:

[50] See study. Older owner occupiers perceptions of home ownership. Joseph Rowntree. (1999).

Table 8 Assessing Current Accommodation Provision.

Area	Information Needed	Purpose Of Information
What is provided, by whom, and where?	**Sheltered/extra care housing** • How many sheltered/extra care/retirement schemes are there, where are they located and who provides them?[51] • What are the number and type of units within schemes eg, bed-sit, bungalows, etc? • How many bedrooms do they have? • How does quantity compare with national figures for the number of sheltered housing units per older person?[52] **Care Homes** • How many care homes are there and where are they located? • How many provide care for specific client groups, eg, individuals with dementia, learning difficulties? • What type of accommodation is offered, eg, en suite facilities? • Who are the providers? • What is the balance in the local market between local authority provision and independent/voluntary sector and between the number of providers? Is the market stable?	Mapping current stock and comparing it against needs and national provision will enable judgements to be made of whether: • There is an over or undersupply of sheltered housing, extra care or care homes in general or for specific groups • The supply of accommodation does not match the distribution of the population now and/or is unlikely to in the future. To assess whether there are sufficient services to meet specific needs (people are less likely to apply for a service that they believe will not meet their needs or where they start from believing that it is probably unobtainable or is not for their ethnic background). To assess the balance and stability of the current market. Is the market diverse, are there good relationships between commissioners and providers, where a fair and affordable price is achieved? Where are there are shortfalls, how will the LA ensure the creation of a diverse market?
Assessment of current stock	**LA sheltered/extra care housing or where nomination rights exist** • What is the quality and accessibility of existing stock? • What is the volume of and reason for voids? • How many vacancies are there for each type of unit, by scheme? • What is the value of stock, including land value? • What is the project repair bill for stock requiring updating?	This information provides an overview of current provision, and the likely costs of refurbishing homes and schemes/ converting to extra care or selling for development. Where there is over-supply this information should inform decisions about which buildings can be refurbished, redeveloped or decommissioned. In analysing current, and determining future, extra care provision it is important to build in user's perspectives on current and planned provision. Questions should be focused on outcomes rather than

[51] The EAC provides local maps of housing and care homes in any locality, district etc. In addition the EAC regularly provides Supporting Peoples teams with lists of local housing and care homes for older people including alms houses, Abbeyfield, etc.

[52] Information can be found at EAC website.

Area	Information Needed	Purpose Of Information
Assessment of current stock	• What is the cost of making current provision accessible to the standards of the local authority? • What sector do people come from into existing accommodation and where do they go on departure? • Does the service meet users and carers needs and how has this been assessed? Is the tenure mix reflective of tenure within the relevant population? • Do schemes provide value for money? **Care Homes** • Does the service meet the needs of users and carers and how was this assessed? • Does the home provide value for money?	outputs and assessing whether existing and planned forms of provision are meeting both the needs and aspirations of current services users, and their relatives and achieving positive outcomes for the individual in terms of quality of life and independence. Most local authorities will have the capacity and experience to conduct user satisfaction studies and there may well be existing resources such as resident panels that can be tapped into.[53]
Availability of Land	• What land is available now and in the future for the development of specialist accommodation? This includes brown field sites or sites realised through re provision or remodelling.	ECH may not be a priority for planners or housing providers. Collecting information on land availability enables commissioners to plan provision for the future and makes planners aware of future requirements.
Future Supply	• What is the current and likely future state of the market? How stable or volatile is it? • Is there a monopoly of providers? • What is known or can be discovered about the future plans of independent providers of care homes and sheltered housing? • What is the current and likely future availability of the workforce?	To enable the assessment of the current market's vulnerabilities and its capacity for change.

The role of existing sheltered housing

Most local authorities and RSLs have a range of ordinary sheltered housing accommodation available, much of which was developed immediately post second world war. Some of that housing is now hard to let, often for a variety of reasons. At the same time policy makers recognise that a new generation of older people are expecting higher standards and different types of accommodation, and arrangements for purchase, lease or rent, to be available to them. The development of extra care may in itself be a challenge to the role of ordinary sheltered housing (OSH), ie, what role should OSH perform if all specialist accommodation should offer the capability of accommodating people with a wide range of health and care needs?

[53] A guide to user involvement for organisations providing housing related support services can be found on the Supporting Peoples website under general documents Care and Repair have produced a housing action toolkit for older people entitled, 'Having Our Say'.

Therefore, the decision as to whether to refurbish existing premises or build new accommodation in order to develop ECH, is a decision facing a large number of local authorities and registered social landlords, as well as some independent sector providers. This decision is likely to be made in the context of a range of factors such as the availability of capital and revenue funding, as well as land availability.

Commissioners and providers need to ensure that a balance is found between best practice and local constraints such as land and building availability, location and cost. If the constraints are so significant that they make it impossible to achieve the required standard for a proposed ECH scheme, then it may be better to use the buildings for some other purpose. Essentially, providers are faced with five options, to:

- Refurbish or remodel an existing ordinary sheltered housing scheme.
- Provide additional services at the ordinary sheltered housing scheme.
- Demolish and build new on the same site.
- Demolish and build new on a different site.
- Disposal of land to acquire an alternative site.

The route by which providers may consider how they arrive at one of the above choices is laid out in the toolkit accompanying this chapter.

Reviewing and mapping community support service provision

There are potentially a wide range of services which may help to sustain people in the community via extra care housing.

Table 9 The range of community based support services

Some of the community support services and provision that may need to be included in the development of an accommodation strategy		
Home care	GP provision	Physiotherapy and support from personal trainers
Day care	Sheltered and extra care housing	
Specialist dementia services	Care and repair services	Assistive technology provision
Meals services	Podiatry services	Community safety
Continence services	Libraries, community transport and other quality of life provision	Occupational therapy and speech and language therapy services
District nursing/community matron		

Identifying and mapping services potentially relevant to extra care will help the local authority answer a number of questions about current provision, such as:

- Is the current service provision appropriately located?
- Is current provision of a comparable standard to other similar authorities?
- Is there an over or under supply?
- Is the balance of services right?
- Is current service provision viewed favourably by existing service users?
- Are the requirements of people with particular needs eg, dementia or from particular communities being met, eg, Black and Minority Ethnic groups?

Evaluating the range and appropriateness of service provision can be helped by breaking down the market mapping activity into a number of discrete areas. The table below provides a guide to the process of undertaking a market assessment. It identifies the range of information needed and why. A market mapping template is provided in the tools and techniques section of this chapter to assist with the activity.

Table 10 Assessing Community Based Support Services

Area	Information Needed	Purpose Of Information
What is provided, by whom, and where?	• What is the range of community support services available, eg, housing repair services, domiciliary care, day care, meals etc? • What volume of services is currently provided to people in care homes, ordinary sheltered housing or extra care? • Who are the providers? • What is the average package of services provided to individuals?	Mapping current provision of community support services against identified needs and national provision will enable judgements to be made about a number of areas. For example: • Whether there is over or under supply of services. • Whether the supply of services matches the distribution of the population. • What is the current demand for services and what are the influencers of such demand.
Assessment of current services	• Are there clear outcomes it is expected that these services will deliver? • What is the current performance of current services against national targets? • Do these services fully meet the needs of users and carers? • Do services provide value for money? • What are the levels of demand for services eg, waiting list for day services, or home support services?	This information, together with the data from Chapter 4, will highlight to local authorities whether community health, care and support services are achieving positive and intended outcomes for people or whether they are having a negative effect. In analysing current provision and determining future service requirements it is important to build in user's perspectives on current and planned provision of community support services. Questions should be focused on outcomes rather than outputs and assessing whether existing and planned forms of provision are meeting both the needs and aspirations of current services users and their relatives, and achieving positive outcomes for the individual in terms of quality of life and independence.

Area	Information Needed	Purpose Of Information
Future Supply	• What is the current and likely future state of the community support services market? How stable or volatile is it (in the public, voluntary and independent sector)? • Is there a monopoly of providers? • What is known or can be discovered about the future plans of providers of community support services? • What is the current and likely future availability of the workforce?	To enable the assessment of the current market's vulnerabilities and its capacity for change. For example, a number of low level preventative services are reliant on grant funding or volunteers and it is important to understand which services are secure in terms of funding and staffing and those that are not.

Developing a picture of what future potential accommodation and service configurations may look like

So far this chapter has considered the quantitative and qualitative aspects of what is available within a local authority area. Deciding on future provision requires more than just an analysis of current provision and means developing a view of potential new forms of accommodation and service provision. The table below outlines additional information sources that may be used and where they are located.

Table 11 Bringing together national information

Source	Where available from
Reviews of best practice	• Housing Learning and Improvement Network (CSIP). • Housing Association, and Community Care, Health journals. • Specific reports produced by specialist housing providers, eg, Hanover Housing Association, Housing 21. • Specific reports produced by HOPDEV, EROSH[54] and professional and trade bodies such as the Chartered Institute of Housing, Association of Retirement Housing Managers and National Housing Federation.
Research evidence of which accomodation services and configuration of services can best deliver particular outcomes	• National research, including work undertaken by the Joseph Rowntree Foundation, The Kings Fund, Personal Social Services Research Unit (PSSRU)/Housing Corporation. • DH Section 64 funded research and other government research councils.
Requirements from guidance and legislation	• National Statutory documents including Government White Papers, ODPM/DCLG material, Social Exclusion Unit, DWP reports and Housing Corporation guidance.

[54] ERSOH is the national consortium for sheltered housing and retirement housing.

Source	Where available from
Recommendations from internal and external reviews and audits	• Audit Commission reports. • Commission for Social Care Inspection Reports. • Findings of local review into services, eg, Supporting People reviews. • Relevant case law, Ombudsman decisions or local policies, practices and procedures.

Developing the gap analysis from supply and demand data

In constructing a picture of what accommodation services for older people, including extra care, may look like in the future, the lead agency needs to bring together the results of the demand and supply analysis to assess where there are gaps. Specific issues to be identified include where there are:

- Issues concerning the quality of provision.
- Gaps or pressure points in the provision of services.
- Overlaps or lack of coordination in the provision of existing services.
- Areas of oversupply or potentiality for de-commissioning.

This information may be brought together and displayed in a number of ways to facilitate this analysis. For example, it can be mapped geographically, by similar services compared by price, by levels of demand assessed against supply, by an assessment of current service provision against future types of delivery, or through comparison with other local authority areas.

Local provision can also be compared with the national picture by using existing benchmarking resources. For example, Supporting People teams will have mapped the supply of sheltered housing against national norms and local authority performance indicators for the Department of Health and are able to give rates of older people in residential care against national rates. Local authorities can also establish local benchmarking groups (if not already established), not only as a way of comparison but to assess the plans of others for future service delivery.

The conclusion of the analysis of services compared to future demand and need is the production of a clear set of statements which define the following:

- The maximum and minimum numbers within the population that might be considered for extra care housing now and in the short, medium and long term.
- Their defining characteristics, eg, need, disability, etc.
- The types of accommodation and services that may be needed, what level or volume of provision is required, what is currently available and suitable, and what needs to be developed for the future and in what location?
- The resource implications of the preferred options.

The diagram below sets out key questions to answer at this stage in order to identify what services need to look like in the future and what particular services need to be developed:

Figure 9 What should future provision consider?

Once the local authority has been able to build a clear picture of what future service provision needs to look like, there is then a need to develop a clear action plan which sets out, over the time period of the strategy, how it will move from the current situation to where it needs to be in the future, and how such change may be stimulated, managed and funded. The following table outlines the market management issues that will need to be considered at this stage so that the local authority is clear, not just about the services it is intending to develop, but also how it intends to work with other agencies and providers to achieve the change.

Table 12 Planning for long term market management

Area	Activities
Market growth	Which sections of the market need to grow, by how much and with what form of provision? Who will be the potential suppliers? What will be the balance between in-house and external provision? Where will funding come from to fuel developments?
Market diversification	Is there a need to encourage new suppliers into a sector or to help assist smaller but specialist or high quality providers to survive? What kinds of new supply need to be supported? Have there been discussions with the independent and voluntary sector about widening forms of provision? Are changes needed to existing procurement arrangements?

Area	Activities
Procurement practice	Are specifications, tendering and contracting arrangements fair and cost effective for providers? What demands are being placed on providers by tender processes? Are there procedures and processes that would allow for a shift in service description from quantity and quality to outcomes?
De-commissioning	What services either in-house or external may no longer be required, either in the same amount or at all? When will de-commissioning need to take place? What processes need to be put in place to support service users through changes? Have the transition costs of changing provision been fully taken into account?

CHAPTER FIVE
TOOLS

This chapter includes tools and guidance on:

1. A Framework for Reviewing and Mapping Community Support Services
2. A Checklist of Considerations in the Decision to Rebuild, Remodel or Refurbish Ordinary Sheltered Housing

A Framework for Reviewing and Mapping Community Support Services

Purpose of Tool

The purpose of this tool is to provide local authorities with a framework for undertaking a market mapping exercise, assessing the appropriateness of current services and helping to identify what configuration of services may be required for the future.

Overall perspective

Whilst the development of a strategy is likely to be across a whole sector, eg, older people, learning difficulties, etc, the review and mapping task is more likely to be completed across different types of service provision, eg, domiciliary care, health based services, etc.

The table below suggests that the appropriateness of provision and identifying what service configuration is required can be helped by breaking market mapping down into a number of discrete activities for each sector, including in house provision. A simple scoring mechanism could then be designed and applied to facilitate good comparisons between different forms of provision where more than one source of supply exists.

The resultant data may be brought together and displayed in a number of ways to facilitate analysis, eg, mapped geographically, like with like services compared by price, levels of demand, relevance to future types of service provision required as above.

For example a service that meets identified needs and delivers good and appropriate outcomes but nonetheless is high cost and relatively isolated may involve decisions about whether the individual service can improve its location and financial efficiency and if not whether an equivalent service can be developed at lower cost and in improved locations that would score higher.

Defined by	Analysis	Score
Who provides what within a given area?	Should include all relevant services not just those the LA commissions. May simply involve describing or mapping the name of provider or company, what service they offer and how many places available.	This starts to bring supply information together with demand by overlaying where services are located in comparison to where populations live now and are anticipated as living in the future. A proportionate distribution of services across the authority scores high. Patchy and idiosyncratic service provision scores low.
Why do they provide it?	Has the LA ended up with a market that is diverse, where there are positive relationships and arrangements between commissioners and providers, where a fair and affordable price is achieved and well	Good rationale behind why a particular provider should provide the service or accommodation gains a high score. Bonus where there are strong relationships with the independent sector

Defined by	Analysis	Score
Why do they provide it? (continued)	monitored outcomes are delivered? Where there are shortfalls in provision it should be possible to describe how these will be met and how local authority funding may be used to maintain diversity in markets, eg, avoiding a local monopoly of care home providers.	and mutual discussions about future need. Service provided by external provider by chance or provided internally because nobody has questioned whether it could or should be externalised scores low. The first the authority knows about independent sector schemes is when the builders' hoardings go up!
At what price	Obviously determining price is not a single issue but brings together the range of factors described here, eg, what services are to be provided, over what timescale, for what number of places, for what outcomes. It should also take into account risk and a reasonable return on investment. Good price determination means the local authority at a commissioning level should be able to itemise the costing components they would expect to see included by a service provider. Price needs to be determined for internal provision as well as external provision.	Low price, well costed services score high. Few drop outs in the market and entry costs not prohibitive. High price with poor financial modelling and planning scores low. Few new providers coming on board.
To what effect	Has work taken place to define beneficial outcomes rather than just volumes of service delivered? This might include a review of what quality standards need to be developed over and beyond National Minimum Standards (NMS). Over and above NMS is there a need to establish benchmarks of quality service provision through standards, audits and guidance.	High quality services that deliver clear evidence of achieving desired outcomes score high. Services only measured by volume and compliance with minimum standards or services that cannot measure performance in either quantitative or qualitative terms scores low.
Current demand	Might be measured by waiting lists or time delay in delivery, whether eligibility criteria have been widened to fill a particular service, and by service user feedback.	High demand scores high (though needs to be balanced against whether this is a monopolistic service or whether there are alternatives). Low demand scores low.

Defined by	Analysis	Score
Future supply	What is the current state of the market and how well can vulnerability, and capacity for change, be assessed.	Diversity of suppliers, with new market entrants and financial stability scores high. Monopolistic supply from either state, independent or voluntary sector suppliers and/or a declining market with financial uncertainty scores low.

A Checklist of Considerations in the Decision to Rebuild, Remodel or Refurbish Ordinary Sheltered Housing

Purpose of Tool

The purpose of this tool is to provide local authorities and providers with a framework for assessing the various options available to them in developing extra care housing. The aim of the checklist is to ensure that all the relevant factors have been considered in coming to a decision, and to establish how these factors tip the balance in favour of one option or another. In answering the questions, it will be important to bear in mind local and strategic aspirations for older people, which should shape the way in which ECH will develop.

Question for Consideration	Notes
Have existing tenants and other stakeholders, such as relatives and local service providers, been consulted? Do these groups all favour a particular option, and if so, which options are preferred?	*It will be important to involve existing tenants, staff, elected members and local populations from the beginning. To make this consultation meaningful, high quality information and mechanisms for dialogue will need to be available for communicating both with potential users and referrers.*

Answers and Comments

Option supported (✔)			
1. No change		5. Demolish and rebuild	
2. Refurbish		6. Rebuild on a different site	
3. Remodel		7. Undertake more preparatory work	
4. Reprovide service		8. Consider other ways of delivering housing with support	

Question for Consideration	Notes
Do relevant strategies at District, County and Regional level favour a particular type of approach? How will prospective partnerships shape the decision to build new, refurbish or remodel?	*In order to succeed, proposals for ECH will have to take account of priorities set out in District Housing, Supporting People, Older People's and Regional Housing Strategies, as well as planning priorities.*

Answers and Comments

Option supported (✔)			
1. No change		5. Demolish and rebuild	
2. Refurbish		6. Rebuild on a different site	
3. Remodel		7. Undertake more preparatory work	
4. Reprovide service		8. Consider other ways of delivering housing with support	

Question for Consideration	Notes
Has the landlord or developer looked at the likely need for ECH places in the area, and the contribution of the planned scheme to the total provision? In the case of refurbishment, will the more generous space standards required by ECH mean a reduction in the number of units, and how will this impact on local provision?	*The landlord will need to know; who are the likely future users of ECH in different localities, their tenure patterns, specialist needs and current use of services, in order to provide the right number of units in the right locations. Guidance on mapping populations and resources can be found in Developing and Implementing Local Extra Care Housing Strategies. Housing Learning and Improvement Network, Department of Health (2004).* *If refurbishment implies the loss of a large number of much-needed units of accommodation, Options 3 or 4 may be preferred. If the proposed refurbishment is in an area where there is over-supply of accommodation for older people, this may both make interim arrangements easier, and also attract a different population of older people, making Option 2 or 3 preferable.* . *If the scheme meets the current and predicted demand for ordinary sheltered housing following a review of provision locally, no change may be necessary.*

Answers and Comments

Option supported (✔)			
1. No change		5. Demolish and rebuild	
2. Refurbish		6. Rebuild on a different site	
3. Remodel		7. Undertake more preparatory work	
4. Reprovide service		8. Consider other ways of delivering housing with support	

Question for Consideration	Notes
Is the building site adequate for peoples' long-term care needs? Are there significant problems with the building, or with its location? Would these problems apply to remodelled units or a remodelled service on the same site, eg, lack of space, unpopular location, and fear of crime?	*Commissioning partners need to be clear about the opportunities and disadvantages of existing arrangements, and the potential for changing them through refurbishments and remodelling the building or reproviding services.* *If people are generally happy with the site but not the building, Options 2 and 3 are indicated. If people feel unsafe or isolated, Option 6 would be preferred. If people are happy with the site but would benefit from enhanced care and support services, such as floating support, Option 4 may be preferred.* *If an alternative site is indicated, what land, if any, is available? Would a better solution be to provide ECH within existing communities of older people such as high rise flats or small estates with static populations which have grown old together and now have a high need for support?*

Answers and Comments

Option supported (✔)			
1. No change		5. Demolish and rebuild	
2. Refurbish		6. Rebuild on a different site	
3. Remodel		7. Undertake more preparatory work	
4. Reprovide service		8. Consider other ways of delivering housing with support	

Question for Consideration	Notes
Is the perception of sheltered housing locally likely to act as a barrier to uptake of the new service? Can those perceptions be changed or are they rooted in local preferences for a totally different kind of service provision? Will the new service demonstrate the step change from ordinary sheltered housing that ECH means?	*Some landlords report that ordinary sheltered housing has a poor reputation locally and is not a preferred option for older people. There is a danger that remodelling the scheme or re-providing the existing services may fail to change that perception. If services have to change demonstrably, this may involve training staff in new skills, and changing the expectations of tenants in terms of independent living. This may be difficult to do when the same staff and tenants remain in a remodelled scheme.* *Where sheltered housing for rent or sale is either in low supply or is an effective market choice, no change may be necessary.*

Answers and Comments

Option supported (✔)

1. No change		5. Demolish and rebuild	
2. Refurbish		6. Rebuild on a different site	
3. Remodel		7. Undertake more preparatory work	
4. Reprovide service		8. Consider other ways of delivering housing with support	

Question for Consideration	Notes
Has the authority/landlord, or developer set out clear standards for ECH buildings? Will a refurbished or remodelled scheme be able to meet them? Does the scheme meet legislative requirements regarding access, etc?	*The Housing Corporation requires that newly built properties should have a life expectancy of at least 60 years, as opposed to 30 years for remodelled properties.* [55] *In order to provide homes for life, all dwellings in the scheme will have to conform to design standards such as 'progressive privacy', fully accessible dwellings, wide corridors and lifts capable of carrying electric wheelchairs and power scooters. Space will be needed for the provision of communal and external areas, with one third of all parking being for the use of residents.*[56] *Minimum space required for a unit of accommodation is 50 sq metres.*

Answers and Comments

Option supported (✔)

1. No change		5. Demolish and rebuild	
2. Refurbish		6. Rebuild on a different site	
3. Remodel		7. Undertake more preparatory work	
4. Reprovide service		8. Consider other ways of delivering housing with support	

[55] See The Housing Corporation Capital Funding Guide April 2004.
[56] See chapter 6 for further reading on design standards.

Question for Consideration	Notes
Has the developer included all relevant factors in their cost projections? Do costs of refurbishment still look attractive when the costs of providing alternative accommodation during works, bringing in to line with Decent Homes Standards and making fit for purpose in the long term, are all considered? Has the authority/landlord established the relative costs of achieving standards for space and building design, assistive technology, and sustainability?	*Capital costs of new build versus remodelling may be difficult to project, as a number of factors need to be taken into account. Where schemes are in good condition but require some remodelling and additional facilities, one authority has assumed these costs to be 40% of new build costs.* *Where existing schemes are in a poor condition and require major alteration, the full cost of new build is assumed. However, this estimate does not include the costs of providing alternative accommodation for existing tenants, or of development period financing.*[57] *It may be necessary to run the new scheme in parallel with an existing scheme scheduled for closure, for some time. Refurbishing existing schemes to provide units for ECH is likely to involve the loss of units, and hence loss of revenue. Hidden costs might include asbestos removal, decontaminating brownfield sites, structural repairs to existing buildings.*

Answers and Comments

Option supported (✔)			
1. No change		5. Demolish and rebuild	
2. Refurbish		6. Rebuild on a different site	
3. Remodel		7. Undertake more preparatory work	
4. Reprovide service		8. Consider other ways of delivering housing with support	

[57] Accommodation Strategy for Older People in Liverpool. Appendices for Final Report. Peter Fletcher Associates. August 2001.

Question for Consideration	Notes
Will the scheme be viable in revenue terms? Will prospective residents be able to afford the rents? Will housing service charges be in place for the upkeep of communal areas?	*Consideration will have to be given to required rent levels, which may have to cover loan repayments. The question then arises of whether these rent levels will be affordable to the likely future residents of the scheme. No scheme which is so costly that rents or shared equity are unaffordable to potential users could be accepted, whether it is new build or refurbished.* *Local authorities have not traditionally used service charges as a means of covering supply and depreciation of furniture, fittings and equipment and communal areas, although some RSLs have found this a useful way of covering such costs.* *Therefore, revenue costs need to be transparent, including rent levels or purchase price, service charges, care and support costs.*

Answers and Comments

Option supported (✔)			
1. No change		5. Demolish and rebuild	
2. Refurbish		6. Rebuild on a different site	
3. Remodel		7. Undertake more preparatory work	
4. Reprovide service		8. Consider other ways of delivering housing with support	

Question for Consideration	Notes
Has the authority/landlord or developer explored likely sources of funding for new build and refurbishment or remodelling?	*Sources of funding for refurbishment may differ from those for new build, and particular funding routes may be open only to one option. For example, one route might be to transfer selected sheltered housing schemes to one or more RSLs as part of a stock transfer, with the provision that these should be refurbished to become ECH Schemes.* *If there is an opportunity to develop ECH via a Section 106 agreement, this would be likely to be new build.* *In some cases, disposal of a redundant scheme as part of an asset management plan could support funding, refurbishment or remodelling costs on another more suitable scheme.*

Answers and Comments

Option supported (✔)			
1. No change		5. Demolish and rebuild	
2. Refurbish		6. Rebuild on a different site	
3. Remodel		7. Undertake more preparatory work	
4. Reprovide service		8. Consider other ways of delivering housing with support	

Question for Consideration	Notes
Has the authority/landlord examined the possibility of adapting the scheme to other uses, including use by other care groups?	*Sheltered housing schemes which are unpopular because they are not in suitable locations for older people might be appropriate for other groups such as homeless people, students, or key workers. By selling the land and/or buildings to other providers or to private developers, landlords can generate funds for new build ECH schemes.* *If this was a possibility, then rebuilding on a different site might be the preferred option.*

Answers and Comments

Option supported (✔)			
1. No change		5. Demolish and rebuild	
2. Refurbish		6. Rebuild on a different site	
3. Remodel		7. Undertake more preparatory work	
4. Reprovide service		8. Consider other ways of delivering housing with support	

CHAPTER SIX

IMPLEMENTING SUCCESSFUL EXTRA CARE HOUSING SCHEMES

CHAPTER SIX: IMPLEMENTING SUCCESSFUL EXTRA CARE SCHEMES

Introduction

Implementing extra care housing successfully calls for a range of factors to all work well with each other. Location of premises (the maxim about 'location, location location' is just as true for older people, or people with a learning disability as it is for the whole population), quality of design and accessibility, good services implemented by motivated staff, affordability and accessibility are all important and the absence of any single factor may mean a whole scheme not working well.

Consideration of each of these areas by commissioners and by providers is essential not only to ensure that operationally the scheme runs smoothly but also to make certain that the scheme adheres to the overall philosophy of extra care and delivers its own particular desired objectives. This chapter takes commissioners and providers through the key areas that need to be addressed and considered during the developmental stages of an extra care housing scheme. These areas include:

- Location.
- Internal and external design.
- The use of assistive technology.
- The management of the scheme.
- The delivery of care and support.
- Management of allocations and maintaining a balanced community.
- Extra Care for BME communities.

The location of an Extra Care Housing Scheme

Location is of considerable importance in the development of extra care and can mean the difference between a scheme and its residents integrating and becoming part of the community, or remaining segregated and isolated. The local authority and providers should have regard to the following site specific criteria when making such a decision:

- The relationship of a scheme to the local community in which it is to be located.
- Level access to the scheme and surrounding facilities.
- Proximity to retail/GP/leisure facilities/places of worship.
- Links to existing services for older people.
- Proximity to other older people's accommodation.
- Easy access to GP/primary care and other community health services.
- Planning requirements constraints.
- Low crime/low risk neighbourhood.
- Easy access to local transport services.
- Potential market for mixed tenure.
- Whether an existing sheltered scheme will be refurbished or land used for new build.

Design and Extra Care

The design of housing and public spaces is of great importance to the prospects for active ageing and well being in older age. Aspects of the internal and external environment can have the effect of enhancing or diminishing the ability for an older person to have a home for life. It is also important to consult with a wide range of prospective occupiers. It is easy for people who are

younger or who do not have disabilities to make assumptions about what other people might want. For example, it often seems to be inevitable that older people are portrayed as wanting tranquil settings with gardens and rural views. For people who have lived all their life in an urban setting this may not be an accurate assumption. Extra care housing through design needs to reflect the lifestyle that older people wish to lead and provide accommodation that does not present barriers to ageing but instead enables and promotes independence and participation.

The design of an extra care scheme needs to adhere to a number of minimum requirements, eg, that space standards should not drop below a certain size (about 50 square metres). Over and above minimum requirements, extra care needs to incorporate design features which can support people with a range of needs. These include:

- Visual impairment.[58]
- Hearing impairment.[59]
- Mobility impairment.
- Cognitive impairment.[60]
- Learning Difficulties.[61]

Schemes that are developed specifically for specialist groups may find that further consideration needs to be given to certain elements of design. This may not always be as simple as it seems in that design features that may work well for some people, say with dementia, may not always work well for people who also have a visual impairment. However, the list below gives some general examples of the design features that may be considered for people with a dementia:[62]

- A simple layout to the scheme possibly incorporating small clusters of flats around a central space.
- Familiar, domestic, homely style.
- Plenty of scope for ordinary activities (unit kitchens, washing lines, garden sheds).
- Unobtrusive concern for safety.
- Different rooms for different functions.
- Age-appropriate furniture and fittings.
- Safe outside space.
- Space big enough for lots of personal belongings.
- Good signage and multiple cues where possible, eg, sign, smell and sound.
- Use of objects and colour orientation to help people find their way, eg, corridors painted in different colours and named.
- Enhancement of visual access.
- Wired for full use of assistive technology.[63]
- Plan to facilitate walking routes.

Design needs to be considered at an early stage of a development, and effective partnerships need to be built with architects who have experience in developing specialist accommodation for older people. Future proofing is also important if schemes are going to remain an attractive option for the future. As Nigel Appleton states:

[58] The RNIB have produced a number of publications that deal with design issues for people with visual impairments.
[59] The RNID have produced a number of publications that deal with design issues for people with hearing impairments.
[60] More detailed design guidance for older people with dementia can be found at:
a) Home Solution. Housing and Support for People with Dementia. Housing Association Charitable Trust. London. Cox, S. (1998).
b) Put yourself in my place: designing and managing care homes for people with dementia. Policy Press. London. Cantley, C, Wilson, R. (2002).
c) The Suffolk Extra Care and Dementia Design and Management Guide. Suffolk County Council.
[61] The Housing LIN fact sheet no. 3. New provision for Older People with Learning Difficulties. Provides guidance on designing for communities with Learning Difficulties. (2003). CSIP.
[62] Several of these points have been taken from the Suffolk Guide, op cit.
[63] Further information on assistive solutions for individuals with dementia care be found at, Dementia Care. A Technology Guide. (2004). Tunstall Group Ltd.

'Looking back at the short-sightedness of so many of our policy decisions over the past forty years we might hope that we could do better. But the evidence is that we continue to put up buildings that will stand for a hundred years or more, finance them over twenty or thirty years but work with models that have no more than ten or at most fifteen years' future proofing in their design. It remains as difficult as ever to secure funding for future proofed design. Who in 2025 will want a one bedroom retirement flat? Yet they are being built because our funding and land use constraints push providers toward them.' [64]

Attempting to future proof at least requires undertaking detailed consultation, not only with residents and prospective residents, but also with people in their 50's and 60's to ensure that they can feed into the design their expectations and requirements of such an environment. Detailed guidance for the design of extra care schemes has been developed by PRP architects on behalf of the Housing LIN,[65] and commissioners and providers wanting detailed information and references should refer to this. However, in brief the following factors should be the main drivers behind the design and development of an extra care scheme:

- To provide a 'home for life' as far as practically possible.[66]
- To create an enabling environment.
- To be domestic in style.
- To create a building to be proud of.
- To enable staff to run and manage the building efficiently and to meet care and support needs of residents.
- To allow individuals to find privacy, comfort, support and companionship.
- To create a resource for the local community.
- To provide green and intelligent housing.[67]

In order to assist commissioners and providers in starting to think about the core elements and design of an extra care scheme, a typical design schedule has been included within the tools section of this chapter. It is intended to act as a starting point, from which to develop some principles about schemes to be developed which can then be further built upon in partnership with designers and architects.

Assistive Technology and Telecare

The term Assistive Technology (AT) is an umbrella term which describes, 'any device or system that allows an individual to perform a task that they would otherwise be unable to do or increases the ease and safety with which the task can be performed.'[68] It has:

'The potential not only to achieve cost savings, particularly in the management of acute conditions, but also is a key component in the drive to allow people the choice of staying longer in their own homes. An additional benefit is that patient autonomy will be increased in that patients will play a more active role in the management of their own conditions.' [69]

The implication of the above definition is that many very simple aids like lever taps, grab rails and poles, electric can openers, walking frames, wheelchairs, telephones with large numbers, are all forms of assistive technology, as well as assistive solutions that rely on technology.

Telecare and Telemedicine are both assistive solutions that rely on technology. Telecare can be described as 'care provided at a distance using information and communication technology',[70] and Telemedicine is the 'provision of medical care remotely by

64 Future Care @ Home. A collection of papers for the Housing Learning & Improvement Network. Ed. Jeremy Porteus. (2005).
65 Housing LIN. Fact sheet no. 6. Design principles for Extra Care. CSIP. (2004).
66 Recent guidance from the national association for almshouses suggests that all housing should be designed to cater for life expectancies of 100 years.
67 Further information on providing green and intelligent housing can be found in Housing LIN fact sheet no. 13. Tackling ECH with environmentally friendly design. CSIP. (2005).
68 The Role of Assistive Technology and Alternative Models of Care for Elderly People. Centre for Rehabilitation and Engineering. King's College London. Cowan, D & Turner-Smith, A. (1998).
69 Delayed Discharges. Third Report. The Select Committee on Health. House of Commons. (2002).
70 ICES Topic sheet. Telecare.

means of information and communication technology. The essence of telemedicine is that it allows monitoring of a person's physiological condition to take place from a GP or consultant's office (or medical centre).'[71]

Within extra care specifically, telecare has the ability to provide a platform by which schemes can support not just the residents of a scheme itself but also the people in need of care and support within the wider community through monitoring and/or a call out service. The Department of Health announced in 2004 that they had allocated £80 million over a two year period for local authorities to further develop innovative approaches with partners to support older people at home through telecare.[72]

The table below illustrates the main types of telecare and telemedicine currently available, and the outcomes that they can achieve not just for staff, but also for older people and their carers, within a scheme and in the surrounding community. Housing LIN, Factsheet 5 'Assistive Technology in Extra Care', CSIP 2004 provides further information on the topic and summaries the most common applications within a scheme.

Table 13 Types of technology and their application

Technology Type	Core Equipment	Outcomes for practitioners, users and carers
Telecare	• Dispersed alarm and telephone with a remote trigger – a pendant, brooch or wrist alarm. • Fall, flood, smoke, carbon monoxide, movement detector and a temperature sensor. • Alternate links to a call centre or on-site staff. Additional devices can be added based on individual needs such as: • Lifting beds or chairs. • Pressure mats – which can be placed anywhere. • Fridge door open/close detector. • Front door open/close detector. • Life style monitoring – systems that can learn an individual resident's routine, and then prompt a response should change be seen. • Electronic prompts, eg, *'Have you remembered to take the red pills today.'* • Physiological monitoring, eg, body temperature, pulse rate and much more. • Video phones.	Provides security on onsite; 24 hour communication system for residents, staff and carers. Enables staff to easily contact each other across site. Provides additional support to residents that allows them to be discharged early from hospital and remain at home. Offers flexibility of a solution that can evolve to meet changing needs. Helps to combat the effects of confusion in dementia and enables monitoring of relative by carer. Enables monitoring at night which reduces staff numbers and gives greater privacy and less intrusion to residents.

[71] Housing LIN. Factsheet no 5. Assistive Technology in Extra Care Housing. CSIP. King, N. (2004).
[72] Building Telecare in England. Department of Health. (2005).

Technology Type	Core Equipment	Outcomes for practitioners, users and carers
Telemedicine	The key equipment is a physiological sensor, commonly incorporated in a wrist band, which sends data via the telephone to a central control centre or direct to a doctor. Typical equipment monitors: • Blood pressure. • Saturated oxygen level. • ECG. • Weight. • Skin temperature.	Contributes to reducing the demand on health services through remote diagnosis and treatment. Enables more timely medical action or therapy. It may give the individual greater control and understanding of their own condition thus enabling more self help. Assists in recuperation, rehabilitation and earlier discharge from hospital.

Best Practice Examples

SMART HOUSE[73]: in partnership with Housing 21 and Bath Institute of Medical Engineering, Dementia Voice has converted an ordinary three bedroom house into a dementia friendly environment that demonstrates how technology and design can assist people with dementia to retain independence especially within their own home.

West Lothian Council: have researched and tested technology as a support mechanism and undertaken intensive staff training in technology and new models of care. As a result it is the first organisation in Europe to successfully mainstream the use of telecare technology within housing, social care and primary care services for older people.

Nottingham County Council: Nottingham is helping to develop confidence in technology by providing IT suites in all sheltered housing and extra care, and providing adult education courses in technology.

The management of an extra care scheme

Given that extra care housing is a growing and developing area and one where there is already a wide diversity of schemes then it is of little surprise that there is a lack of consensus as to what skills and abilities extra care housing managers need. Overall, it is clear from a range of studies that extra care is influenced by three key factors:

- The ethos that a provider organisation ascribes to extra care.
- The objectives that a provider organisation wants a scheme to achieve.
- The background that a manager brings to their role.

In addition, it would be expected over time that added to this list will be the specialist training a manager receives. Clearly whilst existing training in housing management or care is important, if schemes are to achieve the wide range of goals described in the early chapters of this toolkit then a wider knowledge base will be required. Skills already identified include:

[73] SMART homes are properties which incorporate a communication network that connects the key electrical appliances and services and allows them to be controlled, monitored or accessed either by the occupant or from outside the building.

- Care management.
- Housing management.
- Health symptoms recognition.
- Building communities.
- Managing staff, funding and finance.
- Marketing and promotional skills.
- Design.

For many providers in making an appointment the key initial decision is often between an emphasis on care or housing as the table below illustrates:

Role of manager	Advantages of approach
The scheme manager as a housing manager: • Manages the building – including lettings and tenancy issues. • Manages cleaning staff and co-ordinates building related services, eg, repairs and maintenance, gardening etc. • Liaises with care and support or other service providers. • May manage catering staff and handyman service. • May manage low level preventative liaison services including supervision and provision of facilities and management and recruitment of volunteers.	• Separation of accommodation and care is more congruent with community care principles. • Commissioners are less likely to insist on registration. • Separating support and care ensures that housing support services in the shape of low level preventative interventions are not lost.
The scheme manager as housing and care manager: • Is involved with staff from partner agencies in allocating places. • Has line management responsibility for both care and support staff. • Probably involved in deciding whether people meet eligibility criteria for the scheme. • Liaises directly with social workers to increase or decrease care hours as appropriate. • Is responsible for community building within the scheme.	• Avoids danger of demarcation disputes between care and support workers. • Gives control of quality of care – ensures that the philosophy of independent living will be adhered to. • Provides a seamless service.

Table 14 Balancing care and housing needs in appointing extra care housing managers

Whichever of the above routes is chosen or whatever background the manager comes from it is always likely that a balance will need to be struck between these competing demands. Those appointed from a housing background will need to acquire skills in care management and vice versa for those who were former care home or domiciliary care managers.

Further guidance on the management of schemes can be found in Housing LIN, technical brief no.1 Care in Extra Care Housing, CSIP (2005). For independent sector providers the Association of Retirement Housing Managers has produced a code of practice for private retirement housing. It is designed to promote good management practice and sets out the statutory obligations that apply to the management of leasehold properties.[74]

In addition to the issues regarding the management of schemes there are a number of workforce issues which will affect recruitment, training and retention of staff in extra care. Further information on issues to do with workforce can be found in Housing LIN fact sheet no. 15, 'Workforce Issues in Extra Care Housing', CSIP (2004) and Housing LIN report, 'Extra Care Housing, Training and Workforce Competencies', CSIP (2005).

Best Practice Example

Suffolk County Council's Operational Model: Suffolk County Council has developed a template for the development of an operational model for an extra care scheme. Once completed the document will act as a reference to all interested parties (including tenants) as to the nature of the service and how it will be managed so that everyone knows what they can expect from the service. A copy of this model can be found in the Tools section of this chapter.

The provision of care in extra care

Ensuring the delivery of care within an extra care scheme requires local authorities to consider how that care will be commissioned, provided and how to calculate the hours of care required. Detailed information on each of these areas can be found in the Housing LIN Technical brief 1, Care in Extra Care Housing, CSIP (2004).

There is a great deal of diversity in the way that the provision of care within an extra care scheme can be commissioned, managed configured and delivered. However, despite the variety there are a number of features that define and are common to the provision of care within local authority extra care housing schemes.

1. The separation between housing and care provision. This is important if local authorities are to reduce the risk of being seen to provide accommodation and care together within the meanings of the Care Standards Act and, therefore, would be required to register as a care home.
2. An occupant would normally have two contracts. One with the housing provider for the accommodation and related services, and a separate agreement for care. The occupant should be under no obligation to receive care from the provider on site, but more often than not will do so for convenience and because the availability of care on site was one of the reasons for moving to the scheme.

[74] Private Retirement Housing Code of Practice. ISBN: 0-9526691-2-9. Association of Retirement Housing Managers. (2005).

Models of care

Although models of care provided within an extra care scheme may vary, how the care is provided should be distinguished by a number of characteristics. It is these characteristics which make the provision of care in extra care distinctive from traditional domiciliary care provision, and which ensures the creation of an enabling and independence enhancing environment. The table below outlines these characteristics of care.

Feature	Description
24 hour Care and Support Teams	What makes extra care distinct from other forms of supported housing is the 24 hour presence of a care or combined care and support provider. Care may be provided either by on site staff, in house, but with off-site in-house care services or by external domiciliary care providers. Scheme managers with responsibility for both support and care may have a fixed number of support and care hours which they can allocate across a scheme. Sometimes scheme managers may take on the care manager role. Some research suggests that care hours tend to rise on entry to the scheme, but by the end of a year they have usually dropped to a level which is slightly higher than they were receiving at home.[75] However, this finding is disputed by other scheme accounts. In addition to the formal care a scheme may provide or that may be available, the fact that extra care is about people living in their own homes, makes it much more conducive for friends and relatives to also provide care and support in a way that is hard to achieve in care home settings. Where care and support is to be delivered by separate groups of providers it is important that commissioners recognise the increased need for care co-ordination if the service is to appear seamless to the service user.
Flexible and Responsive	Whilst care is delivered on the basis of care plans, in order to maximise the unique benefits of extra care housing, flexibility should be built in to the planning process in order to enable care staff to respond to temporary fluctuations in the need for care.
Independence Promotion	Supporting independence is central to extra care. This means supporting people to do things for themselves rather than simply doing things for people. The way in which care is delivered is critical to achieving this. Staff should be trained to support independent living and care plans written in such a way as to enable this approach.[76] The Housing LIN has reviewed the core competencies for extra care housing and has identified relevant training and minimum occupational standards for staff.[77] An example job description for extra care managers can be found in the tools section of this chapter.

[75] An Evaluation of an Extra Care Scheme. Hanover Housing Association. Baker. (2002).
[76] Housing LIN Guidance Notes ECH Training and Workforce Competencies. CSIP. (2005).
[77] Housing LIN. Factsheet no 9. Workforce issues in Extra Care Housing. CSIP. (2005).

Feature	Description
Holistic Care	As well as the provision of personal and practical care, many authorities advocate the importance of adopting a holistic approach to the provision of care and support in its extra care schemes. Especially important is the provision of effective and appropriate social and leisure activities to encourage independence, healthy living and maintenance of lifestyle and wellbeing.
Balance of Needs	In order to create balanced communities in which there are residents with varying levels of care and support needs, providers will need to manage entry into the scheme in order to maintain this balance. The preferred balance of many providers is the 'thirds principle'. A third of occupants will have few or no care needs, a third will have medium needs and a third high level care needs. However, achieving this may increase the level of voids within a scheme and commissioners need to build this into their costings (see managing tenancy allocations below).

Table 15 Distinctive features of care provision in an extra care scheme

Detailed discussion of models of delivery for extra care can also be found in 'Care and Support in Very Sheltered Housing' from Counsel and Care (2003) and 'Blurring the Boundaries: a fresh look at housing and care provision for older people', written by Christine Oldman and published by Pavilion Press in the series Research into Practice (Joseph Rowntree Trust, 2000).

Managing tenancy allocations and maintaining a balanced community within the scheme

The allocation criteria of a scheme will be largely dependent on the population for which it seeks to provide. For example, schemes that are aiming to divert prospective tenants from care home provision are likely to have similar entry criteria. In contrast, for schemes aiming to accommodate people with a range of care and support needs, the intention is to create a dependency mix through allocation. Whatever the criteria for entry, this needs to be decided well before the opening of any scheme, and as a result of discussion between all the commissioning partners, including the PCT, and the GPs of applicants.

For those schemes which aim to provide a home for life, the balance of dependency within the scheme can only be managed on entry, and people will remain as they get more dependent. Therefore, newly available places may well be assigned to people who are relatively able. Usually it is the scheme manager, in consultation with the allocations panel, who will know what level of dependency is appropriate in a potential new occupant, but the reasoning behind the decision needs to be clearly understood by all involved. Clearly there is a tension to be managed between providing a resource for the most frail or those with high mental health needs as compared to those who are less incapacitated. In making allocations it is important that all partners are represented and that conflicting organisational objectives are made explicit early in the process. For example, housing officers may be concerned to fill voids as soon as possible, while care managers may want to delay allocation to ensure a balanced community.

Where schemes have been developed purely by public subsidy and provide accommodation at a social rent, applicants will usually be required to go on the housing register and will be in housing need. In addition, applicants will usually have some care and support needs. Suffolk County Council stipulates a minimum of 4 hours care and support, with no maximum, which it finds enables a mixed community to be formed. For schemes which include an element of public subsidy and/or the provider is offering shared ownership and/or rented housing alongside leasehold, a lettings policy will usually be agreed between the provider and commissioner and a lettings panel established. Where extra care is developed without public subsidy, entry into the scheme will be dependent on the provider's entry criteria and the individual will usually be required to purchase a long

Best Practice Examples

Leicester City Council: Leicester City Council have produced guidelines for social care and health staff when making referrals to extra care and sheltered housing. Further information can be found in the bright ideas section of the Housing LIN website.

lease.

Extra care schemes for BME elders

For older people from an ethnic minority, the provision of extra care tends to be piecemeal and there is less likely to be a scheme reflecting their needs and lifestyle within their immediate neighbourhood although a number of schemes have been developed recently. These tend to have been driven by BME voluntary organisations and some funded in part by the DH Extra Care Housing Fund, or Housing Corporation Social Housing Grant. A recent survey by PRIAE of Housing Commissioners[78] and providers suggests that current demand for BME extra care housing far outstrips provision, and that both policy makers and providers, and social and private sector housing with care for older people, need to urgently stimulate the housing provision for extra care to BME elders.

There are a number of inhibitors, which may prevent older people from BME communities entering mainstream housing, for example, difficulties in undertaking religious observance in mainstream provision which has different ethnic and religious norms. The recent 20:20 study, 'A vision for housing and care' highlighted a number of issues that need to be considered by LAs and providers in relation to BME communities and the provision of extra care:

- Existing residents in schemes are not all open to an equalities and diversity agenda and, therefore, must ensure that proper support is given to BME elders when moving into schemes.
- LA need to create dialogue with diverse communities to establish their housing and care aspirations.
- Work with older people from diverse communities to develop generic housing models that all older people would want to live in.
- Respond to diverse needs from more affluent older people by influencing private sector developments.

A recent report for Housing LIN, 'Developing Extra Care for BME Elders', CSIP (2005) focuses on issues around providing specific extra care housing to BME elders. It also provides a self assessment checklist for commissioners and providers to consider when developing their extra care housing strategies and delivery plans. The Housing LIN has also produced a useful DVD and accompanying CD resource pack, 'Embracing Diversity: a look at housing with care', CSIP 2006.

[78] MEC UK. Research Summary Briefing. PRIAE. (2005).

Best Practice Examples

Bradley Court: Bradley Court is an extra care housing scheme near Huddersfield, West Yorkshire. It provides 46 flats and a day centre serving 30 further local older people. Kirklees Black Elders Association devised the original idea for the scheme, in response to the large number of black elders in the area living in unsuitable properties. A partnership between Kirklees Black Elders Association, Methodist Homes Housing Association and Kirklees Metropolitan Council developed the project. Cultural sensitivity played a central role in the development of the project from the start, reflecting the needs and preferences of the residents. For example, both European and West Indian food is served on a daily basis, the specific hair and skin care needs of African Caribbean people are catered for, and tenants are free to organize events and activities that suit their preferences and lifestyle.

Fradel Lodge: Fradel Lodge is a supported housing scheme in North Hackney located on Schonfeld Square where there is, in addition, general needs housing provision and residential care. The scheme is run by Agudas Israel Housing Association. It is aimed primarily at the local Charadi community. The development of Fradel Lodge into an extra care service will allow older people from the wider surrounding community access to existing and new community services.

Tia Hua Court [79]**:** Tia Hua Court is an extra care housing scheme for a small community of Chinese elders in Middlesbrough. Chinese elders are few in number in the area and as a consequence tend to be quite socially isolated. Initial concerns over low demand were assuaged by a survey showing a high demand among the Chinese community for extra care housing. Like Sonali Gardens the complex incorporates a community centre and a commercial space for the wider community, but focuses on providing culturally appropriate care for Chinese elders. The planning and consultation phase lasted ten years and involved the local Chinese Association and the Chinese community as a whole in the planning. This resulted in culturally appropriate design, including wider door frames, lots of glass to create a light ambience, no flat number 4 because of the association with bad luck in Chinese folklore, and Chinese subscription satellite television.

Housing LIN Case study no 20, BME: Older Peoples Joint Service Initiatives – current strategies, CSIP, (2005): this case study provides a useful summary of the approach adopted by Sheffield City Council to meet the needs of their local BME population.

HOPDEV: 'AT HOME': an audit tool for housing and related services for older minority ethnic people. The 'AT HOME' toolkit has been designed to help ensure that housing and related services take account of the needs of black and minority ethnic (BME) elders. It will be particularly useful to service commissioners and providers, as well as older people from BME groups.

[79] For further information see Housing LIN. Case study no. 11. Housing for Older People from the Chinese Community in Middlesbrough. (2004). CSIP.

CHAPTER SIX
TOOLS

This chapter includes tools and guidance on:

1. A Checklist for the Design of Extra Care Housing
2. A Checklist for an Operational Policy for Extra Care Housing
3. A Checklist for Skills and Experience for Scheme Managers
4. Planning the Use of Assistive Technology in Extra Care Housing

A Checklist for the Design of Extra Care Housing

Typical Schedule of Accommodation

The following schedule represents a scheme of 50 flats and gives an indication of spaces to consider with suggested floor areas. Project specific factors will dictate which spaces are appropriate and where they are located within the scheme. For example some schemes will offer formal day care and will, therefore, be able to sustain more activity spaces and there will be different requirements in schemes located in vibrant urban settings as opposed to a quiet rural area.

Accomodation	Approximate Area
RESIDENTS ACCOMMODATION	
34 Number One-Bed 2-Person Flats (See Typical Layout in Appendix). 16 Number Two-Bed 3-Person Flats (See Typical Layout in Appendix).	51 sq metres 68 sq metres
COMMUNAL ACCOMMODATION & FACILITIES	
Main Communal Lounge Located near to and visible from the main entrance with a focal point such as a fireplace or similar. Dining and lounge spaces should be linked but should occupy distinctly separate spaces. Views and direct access onto a south facing terrace and garden are a major benefit. Alcoves and niches will allow smaller groups to gather together.	1.5 sq metres/resident
Dining area If possible this room should link to an external terrace to allow dining outside in good weather. This space could be designed in several ways, as a restaurant or café with table service or servery counter, or as a domestic dining room. Allow space for residents using wheelchairs and walking aids.	1.2 sq metres/resident or 2 sq metres/diner
Residents tea kitchen Provide adjacent to lounge and dining space, for use by residents and for refreshments for small functions. Could double up as servery counter for main meals.	10 sq metres
Small lounges or Hobby Rooms (2 minimum) Can be located on upper floors and used for private parties with relatives, small gatherings, specific activities, etc. Should be easily accessible and not located at the ends of corridors or isolated from the main circulation route. The number of these will depend on the size of the scheme and whether the flats are arranged in clusters.	min 15 sq metres each
Communal WCs Located near to entrance area and communal lounge/dining areas. Designed for wheelchair accessibility.	4 sq metres each
Assisted bathrooms (2 minimum) At least 1 per floor, equipped with baths to allow both assisted and independent use by residents. These rooms should be designed to be as domestic as possible, space should allow baths to be located in a peninsula position.	12 - 15 sq metres

Accomodation	Approximate Area
Hairdressing & Beauty Therapy Could be located near to entrance area and might have a multi-purpose use.	12 sq metres minimum
Informal seating spaces Beside main entrance, along corridors and at ends of corridors. Number will be dependant on the individual scheme layout.	3 sq metres each minimum
STAFF & ANCILLARY ACCOMMODATION	
Managers office With views into the main entrance area, space for desk, computer table, chair, plus two visitors chairs and document storage.	12 sq metres minimum
Care Staff office Space for two desks, files storage and table for handover meetings. Privacy is important due to the confidential nature of the work.	15 sq metres minimum
Photocopy Area Easily accessible by all staff.	4 sq metres
Staff overnight room with en-suite facilities The need for this space will depend on staff arrangements and whether night waking staff will be employed.	18 sq metres minimum
Staff rest room with kitchenette Space for table and chairs plus a couple of armchairs. It may be worth considering a staff smoking area, eg, a covered external terrace.	15 sq metres minimum
Staff locker/change room & WC All staff will need locker space and possibly an area for changing clothes. Provide at least two dedicated staff toilets and consider the need for a separate staff shower.	10 sq metres
Guest room with en-suite To be designed for wheelchair user access, accommodating two twin beds with en-suite shower, WC and basin.	20 sq metres
Laundry For use by residents and staff with adjoining external drying yard. It may be appropriate to divide the laundry to provide separate resident and staff areas.	30 sq metres
Sluice room Consider the need for this facility which could be incorporated into the main laundry.	5 sq metres
Main catering kitchen and associated storage and staff facilities The brief for this space will depend on whether a full catering service is to be provided or if the requirement is for a less intensive use, eg, regeneration kitchen.	55 sq metres

Accomodation	Approximate Area
Cleaners storage	5 sq metres each
General storage	15 sq metres minimum
Large re-charging store for electric buggies and scooters	25 - 30 sq metres
Public payphone Consider whether this is required as most residents will have access to their own private telephones.	
SERVICES & PLANT	
Minimum of lift to all floors: minimum 13 person (stretcher size).	2600 x 1800mm shaft approx
Lift Motor Room if required	4 sq metres
Refuse store (including lobby and cupboard for Clinical waste).	16 sq metres
Recycling collection point	6 sq metres
Plant Room & Service Risers The size of plant room(s) will vary significantly from scheme to scheme depending on the method of space heating selected and the extent of individual metering decided upon. Space required for water storage (including the possibility of booster tanks and pumps if the building height dictates) will also vary. As a guide allow 20-25m, but ensure specialist service engineer's advice on size and location at the earliest possible opportunity.	
Electrical Intake/Meter room	10 sq metres

Other spaces to consider

A number of additional spaces should be considered which will of course be determined by factors specific to the site, the scale of development and local need. The need for such additional facilities may be identifiable but it may still be financially prohibitive. Where appropriate consider the following additional facilities:

- Shop.
- Library.
- Therapy Suite.
- Treatment Rooms.
- IT Facilities/Information Points/Touch Screens.
- Café/Bar/Pub.
- Leisure Facilities.
- Outreach staff offices.

External areas

In addition to the brief guidance on garden design given in Section 5 the following should be considered:

- Adequate Car Parking for residents, visitors, staff and visiting professionals, including disabled parking bays.
- Requirements for minibus drop-off under cover, to allow for the anticipated size of such vehicles.
- Emergency and service vehicles – turning heads and waiting bays.
- Maintenance/Garden store.
- Bicycle store.
- Refuse, clinical waste and recycling storage.

A Checklist for an Operational Policy for Extra Care Housing

Purpose of Tool

The purpose of this tool is to provide a template for the development of an operational model for an extra care housing scheme. It is provided courtesy of Suffolk County Council and the Housing LIN. Once completed it will act as a reference to all interested parties as to the nature of the service and how it will be managed.

Supported Housing – Model Operation Policy

Each Supported Housing Scheme must have an Operational Policy. The Operational Policy is a key document in the contracting arrangements for supported housing services. It stands alongside the Contract and Management Agreements. Such a policy must inform all interested parties (including prospective tenants) as to the nature of the service and how it will be managed, and so everyone knows what they can expect from the service. It is the responsibility of the Project Team developing a new Supported Housing service to ensure that an operational policy is agreed and in place prior to the scheme letting. It would be reviewed on an annual basis by the Scheme's Joint Advisory Group (JAG).

The policy must be 'owned' by the Joint Advisory Group and all partners to the service.

An Operational Policy should be divided into sections. As a minimum it must cover the following areas:

- Introduction.
- Service Purpose.
- Objectives of Service Delivery.
- Physical Environment.
- Management Arrangements (support and care and housing).
- Nomination/referral and Allocation arrangements including the County Allocation Policy.
- Staffing Arrangements.
- Quality Assurance and Monitoring.

In addition, the Policy must include a number of key attachments. These should include the following:

- Tenancy/Occupancy agreements.
- Arrears and Evictions Policies.
- Move on Policies.
- Equal Opportunities Statement/Policies.
- Complaints Procedure.
- Confidentiality Policy.
- Joint Advisory Group Terms of Reference.
- Suffolk Supported Housing Standards.
- Domiciliary Care Standards.
- County Allocation Policy.
- Tenants Handbook in an accessible format.

SECTION 1 INTRODUCTION

This section should explain what the scheme provides and how it came into being. It should outline how many people the service is designed for, in what type of housing, and the nature of their support and care needs.

All partners should be identified along with their roles and relationships.

SECTION 2 SERVICE PURPOSE

This outlines who the service is for, what level of care and support tenants can expect and principles of the service. It should be made clear that this is a **housing service**.

It should also identify the core values that underpin the service, outlining the rights that tenants have. These should include information on, for example, access to information, security of tenure and tenant participation.

SECTION 3 OBJECTIVES OF SERVICE DELIVERY

This section is the focus of the Operational Policy. It identifies in more detail the aims of the scheme. This should be agreed between stakeholders in the development process.

The section should then give more detail on:

- Care and support practices, their relationship with Community Care.
- Assessments and Care Delivery Plans.
- The arrangements to deliver person centred care.
- Tenant involvement process.
- Recordings and monitoring arrangements including tenant's access.
- Some information should be included on processes for assessing the ongoing suitability of the scheme for an individual tenant's needs, their legal rights of continued occupation, how move-on arrangements will be made and 'resettlement support' where this is needed.
- Charging arrangements.

SECTION 4 PHYSICAL ENVIRONMENT

Information should be given as to the type of housing – in terms of whether it is newbuild or rehab, number of places, whether it is shared or self-contained accommodation and to what standard it has been built (wheelchair, mobility, lifetime home).

Where the housing is shared information should be included on what shared facilities there are and what areas tenants can exclusively occupy themselves. There should also be information on how staff will work in the building and the nature of any gardens. The section should also cover the scheme's location, the surrounding area and local services.

SECTION 5 MANAGEMENT, SUPPORT AND CARE MANAGEMENT ARRANGEMENTS

This should identify to whom the property belongs, the landlord's relationship with the Care and Support providers and their relative responsibilities. This will include such things as rent collection and property maintenance and other housing management functions.

Some information on rents and service charges should be given, as should an outline of what services are being 'bought' by Social Care Services and/or the Primary Care Trusts.

SECTION 6 NOMINATION/REFERRAL AND ALLOCATION ARRANGEMENTS

This should reflect the County Allocations policy. It should also spell out in more detail for whom the scheme is appropriate. This can then be taken as a guide for referrers and for the Allocations Panel. It must include information on the eligibility criteria for the scheme.

SECTION 7 STAFFING ARRANGEMENTS

This section should include information on staffing levels, skill mixes, lines of authority and accountability. It should also be clear how the need for changes to staffing arrangements would be assessed. Some information on cover arrangements and training arrangements must be included. The document must identify how statutory requirements will be met. The links between tenant's needs, budget and staffing arrangements must be explicit.

SECTION 8 QUALITY ASSURANCE AND MONITORING

This section will identify how the Service will be monitored. There should be recognition that evidence of this will be required from a number of bodies including the Housing Corporation, the local district/borough council and Suffolk County Council.

Scheme providers will be required to have QA systems in place. The JAG will oversee this process.

There is a requirement that each scheme will have a Joint Advisory Group (JAG). The terms of reference of the JAG should be included as an attachment to the Operational Policy.

In addition, the scheme will be expected to meet the Suffolk Supported Housing Standards for which a system of review has been developed. Again the Operational Policy must recognise this and include the Standards document as an attachment.

SECTION 9 COMPLAINTS

This section will identify the different rules by which complaints can be made and resolved.

A Checklist for Skills and Experience for Scheme Managers

Purpose of Tool

This tool provides an example person specification for Scheme Managers, based on a researched set of competencies which local authorities, registered social landlords (RSLs), voluntary and independent sector providers of extra care housing (ECH) may wish to use when staffing their schemes. It is based on the findings of a research project commissioned by the Department of Health Change Agent Team Housing Learning & Improvement Network and undertaken by the Institute of Public Care at Oxford Brookes University. The project has been written up as a full report and is obtainable on the Housing LIN website under the section entitled Other Reports and Guidance. The range of skills described here may not all be present within a scheme manager on appointment. Consequently, the list could be used to indicate future training needs or for defining complimentary skills in other staff.

Person Specification

Domain	Skills and Experience	Yes	No
Scheme Management	Experience of housing/estates management and lettings, licence or tenancy agreements. Experience of managing waiting lists and referral systems. Setting up contracts with tenants, leaseholders or owners. Skills in negotiating with other professionals, eg architects. Knowledge of Health and safety/fire regulations. Basic knowledge of designing for all groups of older people Knowledge of Assistive Technology, its availability, methods of assessment and the ethical issues surrounding it. Understanding the contribution of aids and adaptations to independent living. Experience of managing and planning repairs and maintenance. Skills in promoting and explaining a scheme to visitors.		
Providing Care and Support	A focus on improving the quality of life for older people. Undertakes a person centred approach to working with people. Recognises when older people do/do not need additional support and help. Promotes care by families and friends. Works in partnership with other agencies on behalf of tenants /owners. Basic understanding of medication for the management of particular conditions, eg, dementia, stroke and diabetes. Understands eligibility criteria, allocation, assessment, care and support planning. Knowledge of adult protection issues and the duty of care.		

Domain	Skills and Experience	Yes	No
Providing Care and Support (continued)	Understanding of relevant legislation, registration and accreditation. Understands the causes of dependency. Knowledge or experience of providing advocacy. Knowledge or experience of bereavement counselling. Understanding of anxiety and depression in older and vulnerable adults. Risk analysis and management. Experience of rehabilitation and reablement – encouraging tenants to adopt and discover new skills. Understands the role of prevention in the care of older people, including the role of dental and podiatry services. Experience in the provision of activity based care. Understands the role and potential of intermediate care. Understanding of welfare benefits. Understands the physical, psychological, social, emotional, cultural and spiritual needs of residents. Understanding of how Supporting People, Direct Payments and Fairer Charging policies and practices work.		
Facilities and Maintenance Management	Experience of managing budgets. Experience in managing catering facilities. Experience in managing and maintaining communal facilities for the benefit of tenants/owners, the local community, and the provider. Experience of managing and maintaining communal laundries and bathing arrangements.		
Engaging and communicating	Experience in community liaison and development. Experience of managing anti-social and challenging behaviours. Promotes equality and diversity of employment. Experience of managing relationships with neighbours and the wider community. Understanding of community consultation and empowerment – encouraging, listening to and responding to the views of older people. Knowledge of using different forms of communication with individuals and groups. Skills relating to Intergenerational work and reminiscence therapy. Understands community transport systems and supporting residents in accessing the wider community.		

Domain	Skills and Experience	Yes	No
Engaging and communicating (continued)	Experience of working with statutory, voluntary and independent sector organisations who provide leisure activities to older people in order to increase the range of activities available. Experience of supporting service users' involvement in their social networks and local community. Promoting the principles of lifelong learning.		
Staff Management	Understands the ethos of ECH. Interpersonal/communication skills. Good planning and organisational skills. Skills which help in influencing, and negotiating with others. Experience of managing under pressure/problem solving. Promoting professional development, identifying training needs and accessing training. Experience of managing budgets/financial awareness. Experience in recruiting and retaining staff. Exercises leadership and facilitates team building. Appraisal and presentation skills. Understands roles and responsibilities of other professionals. Understands the complaints policy and accident reporting mechanism. Knowledge of business planning. Experience of managing care staff/liaising with care providers/ managing contracts. Creating a safe working environment. Understands confidentiality and data protection. Experience of working with volunteers. Understands personnel and payroll issues. Experience of managing the allocation of staff.		

Planning the Use of Assistive Technology in Extra Care Housing

Purpose of Tool

The following table reprinted from 'Mainstreaming the Caring Home' Alan Kell and Peter Colebrook in Future @ Home edited by Jeremy Porteus, CSIP, February 2005, offers some useful guidance as to how assistive technology may be used in planning Extra Care Housing.

Item	Essential	Desirable	
Property-based sensors	Smoke Gas Flood Burglar alarm	Electronic shut off values for water and gas	All Units
Smart Home	Strategic location of power points. Internet points and telephone sockets.	One or two fully equipped units provided up-front for identified clients	
Internet	Narrowband Choice of Internet Service Provider	Broadband	
Care	Supporting structure for hoists		
Telephone	External supplier choice for residents	Free internal call system resident to resident	Multiple Units
CCTV	Cross site installation linked to monitoring facility or web cams in strategic locations		
Access	Keyless lock to communal doors	Extended to all doors	
Television	Develop and own infrastructure Terrestrial and cable or satellite Terrestrial to be at no extra cost to residents	A Scheme intranet	
Fire system	Addressable system in main buildings to assist in fast identification of site of fire	Extend to all properties	
Billing for services	Menu of services and charges, cashless system as much as practicable	Access to bill data	
Building management	Heating, lighting, lifts, ventilation	Receive fault alarms Remotely interrogate devices Remotely rectify faults	
Emergency alarm	Radio sensors Resident cancelling facility Local management and remote site back up	Facility to alert relatives in parallel	Extra Care
Personal sensors	Movement detection Fall monitors Bed sensors	Tele-medicine facilities	
Environmental controls in dwellings		Building management package for lighting, music, heating, etc (perhaps an option for sale properties)	Option

CHAPTER SEVEN

MONITORING AND EVALUATING THE SUCCESS OF EXTRA CARE HOUSING SCHEMES

CHAPTER SEVEN: MONITORING AND EVALUATING THE SUCCESS OF EXTRA CARE HOUSING SCHEMES

Introduction

The tradition of monitoring and evaluation in local government has not always been strong. Often measures have involved simply deciding whether a service has or has not been provided against the funding allocated or, in the case of externally provided service, has the service been delivered in the volume, and at the price, agreed? In terms of housing it has often been about managing general supply and demand and managing waiting lists. Whilst such measures are important it does not necessarily tell commissioners whether the service or accommodation that has been purchased is delivering or exceeding the outcomes expected.

Indeed, there is an increasing recognition that if the local authority changes its primary role from provider to facilitator or enabler of provision with wider responsibilities across communities then so the skills of managers need to move from day to day management skills to a more strategic role. Similarly, the data that will be needed to inform that new role will move from analysing 'how much at what cost?' to 'what is the value of this provision in terms of the outcomes it achieves', 'why are we purchasing this service' and 'how do we influence the range of providers to deliver the kind of service that people want and need at the best possible price'?

Therefore, this chapter attempts to reflect that new role for managers, which in turn reflects the potential diversity of providers of extra care and that not all provision will be defined by its social care component. It offers suggestions to commissioners and providers, on understanding what constitutes success in terms of extra care, and how to develop effective measures that will enable an assessment of whether success has been achieved. It concentrates on approaches and tools for evaluating local schemes, although of course local evaluation all contributes to the national picture.

Monitoring the strategy

Before evaluating the development of extra care there may be value in setting up indicators to test the strength of the planning process. Based on the planning approach suggested in Chapter Three the following is suggested as a framework:

Table 16 Monitoring the Quality of the ECH/Accommodation Strategy

Topic	Indicator
Demand Forecasting	Each authority should demonstrate a good understanding of their current and future demographics, and their service user/tenants and be able to identify those people for whom extra care may be appropriate. This takes into account government and other guidance and research.
Supply Forecasting and Development	Each authority should show that they can provide an effective map of provision. This means not just listing stock but being able to analyse the value and use of that stock/service, assess its capacity and capabilities, and identify existing and future plans for development. The supply side analysis should cover all tenure types and providers not just that provided by the local authority. There should be clear references to consultation with the independent and voluntary sectors.

Topic	Indicator
Partnership Planning	There should be a clear business plan for co-ordinating partnership arrangements between agencies. The plan should cover planning, development, implementation and future monitoring. It should be detailed enough to encompass resource commitments from participating agencies and should set clear outcome and output targets.
Planning the Management of the Scheme	Each local authority should have defined a model for the day to day management of the sheltered and extra care housing that they will provide.
Developing the Financial Model	Authorities should be able to show they that have explored the full range of revenue and capital funding possibilities particularly in relation to partnership with the private and voluntary sectors.
Monitoring	Each authority should have a plan for monitoring that schemes are meeting the partnership objectives and an approach to monitoring the quality of life factors that actively involves tenants and their carers. There should be clear statements of the consultation mechanism and the level of support for the proposed approach.

Evaluating Extra Care

There are already a number of expectations from a wide range of sources as to what extra care might deliver. For example:

'Extra care housing offers another choice to the individual; a choice based on security, rights and control. A private home with your own front door but all the support you might expect in a residential home. But it must be more than a housing solution - it must be a community solution which requires the full commitment of housing, health and social care agencies.' [81]

'Studies of the Dutch 'extended' sheltered housing arrangements suggest that it can substitute in part for care home placement, reducing the rate of admission into residential and nursing homes.' [82]

'There are early indications that very-sheltered housing may reduce the incidence and duration of admission to hospital; if this proves to be the case, it will generate significant savings for the NHS that should be considered when comparing forms of care.' [83]

'Extra-care residents improve more than people in traditional forms of care: they show an average mobility improvement of more than 35 per cent; a 20 per cent improvement in daily living functions; a ten per cent increase in sensory ability; and a 25 per cent reduction in medication use.' [84]

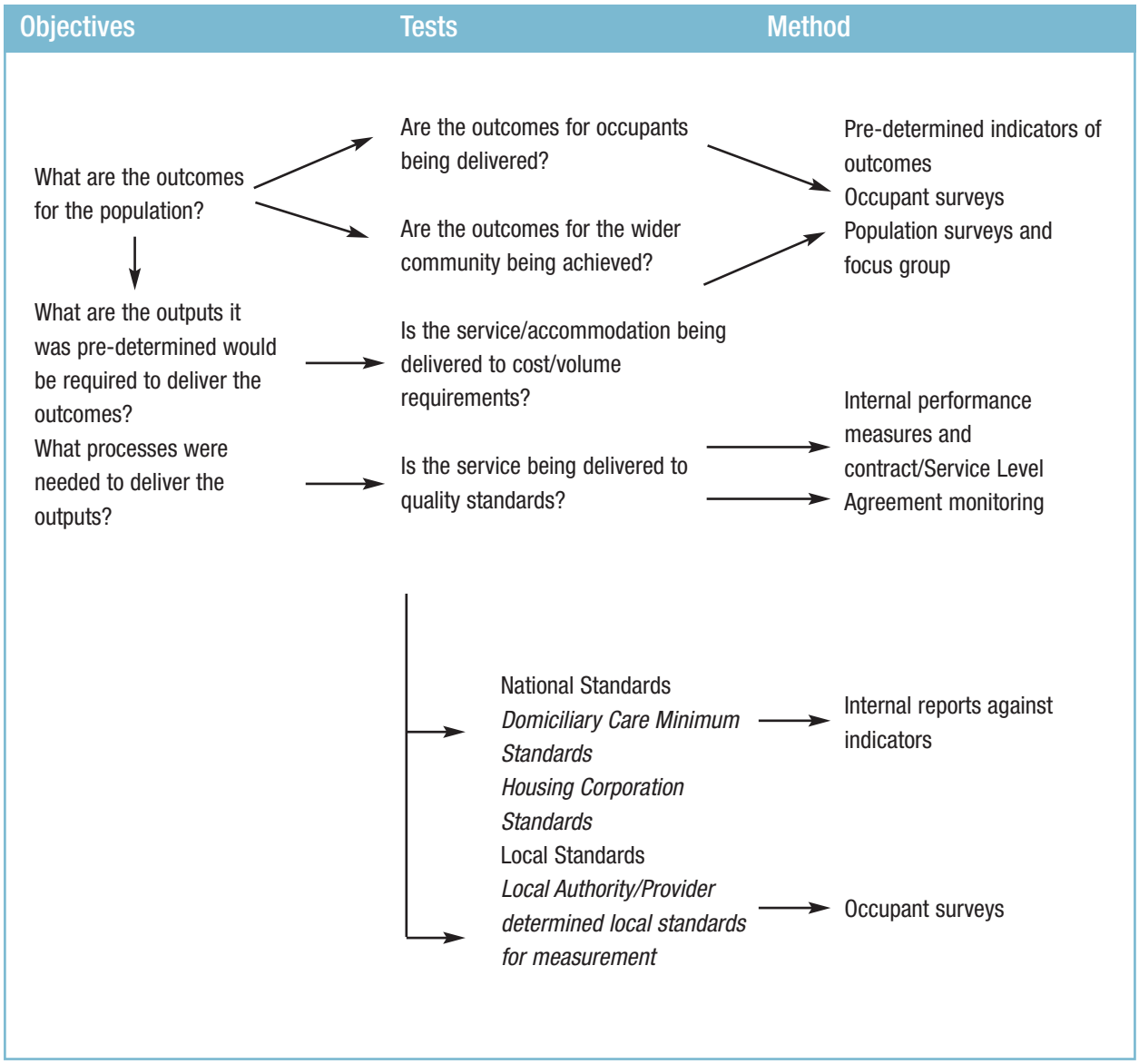
[81] Laing & Buisson Conference on Extra Care Housing. Health Minister, Stephen Ladyman. (February 2004).
[82] Coolen, et al. (1998). From Wanless review
[83] Laing and Buisson (2003/04).
[84] Extra Care Charitable Trust. (2005).

Clearly for any or all of the above statements to be proven requires clarity over the objectives for schemes in the first place as well as quality in the ongoing measurement tools and processes and the capacity to analyse results. Just as a responsible private company launching a new product would want to identify information on its market impact so commissioners of accommodation for older people, learning disability and mental health provision will want to know whether what they have designed or commissioned is delivering the outcomes they anticipated.

However, simply stating that we need to measure the outcomes is only part of the evaluation process. Figure 10 separates out the three basic components of measurement:

- Outcomes: What are we trying to achieve for the population, in this instance both of occupants and of the impact on the wider community?
- Outputs: Are the services we have put in place to deliver the outcomes, achieving their goals and targets?
- Processes: Are the processes put in place being delivered to time and in the right volume and with the right approach to deliver the outputs?

Figure 10 The process of linking objectives to measurement



Setting Objectives

Initially it is likely that amongst the development partnership there will be a plethora of objectives, some of which are held in common, some of which are conflicting and almost certainly where there is a mishmash of outcomes, outputs and process targets. Table 17 illustrates what some of these might be.

Table 17 Potential Objectives for ECH

Stakeholder	Objectives
Housing commissioners	Free up council stock: especially family homes. Revitalise sheltered housing. Develop schemes to meet demand within the local area. Reduce level of voids.
Social Service commissioners	Support more older people in the community. Reduce care package costs. Provide a venue for a range of community based services. Increase take up of individual payments whilst making sure on-site care is fully utilised. Widen the scope of intermediate care provision. Speed up hospital discharges. Reduce interventions required from GPs.
Housing Providers and Care Providers	Ensure provision is not just seen as an alternative care venue but as a desirable home. Rapid sales of properties. Improve staff recruitment and retention.
Individuals/ Carers	Retain community links and reduce social isolation. Improve the quality of life. Retain and improve family relationships.

The subsequent sections of this chapter attempt to breakdown some of the objectives into the three categories described and look at the implications for measuring and monitoring.

Table 18 Characteristics and examples of outcome, output and process measures for ECH

Type of objective	Characteristics	ECH examples
Outcome	Focus upon impact on a given population. Not concerned with details of service levels, availability, delivery or quality. Can be harder to measure than outputs and processes.	Is the scheme a home for life or not? Has the quality of people's lives demonstrably improved on becoming occupiers of the scheme? Based on a pre-determined set of indicators has people's health improved? Have family relationships been maintained? Are the wider community aware of ECH as an accommodation choice?
Outputs	Focus on desired elements of a particular service, ie, service availability, speed of delivery or quality. Can specify arrangements planned to meet outcome objectives. Should be more quantifiable and generally easier to measure than outcomes.	Where applicable, have care hours for people coming into the scheme increased or decreased? Has the development of the extra care scheme had an impact on numbers admitted to care homes in general or specifically on the numbers of people transferring from sheltered housing to care homes? Are there fewer unnecessary and unplanned hospital admissions to hospital? Has the number of referrals to GPs for falls diminished? Has the number of incidents resulting from failure to take medication diminished?
Processes	Are the commitments and ways of working needed to achieve the output objectives. The processes to be put in place to deliver the outputs, eg, procedures and policies.	Has the recruitment of owners/tenants been at the pre-determined level? Are all staff now trained to work with people with dementia? Have delays in care service response been reduced?

Setting Standards

Objectives, whether they are outcomes or outputs, are about what is hoped to be achieved and the volume, cost and characteristics of what is provided. Standards tend to be specific commitments to service quality. As Moulin[85] suggests quality can be defined in a number of different ways:

- Fitness for purpose.
- Conformance to specifications.
- Meeting requirements at an acceptable price.

However, ECH does not start with a blank sheet. There are existing standards that provider(s) already have to meet. For the care element of provision, the regulations for domiciliary care, and associated national minimum standards (NMS) which will be monitored by regulatory inspection by the Commission for Social Care Inspection (CSCI). For the housing element, The Housing Corporation scheme development standards require that Housing Associations should 'Produce appropriate good quality housing to meet identified needs'. The Housing Corporation will assess achievement against the following standards:

- External environment.
- Internal environment.
- Accessibility.
- Safety and security.
- Energy efficiency, environmental sustainability and noise abatement.
- Maintainability, durability and adaptability.

However, if it is accepted that extra care is more than just the sum of minimum care and housing provision with a 'dash of support' then almost certainly commissioners and providers will want to set, via agreed standards, their own additional commitments to quality.[86]

For schemes commissioned from providers by local authorities/health, contract standards will be set which the provider(s) will be expected to meet and which will need to be monitored. These requirements should clearly be set out from the beginning in a service specification so that providers know what is expected of them and how that will be monitored. The national standards referred to above should not need additional monitoring by service commissioners who will have access to public inspection reports.

Standards can also be drawn from research or best practice that indicates that their achievement is most likely to deliver desired outcomes and quality of provision. The table below gives examples of standards and the source(s) from which they have been derived.

[85] Delivering Excellence in Health and Social Care, Open University Press. Moulin M (2002).
[86] For example, Abbeyfield are developing a Quality Charter which enables evaluation of sheltered housing schemes against seven principles of quality of life by means of direct input from scheme residents. An adapted version of this is available in the Toolkit.

Table 19 Deriving standards from external sources

Standard	Source
Prospective tenants should be given opportunities to visit the scheme, meet staff and possibly stay for a trial period prior to moving.	Counsel & Care: Care & Support in VSH. Stirling Dementia Services – Dementia: A Practice Guide for Registration & Inspection Staff.
Regular opportunities and support will be provided to enable tenants and/or their representatives to discuss the running of the scheme, and receive feedback from managers on the results of tenants' input.	Counsel and Care: Care and Support in VSH. Alzheimers Society: Quality dementia care in care homes – person centred care. Suffolk Extra Care/Dementia Design and Management Guide. CSHS Code of Practice.

The following material is based on a set of indicators that the Institute of Public Care developed for the Abbeyfield Society. The standards were identified from materials that explored issues around quality of life for older people including research into matters that occupants themselves described as most important to them.

Table 20 Developing evidence based, occupant centred, outcome focussed standards

Standard	Rationale
Your right to privacy is respected at all times.	The right to privacy is enshrined in the Human Rights Act 1998[87] and highlighted in quality standards in relation to supported housing[88] and care home provision[89]. The Centre for Policy on Ageing asserts that ensuring residents' privacy in any care or support setting should be seen as paramount.[90]
You are able to live as independently as you wish.	Research undertaken by Abbeyfield[91] found that being independent and maintaining control over one's life was of prime importance to residents. A further study[92] also found that maintaining independence and control was one of the main themes identified by older people as forming the foundations of a good quality of life.
You have the opportunity to mix with others and join in social activities.	Past interviews with occupants showed that opportunities for companionship and social activity are important in overcoming feelings of loneliness and improving quality of life.[93] A study[94] conducted by the Audit Commission found that social activities and social networks played a vital part in contributing to improved quality of life and better physical and mental health for older people.

87 The Human Rights Act 1998. HMSO.
88 National Care Standards Housing Support Services. Scottish Executive. (2004) .
89 National Minimum Standards for Cares Homes for Older People. Department of Health (2002).
90 Centre for Policy on Ageing. A Better Home Life. (1996).
91 Independence and involvement: older people speaking. The Abbeyfield Society. Abbott, S. and Fisk, M. (1997).
92 Adding Quality to Quantity. Older People's Views on their Quality of Life and its Enhancement. Economic and Social Research Council. Bowling, A. et al (2002).
93 Opinions and perspectives of Abbeyfield residents, staff and volunteers. The Abbeyfield Society. Kellaher, L. and Schroeder, C. (1998).
94 Older people – a changing approach – Independence and well-being. Audit Commission. (2004).

Standard	Rationale
You are invited to participate in the day-to-day running of the scheme in line with your wishes.	The involvement of occupants in decision making is particularly important for people living in Extra Care. The way the services are provided to them determines to a great extent the way they live their lives.[95] A study[96] into quality of life for older people living in sheltered accommodation highlighted the importance of consultation and identified a range of issues which residents wished to be consulted on. These included security, the emergency care alarm, social activities, local facilities, styles of scheme management and the interface between housing, care and health services.
You receive help and assistance in accordance with your needs.	The Government's National Service Framework for Older People asserts that older people and their carers should receive person-centred care and services which respects them as individuals and which are arranged around their needs. Amongst other things person-centred care means listening to older people while enabling them to make informed choices and involving them in all decisions about their needs and care.[97]
You live in an environment that helps with any communication loss that you might have.	Older people have identified communication as a key theme in relation to their quality of life. A study[98] found that being able to communicate verbally and non-verbally is essential for older people to express themselves, maintain a sense of self, form and maintain relationships, participate in interaction and activities, and make meaning of their experiences.

Developing Indicators

An indicator is a means of telling whether an objective has been achieved. For example, an objective of ECH is to provide a home for life. How is it possible to tell whether this is being achieved? One indicator of this, although perhaps somewhat insensitively phrased, could be, 'the number of ECH occupants who die whilst the scheme is still their home address'. The fourth tool following this chapter gives an example of indicators developed from the set of standards shown in the Table above.

In order to measure effectively, indicators of achievement need to be set at the same time as the objectives and standards. Alongside these indicators needs to be agreement over how they are to be measured and how the costs of measurement get apportioned between the commissioner and provider.

It needs to be remembered that indicators are just as their title suggests, they are indications of whether something is or is not happening and should be used alongside other means of measurement. Making indicators too powerful as a means of measuring can cause services to become indicator, rather than outcome, focused. There are many examples of where concern has been expressed over too slavish a devotion to an indictor based model, eg, turn round time in hospital care as a sole indicator of recovery could lead to premature discharge. As a measuring mechanism it would be preferable to use such an indictor alongside others that showed whether there was a need for readmission, patients' attitude to discharge, carers' capacity to manage.

Therefore, for extra care it would be preferable to use a range of mechanisms to inform evaluation. Some may be simple tests as to whether the service was or was not delivered, was it delivered on time and in the right amount whilst others may require much more sophisticated measuring tools to explore whether somebody's quality of life has improved. The next section explores these issues in more detail.

95 'I don't want to rock the boat' – achieving resident participation and involvement. The Abbeyfield Society. Osborn, C., (2001).

96 'Not everything that can be counted counts and not everything that counts can be counted' – towards a critical exploration of modes of satisfaction measurement in sheltered housing. Health and social care in the community 12(2), p126 to 133. Blackwell Publishing Ltd. Foord, M., Savory, J. and Sodhi, D. (2004).

97 National Service Framework for Older People. Department of Health (2001).

98 Exploring perceptions of quality of life of frail older people during and after their transition to institutional care. Economic and Social Research Council. Tester, S. et al (2003).

Measuring and Monitoring

The point of monitoring is to determine whether indicators are met and, therefore, whether objectives or quality standards have been achieved. It is not about gathering as much information as possible. It is critical to think about what information will be needed for monitoring, at the same time as establishing indicators.

For example a provider may wish to reduce the number of voids caused by hard-to-let sheltered housing units, and remodelling as ECH may be the chosen option. At the point of evaluation the number of empty units can be counted. However, even for this apparently straightforward, quantifiable measure, initial work will have been needed to set a baseline number, to set up recording methods for dates of property vacation and occupation, etc.

In reviewing sources of information, it may be helpful to consider them in stepped ways and only go to the next level where the previous one does not deliver sufficient or sufficiently focussed information:

- Information that is currently collected and used locally to measure performance or quality.
- Information that is currently collected but not used as a form of measurement.
- Information that is currently not collected, but which needs to be in order to effectively measure success.

Monitoring systems should be proportionate and focussed. As a commissioner, making use of the provider's own information is more resource effective, and less frustrating for the provider, than duplicating. For confidence the commissioners may wish to sample occasionally to confirm the provider's findings.

The table below sets out some example objectives, indicators and monitoring methods. The objectives that are set as direction of travel (reduce, improve) could also be set as specific targets to be achieved, eg, no more than 10% of residents move on to more intensive care provision.

Table 21 Linking Indicators and Monitoring

Objective	Indicators	Monitoring method
To offer a home for life.	Most occupiers are still living in their accommodation when they die. All facilities within the scheme are wheelchair and hoist accessible.	Scheme records are maintained that note reasons for vacation of flats. Design standards are fully tested at start. Non-accessible facilities are assessed and change programme monitored.
To reduce admission to residential care.	Numbers per 10,000 OP supported admissions are reduced. Numbers per 1,000 OP supported to live at home increase. Numbers of ex-self funders applying for public funding reduce.	Government returns. Government returns. Council keeps specific records of requests for funding received from those already in residential care.

Objective	Indicators	Monitoring method
To reduce admissions to hospital.	Emergency readmissions to hospital for same condition. Health of occupants improves against a basket of measures, weight, fluid intake etc. Use of on-site gym. Volume of dental checks and treatment increases.	Government returns. Routine health and medication checks.
To improve the recruitment and retention of staff. To respect occupants' privacy.	Time between vacancy being created and start of new staff members. Staff turnover per year in comparison to other care sector posts. Staff do not enter a room without occupant's permission.	Local authority and provider maintain personnel records of leavers and starters. Survey of occupant experience. Direct observation.

CHAPTER SEVEN
TOOLS

This chapter includes tools and guidance on:

1. Standards for the Evaluation of an Extra Care Housing Scheme
2. An Example of a Staff Survey Form
3. Topic Framework for Conversations with Older People
4. Developing Quality of Life Indicators Against Standards

Standards for the Evaluation of an Extra Care Housing Scheme

Purpose of Tool

The purpose of this tool is to allow commissioners and providers to evaluate the success of a scheme across the different domains of Extra Care Housing. It was developed for evaluating a scheme open for a year, but could be used for more established schemes. It was designed specifically for people with dementia but many of the standards are generally applicable to extra care. This tool was developed from work by IPC with Hanover Housing and the London Borough of Barking and Dagenham to evaluate a scheme for people with dementia within the borough.

The standards set out in this table are drawn from a literature review looking at the range of standards and best practice documents that exist in the sector.

The evaluation sources are designed to obtain input from as wide a range of stakeholders as possible, and to include direct observation by the assessor. This enables 'triangulation' of findings.

This model was designed for a scheme where occupants are supported by the local authority, and 'file audits' cover both care management files and occupant files within the scheme. The schedule could be modified for use in other tenure schemes.

Occupant and family surveys need to be written in plain English, and be specific in what is being asked about, rather than asking broad based questions about satisfaction. Particularly for occupants with dementia, consideration needs to be given to support in completion of a survey, and simple means of identifying their response to questions, for example through traffic lights, or 'smiley faces'.

Interviews and surveys of managers and staff cover both housing and care. An example of a staff survey form is given as tool 2. The manager interview should be structured around topic areas identified in the standards.

Observation covers awareness of the location of the scheme within the local area, 'walking' the scheme, and reading policies and procedures.

Standard		Evaluation source
1	Assessment and Allocation	
1.1	Assessment should consider both housing need and care requirements. Referrals should be assessed jointly by key stakeholders, and be carried out by trained staff involving the service user and/or representative fully.	File Audit Manager Interview
1.2	The occupant community should contain a balance of needs and frailties, and have a social, gender and ethnic origin mix.	Occupant & Family Survey
1.3	Good quality information should be available to prospective occupants and their relatives to enable informed choice. Prospective occupants should be given opportunities to visit the scheme, meet staff and possibly stay for a trial period before moving. Prospective occupants should be fully involved in the decision to move.	File Audit Occupant & Family Survey Manager Interview

Standard		Evaluation source
2	Moving In	
2.1	New occupants should be given full information in an accessible form on their rights and responsibilities, the standard of services they should expect to receive, how to complain, the role of managers and staff, and benefits they may be entitled to.	Occupant & Family Survey Manager Interview
2.2	New occupants will be given support and assistance to orientate themselves and settle in to a new environment; they will have access to an OT assessment to ensure their accommodation is fully accessible and enabling.	Occupant & Family Survey Manager Interview
2.3	A strengths-based assessment will be carried out to produce a care plan covering care and support needs, preferences, choices and lifestyles. This care plan will be clear and easy for everyone to understand.	Occupant & Family Survey File Audit
2.4	An early review of the care assessment will be carried out no later than six weeks after a occupant's move.	File Audit
2.5	A key worker will be assigned to the occupant, who will spend time understanding and learning about their life history. As far as possible there should be continuity of care and support workers, and reliability over timing.	Occupant & Family Survey Manager Interview
2.6	A risk assessment will be undertaken within 3 days of moving in and involve the occupant and their representatives. This assessment will focus on enabling people to live their lives and maximise their strengths. It will be reviewed regularly, and as circumstances require.	File Audit Manager Interview
2.7	An assessment will be carried out as to the use of assistive technology with written information given to occupants and their families about the possibilities of the technology proposed, and the right to say no; with the full involvement of occupants and relatives/representatives in the recommendations; the entry of its use on the care plan; regular review to take account of changing needs.	File Audit Manager Interview Occupant & Family Survey
3	Care and Support	
3.1	The culture of the scheme and its partner providers is about thinking of the occupant first and foremost as a person rather than a bundle of dementia symptoms. This is reflected by the language used – staff should feel confident about challenging non-person centred language.	Manager Interview Occupant & Family Survey Staff survey
3.2	Care teams should be responsive to the needs and wishes of individual occupants, providing a level of care that neither encourages dependency nor leaves the occupant feeling unsupported. Abilities, preferences and interests may change as the symptoms of dementia change. As far as is practicable occupants or their representatives should be able to exercise control over timing and type of assistance they receive.	Occupant & Family Survey File Audit

Standard		Evaluation source
3	Care and Support (continued)	
3.3	Services should be designed to achieve maximum rehabilitative effect – if occupants have the ability to carry out tasks for themselves, staff must support them to do so.	Occupant & Family Survey File Audit
3.4	Care and support plans and risk assessments should be stored in a readily visible and accessible place in residents' flats. Care plans should be reviewed regularly with the involvement of the occupant and/or their representative. Reviews should involve both members of the care team and an external care manager. Formal reviews should take place at least every six months, as well as when there are significant changes in a person's needs.	File Audit Occupant & Family Survey
3.5	Staff will provide occupants with opportunities for sustained conversations, when they talk about themselves and their experiences.	Occupant & Family Survey
3.6	A range of preventative services should be available to assist and preserve or promote health and well-being.	Manager Interview
4	The Building	
4.1	The whole building is designed to facilitate independence through high standards of accessibility throughout. It is appropriate for the needs of service users, meeting requirements for independence, privacy and dignity. It meets the Home for Life standard and the latest Housing Corporation Development Standards.	Manager Interview Staff survey Occupant & Family survey
4.2 4.3	A range of facilities for recreational, social and educational activities are provided. The building meets basic principles of good design for people with dementia: • Making sense ("domestic" or home-like environment). • Helping people find their way around (visual cues, maximum use of light, no dead ends, use of colour to distinguish/camouflage doors etc). • Therapeutic environment (enables people to live as full a life as possible). • Safe environment (safe outdoors, use of technology, safety features). • Minimising staff stress (own space away from residents and working spaces). • Barrier free.	Manager Interview Occupant & Family Survey Occupant & Family Survey Manager Interview Staff Survey Observation
4.4	Scheme should be located near to local facilities, public transport to enable occupants to maintain social contact and allow easy access for visitors.	Manager Interview Observation

Standard		Evaluation source
5	Communication and Involvement	
5.1	Individual occupants should be able to participate in decisions about • what they might do. • their care and support. • the activity in the scheme. • and staff will support them in doing this.	Occupant & Family survey Manager interview
5.2	Regular opportunities and support will be provided to enable occupants and/or their representatives to discuss the running of the scheme, and receive feedback from managers on the results of occupants' input. There will be regular means of seeking feedback on services from users to ensure continuous improvement.	Occupant & Family survey Manager interview Observation of minutes
5.3	A clear complaints procedure is provided in accessibly written and verbal form and displayed.	Manager interview Observation
5.4	Staff will ensure all occupants have access to an advocate.	Manager interview
5.5	Carers, families and representatives are supported and involved in the day to day running of the scheme, and consulted about key issues.	Family survey
6	Staffing	
6.1	Staff are clear about their roles, responsibilities and boundaries and are aware of service ethos and philosophy – there should be a set of principles of care to which it aspires.	Staff survey Manager interview
6.2	All staff should have regular supervision and guidance. Staff should have induction and regular training which includes the service ethos/person-centred care, training about dementia and how it affects people, community development skills.	Staff survey Manager interview
6.3	Catering staff need to have detailed knowledge of the importance of food to people with dementia.	Manager interview
6.4	Parent organisations must support managers by ensuring • clarity about roles and responsibilities. • as much autonomy as possible. • they feel valued and supported. • they have ongoing management development opportunities.	Staff survey Manager interview
6.5	Teamwork is encouraged and supported through • regular team meetings. • effective handovers between shifts. • regularised transfer of information between managers (care and estate).	Staff survey Manager interview

Standard		Evaluation source
6	Staffing (continued)	
6.6	Flexibility should be managed by the scheme/care manager • staff able to carry out essential tasks for occupants as required. • staff aware of boundaries. • staff aware of their roles as enablers and facilitators. • flexibility of budgets.	Staff survey Manager interview
7	Partnership Working	
7.1	There should be joint policies between housing, care and support on information sharing and confidentiality.	Manager interview Observation
7.2	There should be a close working relationship between scheme staff, care providers, assessment teams, GPs, primary health care teams, pharmacists, health trust staff.	Manager interview

An Example of a Staff Survey Form

Purpose of Tool

To obtain views from care staff about aspects of the standards set out in the first tool. Engaging with staff contributes both an additional perspective to the evaluation, and enables cross checking of whether policies are actually implemented. This tool was developed from work by IPC with Hanover Housing and the London Borough of Barking and Dagenham to evaluate a scheme for people with dementia within the borough.

Thank you for agreeing to complete this survey to help improve the service offered to occupants of XXX scheme. Your answers will remain confidential and will only be seen by the person conducting this evaluation.

Please provide as much information and comment as you wish either in the spaces provided or on the back of the questionnaire.

1. How long have you worked at XXX scheme? (not with the same employer elsewhere)

Less than 3 months ❑
3 – 6 months ❑
6-12 months ❑
12 months plus ❑

2. Do you have a clear job description, which explains what your roles and responsibilities are?

Yes No Not Sure

3. Do you feel you understand what your responsibilities are? If there are any areas you are unclear about please give examples?

Yes No

4. Do you know what the principles of care are at XXX scheme – do you know how managers want you to look after the occupants?

Yes No Not Sure

5. Do you have regular meetings with your line manager?

Yes No

6. Do you have regular team meetings?

Yes No

7. Do you feel you know enough when you start a new shift about what has been happening, and is going to happen?

Usually Sometimes Never

8. Do you know how do get advice if you need it?

Usually Sometimes Never

9. Do you know what training you can have?

Yes No

10. Is there any training that would help you do your job better?

Yes No

11. Do you have somewhere you can go to relax during your breaks, away from residents and offices?

Yes No

12. Do you find that the design of the building helps you in your work?

Usually Sometimes Never

If not, what causes you problems?

13. Do you think the technology in the building helps you do your job (for example flood detectors, fall sensors, movement sensors)?

Usually Sometimes Never

14. Do you think the technology helps improve the quality of life of the residents of XXX scheme?

Usually Sometimes Never

15. Do you think you know enough about how the technology works, and how to use it?

Yes No

16. Are there any issues you would like to raise about the way XXX works as a scheme for people with dementia?

17. Are there any issues you would like to raise about XXX care agency as an employer?

Thank you for your time and co-operation in filling out this survey.

Topic Framework for Conversations with Older People

Purpose of Tool

To guide and support conversations with scheme occupants to find out what elements of Extra Care they value most, and what if anything they feel is missing.

In managing conversations with older people generally it is best to:

- Use existing consultation methods and forums as far as possible so as not to be too disruptive.
- Have a group of no more than 8 occupants.
- One hour is enough.
- Make the discussion 'funnel shaped' – ie ask a general question first, use what comes out of it to focus on the detail that we ask for later.

Introductory comments:

Thank you so much for agreeing to meet us. We want to hear what you have to say about (name of scheme), about the aspects of living in Extra Care that you particularly value, and about any improvements you would like to see.

Go round the room asking people to introduce themselves, how long they have lived in (name of scheme) and where they lived previously.

If you use a tape recorder – ask permission. Otherwise ask permission to take notes.

The questions:

- From your point of view – what do you most value about living here?
- Could you name three things that you were surprised and pleased with when you first came into the scheme?
- Was there anything that you were surprised to find wasn't available when you first moved in?
- Points arising from this conversation can be used to discuss occupants' expectations of the scheme, whether they are met, and ways in which the scheme has exceeded expectation. Use the following prompts if necessary.

Prompts
Do you feel that you know the different members of staff at (name of scheme) pretty well?
Do you know who to go to if you need more help, or less help?
Do you find it easy to get repairs done?
Do your family and friends feel welcome here, and do they share in decisions about the help you get?
Do you get the right amount of care and support, so that you can get on with doing the things you want to do?
Do you ever feel you get help when you don't really need it?
Are there times when you need help and it's not there?
Can you get advice on your benefits entitlements?
Are you able to choose how you spend your money, and what services you get?
Have you had advice on finance schemes, for example planning for any care needs you might have in the future?
From the point of view of the people here, which are the staff you have most contact with?
What sort of tasks are you most likely to need help with?
Is it fairly easy for you to see a doctor, if you need to?
Is it fairly easy for you to get help with a bath or shower?
Can you get help with taking tablets, if you need it?
Can you get help to stay independent – that is, help with shopping, preparing meals, housework?
Does anyone here need help to get about – for instance, to get to the restaurant or to reach the communal facilities? Is that help there when you need it?
Do you find it easy to find your way around inside the building?
Is it easy for you to get about outside the building?
Do you get support when you want to visit or entertain friends?
Do you depend on staff to arrange social activities?
Do you get encouragement and support if you want to take part in social activities?
Have you taken up a new hobby or interest since you have lived here?
Do you feel more confident in your own skills since you moved here?

Developing Quality of Life Indicators Against Standards

Purpose of Tool

This questionnaire is a means of obtaining occupants' views as to whether quality of life is achieved in a scheme. It further develops the outcome based standards outlined in the previous tool by breaking them down into indicators that would evidence their achievement. This tool is based on work that IPC completed with The Abbeyfield Society.

The questionnaire is sent to occupants of a scheme with a covering letter and offer of independent support in completion. Where it is known that occupants are likely to be anxious, or unable to complete a form without support, the questionnaire is best introduced personally to occupants. The intention behind the approach is that no staff or manager input would be given in completion or review of findings to allow confidence that occupants' views are freely given.

Standard 1	Indicators
Your right to privacy is respected at all times.	a) You have a key to your private accommodation and a key to the front door (if there is a separate front door). b) Your door is always knocked upon when staff or volunteers want to visit and they wait for a reply before entering. c) Your visitors and friends do not have to record their visits. d) You have a private toilet, hand-basin and bath/shower. e) If you have help with personal care, eg, washing and dressing, this is done privately and respectfully. f) You always receive your mail unopened unless you specifically request otherwise. g) You are welcome to install a telephone in your room (at your own expense). h) You and volunteers/staff members identified are the only people who can access any personal information that is held about you. i) You have never heard staff or volunteers gossip about you or your family or any other residents and their family. j) You feel safe and secure in your environment. k) You feel that staff and volunteers always treat you with dignity and respect.

Standard 2	Indicators
You are able to live as independently as you wish.	a) You are free to come and go as you please. b) You can get into communal rooms, eg, stairs/doorways allow wheelchair access. c) You can get into and make use of the garden. d) Your friends and relatives can visit you at any time of the day or night. e) You are able to open the front door for your visitors either personally or via an intercom system. f) You are helped, if required, to participate in activities in the local community, eg, bingo, whist drives, coffee mornings, shopping. g) You are able to make decisions about your daily life, eg, choice of food, mealtimes, bedtimes, how to spend leisure time, etc. h) You have chosen the décor of your private accommodation.

Standard 2 continued	Indicators
You are able to live as independently as you wish. (continued)	i) You live in a house that has equipment, eg, easy access baths, stair lifts, handrails to help maintain your independence. j) If you require equipment that is not available, you receive advice on how you might obtain it. k) You are always provided with food to prepare your own breakfast and hot drinks in your room. l) You receive ongoing and updated information on the local area based on what you need and wish, eg, transport, shops, library, GP, leisure facilities. m) You receive ongoing information on local leisure opportunities, eg, theatres, cinemas, fetes. n) You are helped to follow any spiritual or religious beliefs that you might have. o) You feel that you are treated equally and fairly by staff and volunteers.

Standard 3	Indicators
You have the opportunity to mix with others and join in social activities.	a) You eat your main meals with other residents. b) You sit in communal rooms and chat with others. c) You regularly use communal rooms to join in activities. d) You watch TV or listen to music with others in communal rooms. e) You feel that communal rooms are welcoming. f) You visit other residents in their rooms. g) You have the opportunity to attend a variety of activities, eg, evening socials, coffee mornings, whist drives, lunch parties, birthday celebrations, talks, music evenings, parties, theatre trips and various outings. h) You are able to work in the garden as a leisure interest. i) You participate in activities or outings as much or as little as you wish. j) You are told about any ongoing activities in the house. k) You have made a suggestion for a social activity that has been taken up. l) You feel that you have sufficient opportunities to mix with other people.

Standard 4	Indicators
You are invited to participate in the day to day running of the house in line with your wishes.	a) You receive information and are consulted on matters that affect your daily life. b) Your views are sought and information is given in a number of ways, eg, in writing, through discussion, by attending meetings. c) You receive written information in clear print and straightforward language. d) Your views are sought prior to any changes or alterations being made to where you live. e) You are encouraged to express your views to staff and volunteers through discussion or questionnaires. f) You know how to make a complaint (including any concerns about abuse or neglect). g) You have the opportunity to attend residents' meetings.

Standard 4 continued	Indicators
You are invited to participate in the day to day running of the house in line with your wishes.	h) You and your fellow residents, as a group, are able to take responsibility for some decisions, eg, organising a social event, choosing décor for communal space and hallways. i) You are able to participate in committee meetings either as a residents' representative or as a committee member. j) You have regular contact with non-resident committee members. k) You have seen changes made, within the last year, in response to yours or other residents' requests/comments.

Standard 5	Indicators
You receive help and assistance from staff and volunteers in accordance with your needs.	a) You receive the day-to-day support you request from staff or volunteers including shopping and cooking meals. b) Your dietary/cultural requirements and preferences are met through the meals provided. c) You feel that you are able to speak to staff about any support or care that you might need. d) You receive the information and/or help you need from staff to arrange personal care in your home if required. e) Your health and support needs, including any changes, are monitored and responded to by staff. f) You know that if your needs change to the point where they may be better met by you moving to a new home you will have the information and support to enable you to make that decision. g) You have access to healthcare, eg, GP, district nursing service, dentist etc. h) You have a written plan detailing the outcomes you want to achieve and the support need for this, the plan has been agreed with you and you have a copy. i) You are involved in regular reviews and updates of your support plan and can call a review. j) You can involve your relatives, carers and advocates in the review of your support plan. k) Your plan is updated following the review. l) You have easy access to a call alarm in your accommodation to call for help in an emergency. m) If your alarm is a pendant you can wear it discreetly. n) You are provided with information or help on benefits by staff. o) You can use laundry facilities or a laundry service if available.

Standard 6	Indicators
You live in an environment that helps with any communication loss that you might have.	a) If you have a significant hearing and/or sight loss staff and or volunteers communicate with you by: 1. talking where there is minimal background noise. 2. talking where there is good light and you can see the person's face clearly. 3. talking slowly but not too slowly. 4. not shouting as this can make it more difficult to hear. 5. making sure you understand what the conversation is about. 6. using facial expressions, gestures and body language to help you understand. 7. writing down key words in the conversation if this helps. 8. being patient and trying to understand what it is like not to be able to hear. b) Your accommodation helps with any communication difficulties that you might have by providing: 1. clear signs around the building. 2. a loop system if you wear a hearing aid. 3. flashing lights linked to the front door bell and fire alarm. 4. circular tables in the dining room to make it easier to see people's faces and hear conversations. 5. padded tablecloths and other soft furnishings that reduce background noise. 6. china and tablecloths that contrast with each other and the food making it easier to see the food on your plate. 7. good lighting (without glare). 8. interiors which are painted colours that contrast with faces/hair which means that facial expressions can be seen more clearly. c) You are provided with information by staff and volunteers on how to get in touch with health and social services to obtain equipment that might help, eg, hearing aids, equipment that helps with watching TV/using the telephone, talking books.