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Housing and Dementia Research Consortium Report

Provision for people with dementia within Housing with Care:

Case studies from HDRC Steering Group Providers

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1. Summary

This report describes the findings of a series of visits to Housing with Care (HWC) schemes, undertaken to assess the provision of care for residents with dementia. The case study schemes, visited between September and November 2011, included one specialist or dedicated dementia scheme (specifically designed for people with dementia) and 6 integrated model schemes (people with dementia living alongside other tenants).

The findings showed that there was little specialist provision for people with dementia in integrated model HWC schemes among the six schemes visited, with the exception of one scheme which had adopted the Enriched Opportunities Program (EOP). In contrast, the dementia specialist scheme showed good provision for people with dementia of various forms and severity. A further important finding was the existence of negative attitudes and a prejudice against those with dementia, exhibited by other residents, which management were aware of and showed a desire to reduce.

It is recommended that the findings of this study be used as the basis for a larger scale survey in order to build up as full a database as possible of the provisions for people with dementia within HWC schemes.

2. Introduction

The objectives of Housing with Care (HWC) are to enable the residents to live in a self-contained unit within a development that provides flexible person-centred care services with an ethos of homeliness, choice, independence, privacy and minimising the need to move (Dutton, 2009; HDRC. 2010). Evidence suggests that HWC offers an effective alternative to residential care, prolonged residence in the same home and can delay or even prevent moves to nursing care (Dutton 2009; Netten et al, 2011). Independence is a key objective of HWC and an HDRC scoping review of the literature relating to HWC and people with dementia suggested that this is achievable for people with early to moderate stages of dementia (Dutton, 2009). The review also showed that there is strong evidence and general agreement that it is not appropriate for people to enter HWC when they already have advanced dementia (Dutton, 2009).

Many people with dementia are able to live in HWC until the end of their lives. However, due to a number of factors it is not possible to enable all tenants, with or without dementia, to remain in the same home through to the end of their lives. As dementia and/or other

conditions progress, the need for care and support increases and, inevitably, the ability to live independently declines (Dutton, 2009).

The HDRC review found that studies relating to people with dementia in HWC settings consistently highlight the importance of person-centred care, developing staffs' knowledge and expertise in dementia, partnership working and joint working (Dutton, 2009). Thus, these factors could be used as a measure of the success of HWC accommodation for people with dementia.

A recent evaluation of 19 HWC schemes that opened between April 2006 and November 2008 in terms of delivering person-centred outcomes, costs and cost effectiveness and improving choice showed that HWC can provide many people with an effective alternative to residential care and offers an attractive option for older people who value their independence and high quality design and service delivery (Netten et al., 2011). Outcomes were generally positive with most residents reporting a good quality of life, enjoying a good social life and the social activities on offer and making new friends. About a third of those who died during the study were able to end their lives at the scheme and 90% of those still alive at the end of the study remained in the scheme. For most of those followed up, physical functional ability appeared to improve or remain stable over the first 18 months compared to when they moved in and more than half showed improvement or remained stable by 30 months. Cognitive functioning remained stable for the majority of those followed up, but at 30 months more had improved than had deteriorated. In terms of costs and cost effectiveness, the better outcomes and similar or lower costs found in the study show that HWC is a cost-effective alternative for equivalent people who currently move into residential care. In terms of improving choice, the study concluded that more capital investment and better marketing strategies were needed to ensure that HWC is made more available and appealing to more able older people, as without continuing to attract a wide range of residents HWC may lose its distinctiveness from residential care.

The EAC website, extracarehousing.org.uk, has a database of around 1160 schemes in the UK that claim to provide or facilitate care. Different models of HWC have been developed over 300 providers across public, voluntary and private sectors (extracarehousing.org.uk). The different models for supporting people with dementia can be categorised as:

- An integrated model, where the people with dementia live in flats alongside all other tenants, or
- Dementia specialist models, of which there are two main types:
  - Separate, in which people with dementia are clustered together within a separate self-contained area of the scheme (e.g. a wing or floor)

- Specialist or dedicated, which is a scheme where only people with dementia live.

It is also possible to have schemes which combine housing with care and a dementia-specialist residential home on a single site.

Research studies by Housing 21 and Hanover suggested that around a quarter of HWC residents have some level of dementia. Other studies indicate that there are very wide variations in prevalence of dementia with some schemes having few cases and others having many (Dutton, 2009). The HDRC has estimated there are 2,384 residents with diagnosed or suspected dementia within HWC properties among its core member organisations (see Table 1, below). The estimate is based on the number of properties rather than of occupants and uses a 20% estimate level for occupants with dementia, based on in-house work. Estimates range from 15% to 35%+ and actual numbers will be affected by: model of scheme (including entry criteria); availability of appropriate care (both social and health); move-on policy and practice; length of time in operation.

Table 1: Number of HWC properties among core HDRC members and estimated number of occupants with diagnosed or suspected dementia

Organisation	Number of HWC schemes	Number of properties	Estimated number of people with dementia (20%)
Anchor	29	1,055	211
ExraCare Charitable Trust	28	3,420	684
Hanover	60	2,461	492
Housing 21	98	3,600	720
MHA	29	1,254	251
Thomas Pocklington	2	132	26
Total	**246**	**11,922**	**2,384**

The extent to which the different needs of people with dementia can be met within HWC depends on the combination of characteristics of the particular scheme, e.g. size, location, design, staff training and skills, use of AT, policies and procedure, approach to security. Some of these factors are briefly examined in the following sections.

In this report the term “residents” will be used to describe the people living in these HWC schemes. It is recognised that some schemes prefer alternative terms such as “occupants”, “clients” or “service users”.

2.1 Staff skills and training

HWC is populated by a disparate workforce comprising a combination of housing professionals, social care staff, housing-related support staff and a range of ancillary staff, configured in a variety of ways. All HWC staff have an important role to play in supporting people with dementia, and the community within which they live. A study by Kitwood et al. (1995) identified the role of housing staff as critical in the integration of tenants with dementia. The National Institute for Health and Clinical Excellence (NICE) and the Social Care Institute for Excellence (SCIE) published a joint Clinical Guideline on the management of dementia in 2006. One of the key recommendations was dementia-care training for all staff working with older people.

People with dementia and their carers need to be supported and cared for by a trained workforce, with the right knowledge, skills and understanding of dementia to offer the best quality care and support. The Alzheimer's Society Home from Home report (2007) stated that, while some of the personal skills required for good dementia care cannot be taught, good induction and ongoing training are needed to develop a good staff team and have important benefits for both staff and residents. The Home from Home report found that many carers felt the care home staff's knowledge of dementia care needed much improvement. It also found that dementia care training can reduce staff turnover and increase job satisfaction; 91% of care home staff said they would like to further their skills in dementia care, with a preference for one-day courses (Alzheimer's Society, 2007). Thus, providing adequate training and support is likely to improve staff morale and ease recruitment and retention problems in dementia care. According to the Alzheimer's Society (2007) the top challenges to providing good dementia care from a care home manager's point of view are developing a staff team with the right attributes and skills and keeping them motivated.

The National Dementia Strategy, "Living Well with Dementia" (Department of Health, 2009), highlighted the importance of an informed and effective workforce for people with dementia. With respect to Objective 10 (considering the potential for housing support, housing-related services and telecare to support people with dementia and their carers), the strategy recommends: "Staff working within housing and housing-related services to develop skills needed to provide the best quality care and support for people with dementia in the roles and settings where they work". The need for improved training is a priority that runs across all the themes in the National Dementia Strategy which recognises that a lack of understanding of dementia in the workforce can lead to care practices that have a negative impact on the person with dementia and their carers.

2.2 Physical design of complex

Design of the physical environment has an important role to play in the health and wellbeing of people with dementia. Building design that supports people with dementia and meets their needs can improve their quality of life, alleviate symptoms and reduce stress levels. Good design can also maximise independence, particularly in terms of assisting vision, orientation and wayfinding through use of appropriate lighting, signposting, colour and colour contrast, and use of materials and items of interest such as artwork and memorabilia as visual cues (Dutton 2009, Housing21, 2011). There is general consensus in the field of inclusive building design that if people with dementia can easily orientate within and navigate around a building, then the building will be easier to use for everyone.

2.3 Assistive technology and other aids

There is a wide range of assistive technology (AT) devices available to support people with dementia. Appropriate use of AT that addresses the difficulties experienced by a person with dementia can: increase independence, quality of life and health; reduce the risk of accidents and injuries and increase safety and security. It can also increase the freedom, quality of life and reduce the anxiety of the carer (Kerr et al., 2010). For example, there are AT devices that can help a person with dementia with: orientation (time and place); navigation indoors and out; remembering to take medicines and carry out daily tasks such as eat and drink. There are “passive” (require no user input) devices that monitor a person's movement and routines such as eating, sleeping and toileting. Carers / care staff can be alerted in the event of a fall, walkabout, injury, dehydration, an episode of incontinence in bed and when a person leaves their flat or the building. Electronic location devices track a person’s location so that they can be found if they have gone out and become lost and disorientated. Safety and security in the home can be ensured using devices such as temperature, smoke, CO2 and flood detectors or flood prevention devices that stop sinks and baths overflowing (Kerr et al., 2010).

Assistance for people with dementia does not have to be expensive or complex or involve technology. Some very simple low-tech measures can be very effective, such as use of pictures as orientation aids and reminders: a picture that has a special meaning to the resident stuck on their front door can help them to identify their flat (this is where knowledge of the individual’s life story becomes useful); transparent doors on cupboards and units in the flat show the residents what is behind them; signs on doors that cannot be transparent, such as “Sarah, this is your toilet”; reminder boards showing the routine for the day.

2.4 Activities

The Alzheimer's Society Home from Home report (2007) found that the availability of activities and opportunities for occupation is a major determinant of quality of life, affecting mortality, depression, physical function and behavioural symptoms, but that these activities are seldom available despite the fact that staff enjoy providing opportunities of activity and occupation and would like to be able to do more of this within their work – they felt that they did not have the time for such activities. The HDRC scoping review of the literature (Dutton, 2009) found that activities have the potential to improve quality of life, delay functional decline, and increase length of tenancy for people with dementia in HWC settings. It is important to have a range of activities to choose from, the choice to join in or not and the opportunity for social interaction (Dutton, 2009).

2.5 Partnership and joint working

The HDRC scoping review of the literature (Dutton, 2009) found that, within HWC, coordination and partnership working were important factors in enhancing the quality of life of people with dementia. It is important to have joint support and joint care plans, enabling a 'seamless service' (Dutton, 2009). Schemes that are able to provide a better quality of life for residents with dementia have: integrated local strategies for housing, health, and social care services; interdisciplinary working in referral, assessment, care planning, and the provision of services; agreed arrangements for tenants to receive timely and appropriate community health services (physical and mental health services); promotion of links with the wider community (Vallelly et al., 2006). Similarly, Croucher et al. (2007) recommended that "Resources for housing with care must include appropriate support from community health and specialist health care services". In a case study of Duddon Mews (an extra care scheme for people with mental health problems and physical frailty), Garwood (2008) found that effective partnership working between key partners "resulted in the development of a much valued, innovative resource for older people with dementia and other mental health problems". It is clear, then, that to ensure a good quality of life for people with dementia living in HWC settings, it is important to have strong partnership and joint working, and integrated strategies between social care, health and housing (Dutton, 2009).

2.6 The Enriched Opportunities Program

The Enriched Opportunities Program (EOP), developed by the ExtraCare Charitable Trust and resulting from a Joint research project with the University of Bradford, was designed to support residents with dementia and dementia-related conditions. Key aspects of the program are: individualized assessment and casework; activity and occupation; a specialist staff role; staff training; management and leadership. The programme offers tailored activities for residents with dementia, aiming to reduce the disabling effects of the condition and is implemented through specially trained support workers – the "EOP Locksmiths". A research project to measure the impact of the programme on residents and staff and compare the results with sites without EOP demonstrated a number of positive outcomes for people's lives including: residents being less likely to move out into a care home and less likely to spend time in hospital as an in-patient; residents rating their quality of life more positively, being more active, having more fun and a greater variety of things to do (Brooker et al, 2009). A review by the National Audit Office (Xu, 2010) concluded that, by providing a proactive and integrated service between health, social care and housing services, the EOP demonstrates that people with dementia can be effectively cared for in HWC and if the EOP programme is implemented in all HWC in England, savings of around £21 million could result over a two year period through reduced inpatient care and less use of more intensive housing care provision.

3. Aim and objectives

The aim of this study was to gain an understanding and provide an overview of the policies, procedures and provisions for people with dementia within a selection of HWC schemes from among the HDRC core members.

More specifically, the objectives were to:

(a) determine the policies, procedures and provisions that are in place for people with dementia;

(b) compare the case study schemes in terms of these policies, procedures and provisions;

(c) identify how, and how well, the schemes have met the objectives for residents with dementia of person-centred care, developing staffs' knowledge and expertise in dementia, partnership working and joint working.

4. Method

The purpose of this study was to examine and compare the policies, procedures and provision that are in place for people with dementia within a selection of HWC schemes from among the HDRC core members. The criteria for inclusion in this study were that a scheme should aim to include people with dementia at point of entry (this may be a scheme designed specifically for people with dementia, or may include a proportion of people with dementia) and that there are people with diagnosed dementia currently living at the scheme.

4.1 Profiles of the schemes visited

Table 2 provides summary profiles of the seven HWC schemes that were examined in this study. All schemes were built or renovated within the last 11 years (see figures 1-3). Schemes 1, 3, 5, 6 and 7 were Housing with Care schemes and Scheme 2 was a HWC village. Scheme 4 provided both HWC and sheltered accommodation (in separate areas of the building, but with no physical barrier between them).

With respect to the model adopted for residents with dementia, Schemes 1-6 used an integrated model, that is people with a range of needs and disabilities including dementia were dispersed throughout the scheme. While adopting an integrated model with respect to people with dementia, Scheme 6 was a sight loss specialist HWC scheme. Scheme 7 was a dementia specialist or dedicated HWC scheme, targeted specifically, and exclusively, at people with dementia. At Schemes 2 and 3 the ExtraCare Charitable Trust was responsible for the care management and at the time the scheme visits took place, the EOP (see Section 2.6) was in operation at St Crispin Village (Scheme 2) and about to be implemented at Imperial Court (Scheme 3). At the time of writing this report, the EOP had been fully implemented at Imperial Court and across the whole of ExtraCare's housing schemes and villages.

Figure 1: Scheme 1, Poppyfields

Figure 2: Scheme 4, Olive House

Figure 3: Inside Scheme 2, St Crispin Village

Table 2: Summary details of the six case study schemes

	Scheme 1	Scheme 2	Scheme 3	Scheme 4	Scheme 5	Scheme 6	Scheme 7
	Poppyfields	**St Crispin Village**	**Imperial Court**	**Olive House**	**Henry Court**	**Pocklington Place**	**Cherry Tree**
Scheme type	HWC	"Retirement village", HWC with EOP	HWC	HWC and sheltered	HWC	HWC for people with sight loss	HWC
Scheme model (in terms of people with dementia)	Integrated	Integrated	Integrated	Integrated	Integrated	Integrated	Dementia specialist.
Year built	2004	2006	2000	2008	2007	Renovated 2007	2007
Housing management	Hanover	Midland Heart	Spire Homes	Hanover	Anchor	Thomas Pocklington Trust	Housing 21
Care Management	Housing 21	The ExtraCare Charitable Trust	The ExtraCare Charitable Trust	Housing 21	Anchor	Thomas Pocklington Trust	Housing 21
Location	St Neots	Northampton	Rushden	Hammersmith, London	Coventry	Birmingham	Moreton, Merseyside
Type of location	Suburban	Suburban	Urban	Urban	Suburban	Suburban	Suburban
Accommodation	31 flats 1 bedroom 3 interim care flats. To rent.	260 flats 1 and 2 bed 10 bungalows. To buy, part buy or rent.	41 flats 1 and 2 bed. To rent	50 flats 25 HWC, 25 Sheltered. 1 and 2 bedroom. To rent.	40 flats 1 bedroom for 1/2 people. To rent.	64 flats 1 and 2 bed To rent, part buy and buy.	10 flats (one for 2 people). To rent.
Number of tenants at time of visit	31	332	45	30	41	66	10
Number with dementia	4 diagnosed, 2-3 suspected onset.	28 diagnosed, 23 suspected onset.	3 diagnosed, 4-5 suspected onset.	5 diagnosed, 5 suspected onset.	9 diagnosed, 1 suspected onset.	7 diagnosed, 3-5 suspected onset.	10 diagnosed

4.2 Procedure

During each visit to the case study schemes, the researcher used an interview script to elicit information about policies, procedures and provisions for residents with dementia. The interview questions are given in Appendix 1. The interviewees were management and/or staff (either individuals or a group). For Scheme 7 (dementia specialist), the questions were used in a phone interview with the scheme manager.

The interviewees at each case study scheme were as follows:

- Scheme 1, Poppyfields – Area manager, Estate manager, Support Worker.
- Scheme 2, St Crispin Village – Regional Manager (Enriched Opportunities Program), 2 EOP locksmiths.
- Scheme 3, Imperial Court – Regional Manager (Enriched Opportunities Program), Care manager.
- Scheme 4, Olive House – Care Manager.
- Scheme 5, Henry Court – Housing manager, Care Manager.
- Scheme 6, Pocklington Place – Housing Manager, Support Worker.
- Scheme 7, Cherry Tree – Scheme manager (care and housing)

4.3 Limitations of the study

Only a small number of schemes were examined from within a select group of housing providers. Furthermore, schemes that adopt the separate model (people with dementia are clustered together within a separate self-contained area of the scheme) were not included in the study. Thus, the findings of this study cannot be considered representative of all HWC schemes in England but they will be indicative of the provisions for people with dementia within HWC.

5. Findings

5.1 Scheme features and provisions for people with dementia

5.1.1 Policies and Procedures, Eligibility and exit criteria

Integrated model:

For all integrated model schemes (1-6), when an individual had been referred to the scheme they were given an assessment which included an assessment of mental capacity and a risk assessment. An individual would then be allocated a place at the scheme if it was considered suitable for them, that is, if it was felt that the scheme could meet their needs, and they were expected to remain living there for a while. In practice, for people with dementia, this usually meant that only those with low level / mild dementia will be considered eligible for a scheme. For all of the schemes, except Scheme 2 (which had a standard operating procedure for referrals with dementia under the EOP), there were no eligibility criteria that referred specifically to people with dementia. Most of the interviewees stated that the individual must demonstrate the capacity to understand the tenancy agreement to be considered eligible. They stated that a family member could sign the tenancy agreement if they had a Lasting Power of Attorney, but the individual being assessed still needed to be able to understand the agreement.

Once a person was accepted into a scheme, they had their own care plan. Reassessment occurred every 6 or 12 months, but it could be at any time if a resident's needs changed, necessitating a change to the care plan.

In terms of allocations, all integrated model schemes had targets for balance of dependency. Schemes 1, 4, 5 and 6 tried to keep to the 1/3 low, 1/3 medium and 1/3 high level of care target, although this did not always work out in practice. Allocations could be refused if this balance was becoming too off target. Schemes 2 and 3 worked on 5 levels of care for balance of dependency targets. At Scheme 2 (retirement village), 50% of the residents had no care needs, they had simply made a lifestyle choice.

At Scheme 2, if an individual referred to the scheme had been diagnosed with dementia, their initial assessment was carried out by an EOP locksmith. The individual would then be offered a home if their needs could be met and they will fit in (i.e. they are able and happy to re-orientate to a new environment). The standard operating procedure was: referral; screening (to ensure that dementia is the cause of the symptoms); profiling (assessment period); communication (communicating to the rest of the care team the appropriate techniques for the individual assessed and writing these into the individual's car plan). Individual assessment and case work applied the 'Enriched Model' of dementia care.

At all the integrated model schemes the managers stated that the policy was to do as much as possible and put measures in place to help a resident to stay. They gave examples of this policy for residents with dementia such as introduction of personalised memory aids, installation of AT equipment and reassessment of care and support needs when these appear to have significantly changed. There was an understanding of the importance of getting to know the life history of a resident with dementia, in order to better understand how to meet their needs. However, if a resident's needs could no longer be met, they became a risk to themselves or others, or (according to Scheme 2 staff) their behaviour caused their dignity or the dignity of others to be compromised, then a transfer would be recommended and the family advised of the most appropriate course of action. There appeared to be good support for residents during the transition process. Some managers spoke of the problems that could occur when there is no family and a tenant refused to move out – it would then be necessary for the housing provider to go to court for an eviction. However, until an eviction could be obtained, the individual would continue to receive care at the scheme. This scenario had not occurred at any of the schemes in this case study.

The main reasons given for tenancies coming to an end for people with dementia at the integrated model schemes were: the individual becomes a risk to themselves or others; disruptive behaviour towards other residents; loss of dignity; refusing care; self neglect; care needs can no longer be met. There were no formalised exit criteria that refer specifically to people with dementia.

Dementia specialist model:

At Scheme 7, being a dementia specialist scheme, the eligibility criteria differed to those of the other schemes, in that allocations were only given to people who had been diagnosed with dementia (any form of dementia, at any stage/level of the disease classified as low, medium and high). When an individual was referred to this scheme, they were given a formal assessment by Social Services and also spent a half or full day with the scheme manager who carried out an informal assessment. Based on the Social Services assessment, an allocation panel (mainly Social Services representatives and the scheme manager) decided if the individual would be accepted into the scheme. The scheme manager was on the panel and provided her input on whether she felt a person would fit in. Priority was given to anyone who was coming out of hospital and could not go back into their own home. Signing of the tenancy agreement was timed to occur when the individual showed the capacity to understand it, albeit possibly transient capacity. Families who have a Lasting Power of Attorney could sign for the potential tenant if they lack the capacity to do so themselves. Each resident had an individual care and support plan. Basic plans were provided when a person first entered the scheme, then after the first two months fuller plans were put in place.

New residents were also given a risk assessment by both Social Services and Housing 21, and consequently had two sets of paperwork relating to this assessment. At the time of the interview, the manager was also introducing a needs form which described a resident's needs and life story. When an individual's needs changed and new care and support plans were needed, a reassessment was given. In practice, reassessments, and updating of the care and support plans, occurred every 3-6 months. As with the other schemes the aim was to keep a resident at the scheme for as long as possible, putting in measures to enable this. The primary reason for tenancy coming to an end was loss of mobility to a point where the scheme could no longer meet the individual's needs. Tenancies could also end if a resident became a high risk to their own safety or the safety of others and the risky behaviour could be predicted. For example, one resident started mopping the floors with oil (thinking it to be cleaning fluid), which put residents and staff at risk of slipping and falling. In such cases, a procedure was followed before taking the decision to end the tenancy: examination by a GP to eliminate other, physical, causes; assessment by the Social Services; consultation with the family; and, if appropriate, trying a change of medication.

5.1.2 Staff skills and training

Table 3 summarises the level of staff training in dementia awareness and care at each of the case study schemes.

Table 3: Staff training in dementia awareness and care

Scheme	**Training provision in dementia awareness and care**
1. Poppyfields	2 day course for all extra care managers. If a manager requested more training it would be provided. Refresher course every 2 years.
2. St Crispin Village	1 day course for every member of staff. 5 day course for senior staff at Worcester University and bespoke training for EOP locksmiths. Some locksmiths receive training in dementia care mapping.
3. Imperial Court	1 day course as part of NVQ (90% of staff), with refresher courses. Optional: primary care trust dementia training.
4. Olive House	Housing21 dementia awareness course for all staff. 2 day course for half of the staff at Bradford University.
5. Henry Court	1 day course with refresher courses.
6. Pocklington Place	None.
7. Cherry Tree	An NVQ in dementia care (5 months), all staff together. Refresher courses. Special training on administering drugs.

Integrated model:

It can be seen that the degree of training for the integrated model schemes varied between schemes, ranging from none to 5 day university run courses. For the specialist scheme (Scheme 7) the management and staff had an NVQ in dementia care. They also had to receive special training on administering drugs to the residents, which may need updating as the drugs change.

Stress management for staff at the integrated model schemes consisted mainly of talking to management staff and team leaders and sharing a task with other members of staff if the individual resident was particularly demanding. The ExtraCare Charitable Trust offered a helpline for staff suffering problems at work and if a member of staff was unable to cope with a resident, there were operational support teams and support mechanisms in place. The area manager at Scheme 1 felt that all staff, including catering staff, should receive training in understanding dementia so that they would know how to deal with challenging behaviour.

Dementia specialist model:

At the dementia specialist scheme (Scheme 7) there was a higher ratio of staff to tenants than at the integrated model schemes (1:2 at any time of day). Nights were covered with one waking and one sleeping shift; the sleeping night was added to allow the care provision for a tenant that required two staff to provide assistance. In terms of stress management: staff were assigned a different resident each day (as some tenants could be more demanding than others); the staff all supported each other in their work; there was good communication between members of staff; staff were given time off after a particularly stressful episode and there was counselling available if required.

5.1.3 Facilities

In terms of facilities offered to residents, all integrated model schemes provided a restaurant / dining room, assisted bathing, laundry, guest suite, lounge, hairdresser, gym, garden and a room for activities / hobbies / arts and crafts. Most schemes provided a second smaller lounge or quiet room, a computer / IT room with IT classes and green house for the gardening club. Table 4 gives a summary of the facilities provided at the case study schemes.

Table 4: Scheme facilities

	1 Poppyfields	2 St Crispin Village	3 Imperial Court	4 Olive House	5 Henry Court	6 Pocklington Place	7 Cherry Tree
Laundry	√	√	√	√	√	√	√
Assisted bathroom	√	√	√	√	√	√	√
Independent bathroom		√	√				
Main lounge	√	√		√	√	√ + bar	√
Small / quiet lounge	√	√	√		√	√	√
Guest suite	√	√	√	√	√	√	√
TV room			√ TV area				
Restaurant / dining room	√	√	√	√	√	√	√
Café / coffee lounge		√					
Shop	√	√				√	
Hair / beauty salon	√	√	√	√	√	√	
Gym / fitness room / spa		√	√				
Massage		√					
Library	√	√	√				
Computer / IT room		√	√ IT area			√	
Hobbies / activity/ craft room	√	√	√	√	√	√	
Woodworking room		√					
Village hall		√					
Cinema							
Garden	√	√	√	√ roof terrace	√	√	√
Green House	√	√	√			√	√
Snooker / pool room		√					
Indoor bowling		√					
Cash machine		√					
Chapel		√					
Well-being centre		√	√				
GP surgery		√					
Day Centre				√			

Integrated model:

The only integrated model scheme to provide a facility specifically for residents with dementia was Scheme 2, which had an “Enriched Opportunities Suite” for activities tailored to people with dementia. This suite included a kitchen with transparent cupboard doors. Scheme 1 had a nostalgia / reminiscence room but this was not used.

Some schemes offered more interaction with the general public by enabling the facilities to be used by the local community. Scheme 6 (Pocklington Place) operated a “Community Hub” whereby all of the facilities on the ground floor were available for use by the general public – the hairdressers, restaurant and activity room were open to all ages, the IT suite was for the over 50’s only. Door entry security systems operated to the residential areas.

The interviewees commented that such interaction with the local external community had caused some conflicts at first but the situation was improving. They felt that the Community Hub would ultimately benefit the residents and the local community. A number of external groups used the facilities to meet and carry out activities and classes, offer information and advice and run support services. They could not think of any particular benefits to those residents with dementia except for the access to the Working Age Dementia group...

Hanover management stated that: we actively encourage the use of facilities on all of our estates to older people in the community.

Most schemes did not currently offer their facilities for use by the local community and had entry security systems on the front door and doors to residential sections (a keypad and intercom for visitors and key fob / card key for residents).

Dementia specialist model:

Scheme 7 (dementia specialist) had fewer facilities than the others and the manager felt the lack of available rooms to be a weakness of the scheme (See Section 5.2.2). Opposite the scheme was a hairdresser, chip shop, general store, post office and a park which residents made use of (accompanied by a member of staff). A fob controlled entry system operated at this scheme.

Unlike the integrated model schemes, which provided a selection of set meals at a specific time each day, the kitchen at Scheme 7 was open all day every day, with residents constantly being invited by staff to have cups of tea and biscuits (a good way to keep them hydrated). Staff would try to arrange it so that people had lunch together, if possible, as this helps with appetite. Each resident at Scheme 7 had their own personalised routine, which may involve eating meals at odd times. To further stimulate appetite, red plates were used, which, according to the manager, have been found to encourage eating for people with dementia by making the food stand out.

5.1.4 Physical design of complex

Integrated model:

The integrated model schemes tended to have different colour schemes / design themes on each floor of the building (see Table 5, below) which can help with orientation and wayfinding for people with dementia. Staff interviewed stated that this design feature was not intended specifically to assist people with dementia, however, they may have been unaware of the original intentions behind specific design features of the building. Two of the schemes also had different colour front doors to the flats.

Table 5: Summary of physical design features that can assist people with dementia (integrated schemes).

	Scheme 1	Scheme 2	Scheme 3	Scheme 4	Scheme 5	Scheme 6
	Poppyfields	**St Crispin Village**	**Imperial Court**	**Olive House**	**Henry Court**	**Pocklington Place**
Number of floors	2	4	2	5	3	3
Difference between floors / flats	Floor colour scheme.	Floor colour scheme. Front door colour.	Floor design theme. Front door colour.	Floor carpet colour.	Floor colour scheme.	Floor colour scheme.

For all the integrated model schemes the staff interviewed stated that if any resident could not find their way to and from their flat they would be escorted by a member of staff.

Dementia specialist model:

In Scheme 7, the dementia specialist scheme, the physical design of the building and the decoration was tailored for residents with dementia:

- No patterns on the walls or floor (people with dementia may see patterns in 3D and try to touch or grab them, pulling wallpaper off)
- No visible junctions on the floor between rooms at doorways (people with dementia tend to step over these).
- The two floors had different colour schemes.
- All communal rooms had high contrast, colour coded, orange doors, to make them easy for people with dementia to distinguish. These doors also had glass panels (except the toilet), so that the residents could see what was behind them.
- Contrasting colour handrails.
- The assisted bathroom had contrasting orange tiles around the bath and sink for ease of recognition.
- All toilets (communal and in the residential flats) had a blue seat to aid recognition.
- Vinyl floors in communal areas and in the kitchens and bathrooms of flats for ease of cleaning.

Sight loss specialist scheme:

Scheme 6 was specifically designed for older people with sight loss. While the staff interviewed could not think of any particular design features intended to assist those with sight loss which had hindered those with concurrent dementia, they felt that the physical size of the scheme was too large and confusing for people with dementia to orientate themselves and navigate around.

5.1.5 Features of individual properties

Integrated model:

For most of the integrated model schemes none of the individual flats contained features that were specifically designed to assist people with dementia. Scheme 3 provided reminder boards in the rooms of those who needed them, showing the day, activities for the day and times. In some schemes the resident's family had provided orientation aids and memory aids, such as pictures that have a meaning to the resident stuck on the outside of the flat door and white boards listing the routine for each day. For all these schemes, the staff interviewed stated that if a particular need arose at any time they would try their best to provide the necessary adaptation, following consultation with the family.

Dementia specialist model:

In the dementia specialist scheme (Scheme 7) meaningful pictures were displayed on the outside of front doors to help residents find their own flat. Within individual flats, signs were used to help the occupant orientate themselves, such as "Mary this is your toilet" – such signs were always personalised (e.g. rather than just "Toilet") and kept up to date (people with dementia can keep changing their name as the condition progresses and they loose more and more of their memories, starting with the most recent and working back in time). The toilet had a blue seat cover, and was of the old-style pull-chain type, which people with dementia find easier to use. In a flat's wet room, contrasting (orange) tiles surrounded the shower and sink, highlighting these items. All cupboards and kitchen units had glass doors so that the resident could see what was in them. Medication cupboards were locked and only accessible by staff who were responsible for administering medication (with consent).

5.1.6 Use of assistive technology

Integrated model:

Assistive technology (AT) was not widely used in the integrated model schemes. However, for all these schemes, the staff interviewed stated that if a particular need arose they would provide the necessary devices, after consultation with the family and possibly with financial assistance from the local authority if the devices were not within the scheme's budget. In most schemes there was a resident whose tendency to walk about necessitated the fitting of door usage sensors on that individual's front door, to alert care staff when the individual has left the flat. In Scheme 5 one resident had a tendency to leave the kitchen taps running and flood the floor, so a flood detector had been fitted. Pendant alarms were provided at the schemes for any residents who needed them.

Dementia specialist model:

The dementia specialist scheme, Scheme 7, made more extensive use of AT, with door usage sensors on every door to alert staff to the residents movements and self-releasing safety plugs on all the sinks and baths to prevent flooding incidents. Bed enuresis sensors were fitted for those who needed them and, for those who tended to fall out of bed, sensors were used to detect when they had left their bed. All residents wore pendant alarms. The manager did have a wish list of additional AT devices that she felt were necessary for her residents (see Section 5.2.3, below).

5.1.7 Range of activities

Integrated model:

In Schemes 1, 4, 5 and 6 residents with dementia simply joined in with the daily activities offered (if they wanted to) and the staff that ran the activity would be aware of an individual's needs and take these into account. Common activities for all residents included reminiscence groups, reading groups, gardening clubs, arts and crafts, card games, knitting groups, bingo, quiz session, film evenings, men's clubs, ladies clubs, exercise / keep fit sessions, coffee mornings. Most schemes also offered 1-2-1 sessions to residents with particular interests. The management / staff interviewed understood the importance of getting to know the life history of an individual resident, in order to better understand their interests. There was a flexible attitude towards the activities offered and, while residents were encouraged to join in, it was their choice whether to do so or not. These schemes did not provide activities specifically aimed at residents with dementia.

As part of the "Community Hub" in Scheme 6 (sight loss specialist), a number of external groups used the facilities to meet and carry out activities and classes (e.g. IT, Zumba, painting and drawing, arts and crafts, NHS manicure services, nostalgia sessions), offer information and advice and run support services (e.g., depression, anxiety, bereavement, NHS no-smoking clinic, slimmer's world, Wellbeing clinics, spiritual healing, Stroke club). The NHS "Working Age Dementia" group met at the scheme and residents could be referred to this service. A number of the services were run on a referral basis and residents could be instantly referred to these external groups.

The ExtraCare Charitable Trust schemes (2 and 3) provided activities specifically aimed at residents with dementia. As part of the EOP at Scheme 2 a number of therapy sessions were available specifically for residents with dementia, including cognitive stimulation, dance, music and poetry. There was also a workshop day offering orientation, sing-along, reminiscence, lunch and meditation. Scheme 3 offered a reminiscence group and volunteer befriending 1-2-1 sessions for residents with dementia, otherwise such residents could join

in the regular activities or special 1-2-1 sessions could be provided for those with specific interests.

Dementia specialist model:

Scheme 7 (dementia specialist) used to have structured activities, with a daily schedule of activities such as arts and crafts, sewing, knitting, reading, a film night and a fish and chips night. This worked when most of the residents had mild dementia. Now that the residents' dementia had progressed, staff found that structured activities were not working and it worked better to ask any residents seated in the lounge what they would like to do (making suggestions based on the known interests of the individuals - all tenants had life story books). Due to their high popularity, the film night and fish and chips night were still scheduled. Group activities were still encouraged, such as cognitive stimulation therapy and singing and dancing. Staff would also arrange pamper days, bake days and communal cooking sessions. Buffets and parties were common to help maintain a happy, communal atmosphere. Sessions were also arranged where residents would practice signing their own signatures.

As already stated, each resident at Scheme 7 had their own personalised routine, which could involve some activities at night, although, as much as possible, the staff tried to encourage people to go back to bed at night to provide some structure to their days and reduce "sundowning" (when a person with dementia becomes more confused, restless and insecure late in the afternoon or early evening). The manager reported having to cope with an increased amount of sundowning when the clocks are changed.

5.1.8 Other on-site services

There were few other on-site services specifically tailored for people with dementia. For all schemes, community psychiatric nurses (CPN) or district nurses would visit if necessary. At Scheme 1, a care team ("Hanover on call") would visit and check on the residents with dementia every day. At Scheme 2 a community mental health team would visit to work with individuals who needed this support and at Scheme 3 there was an on-site wellbeing advisor who assessed health and wellbeing and provided advice to individuals. At Scheme 7 (dementia specialist), the visiting CPN and GP specialised in dementia.

Scheme 4 shared the premises with a day care centre and the residents and day care clients shared some activities. Scheme 5 had a day centre for people with dementia next door, to which one of their residents had been referred and attended every day.

5.2 Staff Perspective: Achievements and challenges

5.2.1 Achievements

For the integrated model schemes 1-5 the management / staff interviewed were generally satisfied with their achievements with respect to the set up and provisions for people with dementia. They considered their strengths to be their ability to be flexible and adapt to the needs of individual residents. At Scheme 2, the EOP was considered their most positive achievement with respect to residents with dementia and at Scheme 3 the management felt that any challenges they may currently experience with respect to residents with dementia would be eliminated once they got their EOP locksmith.

The staff interviewed at Scheme 1 were keen to emphasise the benefits of HWC for people with dementia, as compared to living in the community; its strength being that there is an onsite team with which residents can build up a relationship and there is (or should be) flexible support for people with dementia.

5.2.2 Challenges

The main challenge for management and staff with respect to residents with dementia at the integrated model schemes was the existence of negative attitudes and prejudice against such residents.

At Scheme 2 the negative attitude and prejudice of other residents and, “to some degree”, staff, was considered an important issue by the EOP locksmiths interviewed. Dementia awareness and care training had helped to improve the situation with respect to scheme staff; even so, staff could still become frustrated and impatient when dealing with residents with dementia because such residents could be more difficult and required more time and effort to deal with than other residents. With respect to the attitudes of other residents, the EOP locksmiths felt that the issue needed “tackling in some way so as to improve the situation”. The EOP regional manager has subsequently stated that ExtraCare’s work to raise awareness through resident training and a resident volunteer program to support EOP had reduced prejudice and stigma.

Scheme 4 had problems with residents (both HWC and sheltered) complaining about those with dementia. The care manager felt that some complaints were justified, when the behaviour of the individual with dementia was having a negative impact on another resident’s life, while other complaints were attributed simply to people being “intolerant”, “prejudiced” and “inconsiderate”. She felt that greater tolerance could come from improved understanding through communication, information and education. To this end, the Alzheimer’s Society had visited to give a talk about dementia to increase awareness among

residents and try to build bridges between the sheltered housing and HWC residents. In terms of the attitudes of staff it was simply acknowledged that residents with dementia have a high care demands.

At Scheme 6 (sight loss specialist) the other residents were said to be “up in arms about people with dementia” because they felt that they had to look after them in communal areas and they were disruptive during classes and activities. At Scheme 6 the staff interviewed also felt that the large physical size of the scheme could be a drawback for people with dementia in that they could so easily get lost. They felt that smaller schemes were more suitable for people with dementia. This view is supported by evidence in the literature that larger schemes can be disorientating and confusing for residents with dementia (HDRC, 2009). It is also supported by the fact that the manager at Scheme 7 (dementia specialist) felt that the small size of the scheme was a benefit to the residents; particularly in terms of the staff being able to get to know the small number of residents and their families well and making personalisation easier.

The manager of the dementia specialist scheme, Scheme 7, felt that the lack of rooms for activities was a weakness at her scheme and it would be an improvement to have a separate room for activities and cognitive stimulation therapy (currently conducted in the dining room which served as a multifunction room). There was a therapy room which had a bed in it to accommodate the sleeping night member of staff, which meant that it currently could not be used for its original purpose. Lack of space was a challenge for this scheme.

The manager of Scheme 7 also listed a number of strengths of the scheme. In terms of physical design, the fixtures, fittings, features and decoration were specifically designed to assist people with dementia with recognition, orientation and wayfinding. In terms of contact with staff, each resident was assigned a key worker who was then able to get to know the resident well and build up a good relationship with them. All tenants and staff had been on holiday together. The staff at the scheme had a good relationship with the visiting CPN, district nurses, GP and local hospital. Being a research and development scheme, it also had a good relationship with the University researchers who conducted studies there.

5.2.3 What could be done differently

The predominant change desired by the staff interviewed at the integrated model schemes was a greater acceptance and tolerance of residents with dementia, particularly in terms of the attitudes of the other residents. They wanted to be able to implement some means of tackling this issue.

At Scheme 1 the staff wanted like to offer activities that were tailored for people with dementia, which would in turn improve take up of activities amongst residents with dementia.

In terms of the physical design of the scheme, the care manager at Scheme 4 expressed the desire for better distinction between the building's floors in terms of colour scheme and different coloured doors on the residential flats to assist with orientation and wayfinding for residents with dementia. Space was also an issue at this scheme and the manager wanted a larger space for activities and entertainment. She also felt that an 'open café', where residents could choose the meal they want when they want it, would be better than the current set up with residents being served a set lunch (with 2-3 choices) at the same time each day. She also wanted a scheme bus to take people out and about, as there had been problems getting residents to agree to pay for a bus for outings.

As already stated, at Scheme 7 (dementia specialist), the manager wanted a separate room for activities and cognitive stimulation therapy. On her wish list for AT devices were fall detectors and electronic location devices based on GPS technology to locate a resident who may have left the scheme and become disorientated and lost. The latter device was considered especially important, particularly when people first move into the scheme. The manager was keen to improve the safety and security of the residents with these AT devices.

6. Summary of findings

- For all of the integrated model schemes, except Scheme 2 (which had a standard operating procedure for referrals with dementia under the EOP), there were no eligibility criteria that referred specifically to people with dementia. Eligibility for all referrals was based on whether the scheme would meet the individual's needs and whether that individual would fit in. The individual also needed to demonstrate understanding of the tenancy agreement. Similarly, there were no formalised exit criteria specifically for residents with dementia. A diagnosis of dementia was an eligibility requirement for the dementia specialist scheme (Scheme 7).

- Apart from different colour schemes / design themes on each floor of the building and, at two schemes, different coloured flat doors, there were no special provisions for people with dementia at the integrated model schemes in terms of the physical design of the complex.

- There was also little provision at the integrated model schemes in terms of the features of individual flats – only Scheme 3 provided reminder boards. Most adaptations were made by the resident's families, although the staff interviewed stated that if a particular need arose they would try their best to provide the necessary adaptation.

- Assistive technology for people with dementia was little used at the integrated model schemes, but would be provided on an individual basis if a specific need arose. A door usage sensor on the front door of the flat of an individual who tends to walk about was the most common device in use.
- Of the integrated model schemes, only Schemes 2 and 3 provided activities tailored for people with dementia. Scheme 2 offered a wide range of activities under the EOP.
- The level of training in dementia awareness and care varied between integrated model schemes, ranging from none (Scheme 6) to 5 day university run courses for senior staff and EOP locksmiths (Scheme 2).
- Other on-site services for people with dementia consisted of visits from care / mental health teams and community psychiatric nurses or district nurses.
- The main challenge for management and staff with respect to residents with dementia at the integrated model schemes was the negative attitude and prejudice of the other residents towards those with dementia. Altering this attitude was the predominant change desired by the staff interviewed.
- As should be expected the dementia specialist scheme, Scheme 7, was more extensively tailored to the needs and abilities of residents with dementia in terms of policies and procedures, the physical design of the complex, features of individual rooms, use of AT (although the manager wanted to improve the safety and security of the residents with the addition of fall detectors and electronic location devices), activities, longer and more in depth training and good stress support for staff. The small number of residents and high staff to resident ratio meant that the staff could build up a good relationship with each of the residents and a greater level of understanding of an individual's needs and life story, thereby enabling greater personalisation of the care provided.

7. Conclusions and discussion

Within the majority of integrated model HWC schemes in this case study, there was little tailoring of policies and procedures, physical design of the complex, features of individual properties and activities to the needs and abilities of residents with dementia. The exception was Scheme 2, which provided the Enriched Opportunities Program, ensuring greater

tailoring of policies and procedures and greater personalisation of care and activities for residents with dementia.

There is strong evidence and general agreement that HWC works best for people with dementia if they enter such housing when the dementia is at an early stage or mild / low level. It is not appropriate for people to enter HWC when they already have advanced dementia. However, it appears that a relevant requirement for people with dementia is not formally specified in the eligibility criteria for integrated model HWC schemes (with the exception of Scheme 2 with the EOP). Rather, it is assumed that the general requirements of being able to meet the needs of the individual and the individual having the capacity to understand the tenancy agreement, albeit possibly transiently, will cover those with dementia. Similarly, the general exit criterion of the scheme no longer being able to support the needs of the individual is relied on to cover those with dementia. There is a lot of scope for subjectivity on the part of those doing the assessing. The allocation panel can play an important role in checking and balancing, but without any jointly agreed written criteria for them to apply, there is a risk of disagreement. There are pros and cons to explicit eligibility and exit criteria, or guidelines, relating to people with dementia. The current approach of not explicitly distinguishing people with dementia within the criteria provides flexibility and may reduce stigmatisation. However, not having any guidance can lead to misconceptions and unrealistic expectations on the part of the public and professionals. One solution would be to have more explicit criteria or guidelines that outline what the scheme can and cannot cater for, with an emphasis on the importance of individual assessment and flexibility. The extent to which the different needs of people with dementia can be met depends on the combination of characteristics of the particular scheme, e.g. size, location, design, staff training and skills, use of AT, policies and procedure, approach to security. Eligibility and exit guidelines should not be too prescriptive because the symptoms of dementia vary greatly from person to person. Drawing on the reasons given for moving a person out of a scheme, guidelines could include such recommendations as: the person should, with support, still be capable of accepting and learning a new living environment and becoming part of the community; their behaviour can be predictably managed in a HWC context; they should not exhibit behaviours that are likely to be excessively disruptive or risky to themselves or other residents; they can understand the rudiments of a tenancy agreement; the amount of care and human contact they require can be realistically met by the scheme. The assessment would need to be carried out by someone who has a good understanding of dementia and the strengths and limitations of the scheme.

It was clear that those interviewed at Scheme 6, a specialist scheme for people with sight loss, felt that their scheme was too large and not appropriately designed to fully meet the

needs of people with sight loss and dementia and they believed that such residents did not really fit in. However, as sight loss and dementia are both conditions associated with old age, it is inevitable that there will be older people living with both conditions who, therefore, need to be accommodated in HWC schemes. The management and staff at this scheme had not received any training in dementia awareness or care which may explain their tendency to put any difficulties with such residents down to the scheme not being suitable. However, the belief that a smaller scheme is better suited to people with dementia is supported by the literature and the view of the management at the dementia specialist scheme (Scheme 7) that the small number of residents at this scheme was of benefit to the residents and was indeed one of its strengths.

In terms of the physical environment, it is concluded that, with the exception of the scheme running the EOP, there was little provision for people with dementia in the case study integrated model HWC schemes. However, management showed willingness to make adaptations and provide AT devices, if necessary. The fact that this was rarely necessary is perhaps testament to the fact that residents with dementia living in such schemes tend to have a mild or low level of dementia. In contrast, and as one would hope would be the case, the dementia specialist scheme showed better tailoring of the physical environment and more extensive use of AT for people with dementia of various forms and severity. Even so, the manager wished for more in terms of space available for activities and AT.

Residents in the integrated model schemes displayed a negative attitude and prejudice against those residents with dementia. The management were fully aware of this situation and expressed a desire to change it but, as yet, had made little progress towards doing so. Dementia awareness sessions, tailored to older participants, may help to alleviate the problem. Clearly, there is still a stigma attached to dementia which may take some time and effort to eliminate.

So, how well did the case study schemes meet the objectives for residents with dementia of person-centred care, developing staffs' knowledge and expertise in dementia, partnership working and joint working? The formal policies and procedures for the integrated model schemes without EOP had little tailoring to the needs of people with dementia. However, the existence of personal care packages for all residents, which are regularly reviewed and can be reviewed at any time if necessary, showed a person-centre approach to care. The integrated model schemes also demonstrated a person-centred flexibility and adaptability, within the constraints of their financial limitations. Management and staff training in dementia awareness and care varied considerably between the integrated model schemes with Scheme 2 having the most extensive training (due to having the EOP program). The level of

training that is required, and how often it needs to be refreshed, to ensure good, or even adequate, staff knowledge and expertise in dementia is not known and requires research. Providing staff with more knowledge and expertise in dementia may help to alleviate the problem of lingering negative attitudes towards residents with dementia among staff. Nevertheless, the fact that most of the integrated model schemes, apart from Scheme 6 (sight loss specialist scheme), ensured that management and / or staff were trained, to the minimum level of a 1 day dementia awareness course, shows that they are committed to developing staff's knowledge and expertise in dementia.

Strong partnership and joint working, and integrated strategies between social care, health and housing have been shown to effectively enhance quality of life for people with dementia living in HWC settings. Information on such organisational and operational aspects was not collected in this study, although there was some evidence to suggest integration with local health and social services (visiting community psychiatric nurses, district nurses, mental health teams, use of local day care centres).

It is worth reiterating that, due to the small number of schemes examined from within a select group of housing providers and the fact that not all HWC models for supporting people with dementia were included, the findings of this study cannot be considered representative of all HWC schemes in England, but they will be indicative of the provisions for people with dementia within HWC.

It is recommended that a larger scale survey of provisions for people with dementia within HWC be carried out in order to build up as full a database as possible of the approaches used and any adaptations made in order to meet the needs of people with dementia within HWC schemes. The findings of the study described in this report could inform the development of the survey.

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Appendix 1: Interview questions

1. HWC model

a. How would you describe the model of your housing with care scheme? (Tick box)

MODEL	√
Integrated (People with a range of needs and disabilities including dementia dispersed throughout the scheme)	
Separate (A separate unit for people with dementia as part of a generic housing with care scheme)	
Specialist or Dedicated (Housing targeted specifically – exclusively or almost exclusively – at people with dementia)	
Other (e.g. A development combining housing with care and a dementia-specific residential home on a single site). ***Please explain:***	
Please elaborate on your particular model if you would like to:	

b. How many housing units are there at the scheme, and of these how many are intended specifically for people with dementia (if pre-determined)?

c. How many tenants are there?

d. How many tenants do you know, or strongly suspect, currently have dementia?

2. Eligibility criteria for people with dementia

a. In terms of people with dementia, do eligibility criteria for entry to the scheme specify those for whom the scheme would be suitable and / or those for whom it would not? If yes, what are these criteria? Are there limits to entry and if so how are these defined?

b. Do you have formalised exit criteria?

c. What do you find are the main reasons for tenancies coming to an end (especially for people with dementia)? E.g. challenging behaviours, difficulty providing the necessary levels and flexibility of care in response to increasing care needs, availability of resources, targets for balance of dependency.

3. Scheme features

We would like to know if the features of the scheme and its operation have been tailored for people with dementia in any way. Please indicate those which apply. We are also interested in your opinions of these features.

a. Physical design of complex
e.g. scale, clustering, visibility, aids to orientation, use of colour, lighting, shared rather than individual kitchens etc

- Is it tailored for people with dementia? In what way?
- Strengths: In your opinion, which aspects work well? Why?
- Weaknesses: In your opinion, which aspects do not work well? Why?
- What would you do differently? Do you have a wish list? What are the obstacles to doing this?

b. Features of individual properties
e.g. kitchen equipment, orientation aids such as see-through cupboard doors

- Is it tailored for people with dementia? In what way?
- Strengths: In your opinion, which aspects work well? Why?
- Weaknesses: In your opinion, which aspects do not work well? Why?
- What would you do differently? Do you have a wish list? What are the obstacles to doing this?

c. Use of assistive technology
e.g. door entry systems, exit monitors, movement activated lighting, etc.

- Is it tailored for people with dementia? In what way?
- Strengths: In your opinion, which aspects work well? Why?
- Weaknesses: In your opinion, which aspects do not work well? Why?
- What would you do differently? Do you have a wish list? What are the obstacles to doing this?

d. Range of activities
e.g. reminiscence groups

- Are they it tailored for people with dementia? In what way?
- Strengths: In your opinion, which aspects work well? Why?
- Weaknesses: In your opinion, which aspects do not work well? Why?
- What would you do differently? Do you have a wish list? What are the obstacles to doing this?

e. Staff (levels, training, skills and knowledge, stress management)
e.g. more detailed training on understanding dementia, and dementia care

- Is it tailored for people with dementia? In what way?
- Strengths: In your opinion, which aspects work well? Why?
- Weaknesses: In your opinion, which aspects do not work well? Why?

- What would you do differently? Do you have a wish list? What are the obstacles to doing this?

f. Other on-site services
e.g. day services, community nursing services

- Are they tailored for people with dementia? In what way?
- Strengths: In your opinion, which aspects work well? Why?
- Weaknesses: In your opinion, which aspects do not work well? Why?
- What would you do differently? Do you have a wish list? What are the obstacles to doing this?

g. Policies and procedures
e.g. individual assessment and reassessment, risk assessments, addressing behavioural symptoms, ethos, signing of tenancies, support when moving in and out, etc

- Are they tailored for people with dementia? In what way?
- Strengths: In your opinion, which aspects work well? Why?
- Weaknesses: In your opinion, which aspects do not work well? Why?
- What would you do differently? Do you have a wish list? What are the obstacles to doing this?

h. Other aspects that benefit or are drawbacks for people with dementia
(please specify)