



STRATEGIC INNOVATION & PEER LEARNING  
*In housing, health, care and support*



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# APPENDIX E

## THE SUB-REGIONAL WORKSHOP

### PRESENTATIONS



Putting **People First**  
Transforming Adult Social Care



**South West Regional Collaborative Workshop -  
Housing with Care and Support with Dan Short/  
Rob Griffiths from CSED**

# Agenda



- 10.30 Introductions:
  - Welcome (by Host DASS)
  - CSED what it is/ Underlying approach (Dan Short)
  - Individual participants with their aims for the day (All)
- 11.00 Discussion of the drivers for Improvement (Pat Palmer)
- 11.30 Coffee
- 11.40 Support related housing and whole system efficiency
  - Fit with delivery of cost savings and Challenges arising from Use of Resources work (Dan Short)
  - Presentation of a range of models with discussion of pros and cons (Rob Griffiths)
  - The key challenges (All)
- 13.00 Lunch
- 13.30 Looking forward (4 short facilitated discussions of around 25 minutes each)
  - Tell us what the South West is doing well and can therefore build on?
  - Identify the main opportunities to improve?
  - Discuss what might stop us taking the opportunities?
  - Identify how by working together the barriers can be overcome
- 3.20 Next steps:
  - Each authority to identify 2 or 3 key actions it will take
  - Collective discussion about support needed inc. peer support and external support

# Welcome by Jane Smith



# CSED – Introduction and underlying approach



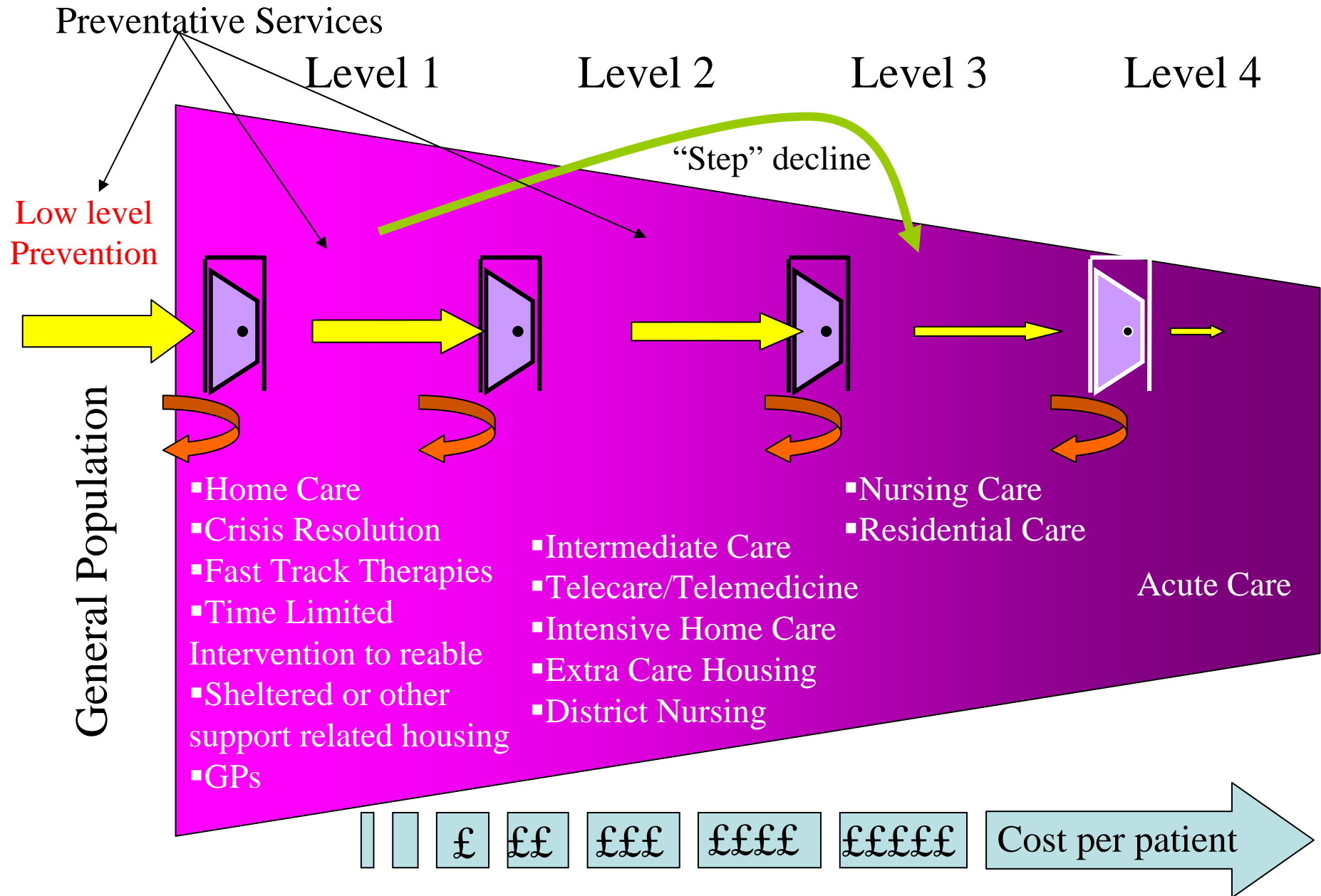
- Programme within DH Social Care, Local Government and Care Partnerships Directorate established in 2004 following Gershon
- Supporting adult social care achieve necessary 3% savings p.a.
- Team of independent consultants
- Reports to Shaun Gallagher Director of Social Care and Policy in the DH Social Care policy and Innovation Division
- CSR07 Programme launched April 2008
  - Tim O'Connor Programme Director
  - c. 35 staff supporting 150 CSSRs and advising on efficiency in other DH programmes

# Underlying Approach - Cost Effectiveness

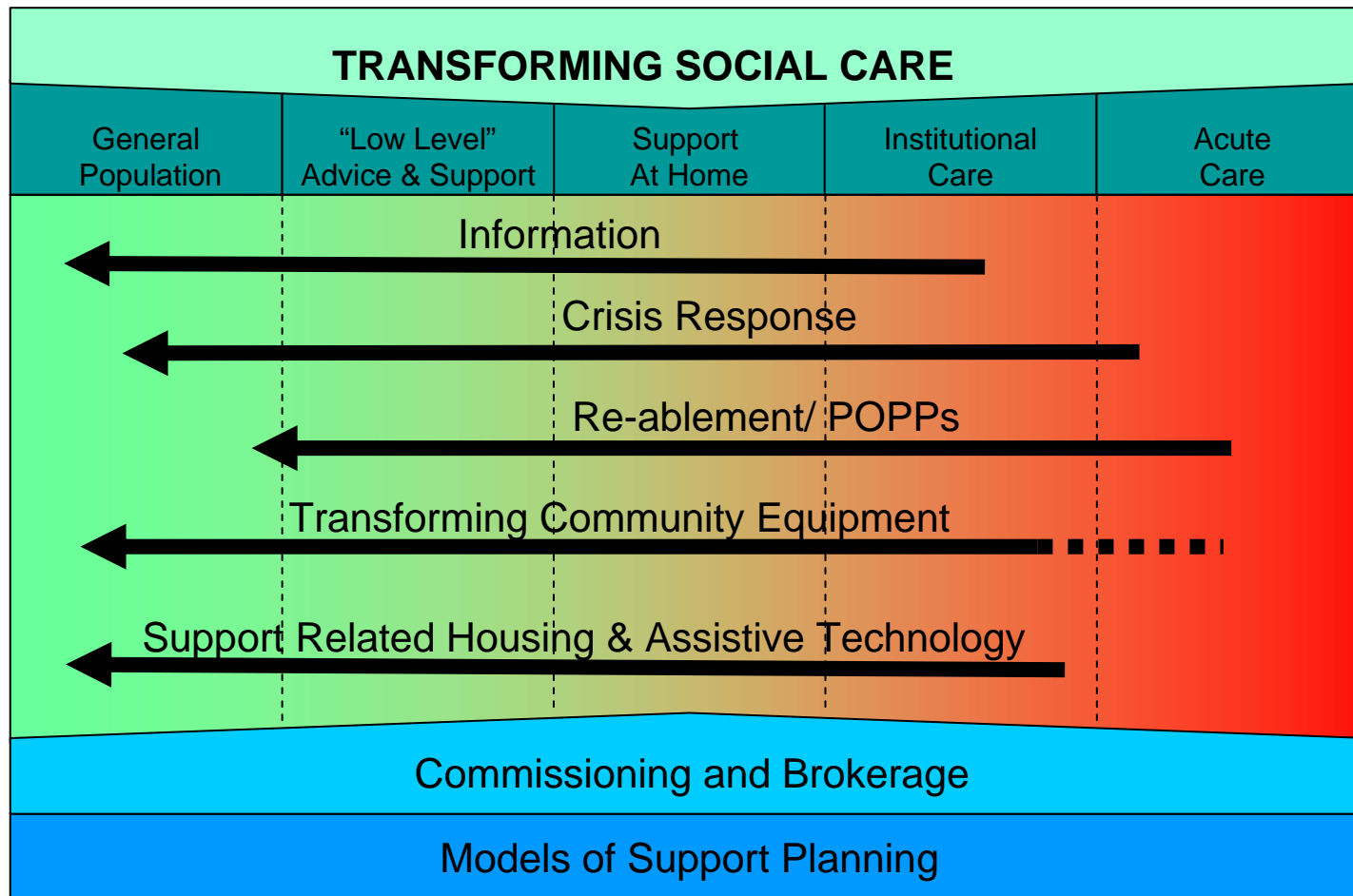


- Most current 'outcomes' (user satisfaction surveys) measure 'Effectiveness' not 'Cost effectiveness'
- People may choose different ways of achieving outcomes from those used now
- Outcomes are the key to moving to using resources in ways that are cost effective.

# In Practice For Older People This Looks Like:



People choose less dependent options: This is typically more cost effective





# Individual objectives for the day



# Housing Support Unit (South West)

‘Working towards the delivery of better housing options for older people in the SW’

Pat Palmer South West Housing LIN & South West HSU Lead

# Drivers for Change



- Startling demographics
- Cost efficiencies – ‘John Bolton challenge’
- Rising aspirations – a consumer generation
- Personalisation agenda

# The Challenges



- The need for a clear strategic vision
- Partnership working – means ‘buy in’ and commitment - joint strategies
- Dwindling resources – effective Use of Resources is the key tool for communicating the need for change
- Capacity issues and time to think ‘strategically’ -we need to work collaboratively
- The need for effective models for the South West

# Identify solutions

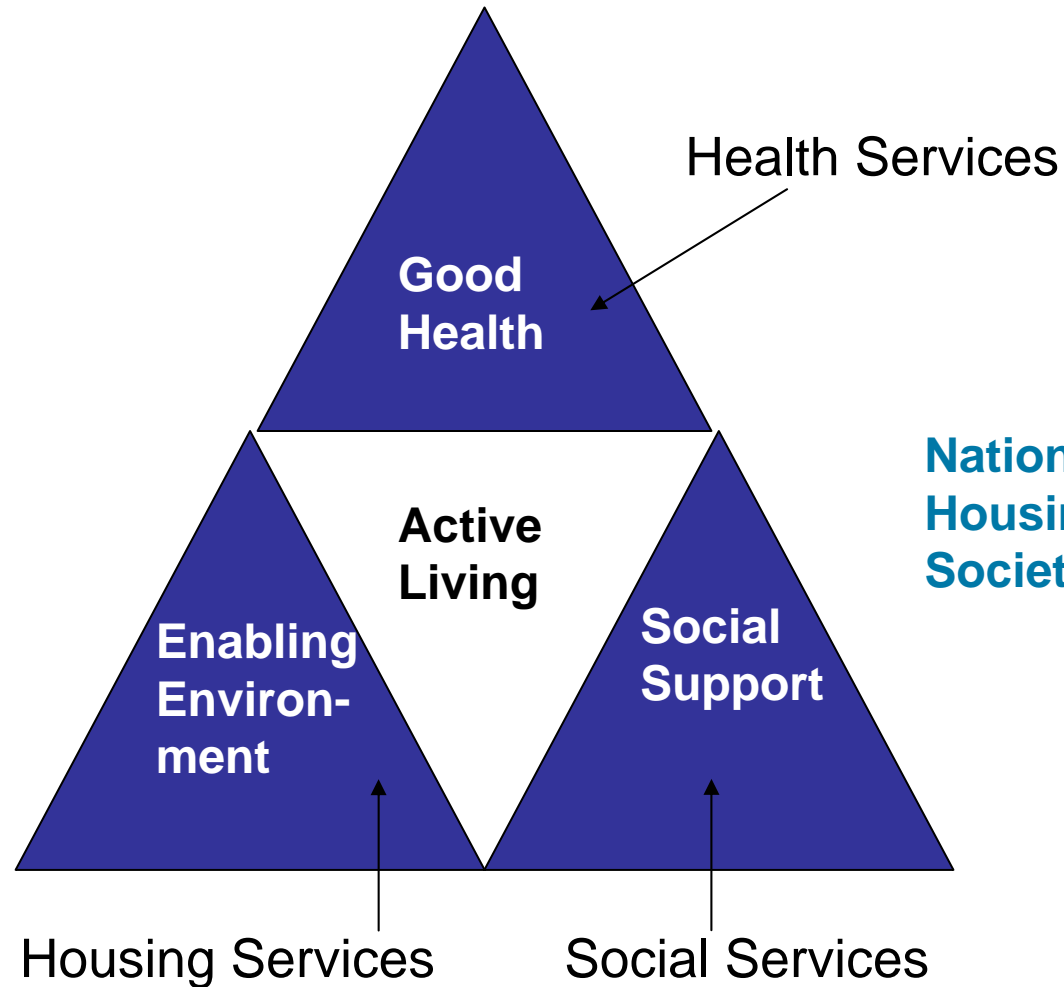


- The importance of understanding the market
  - Demand
  - Provision
  - Aspirations
- Models that deliver the desired outcomes

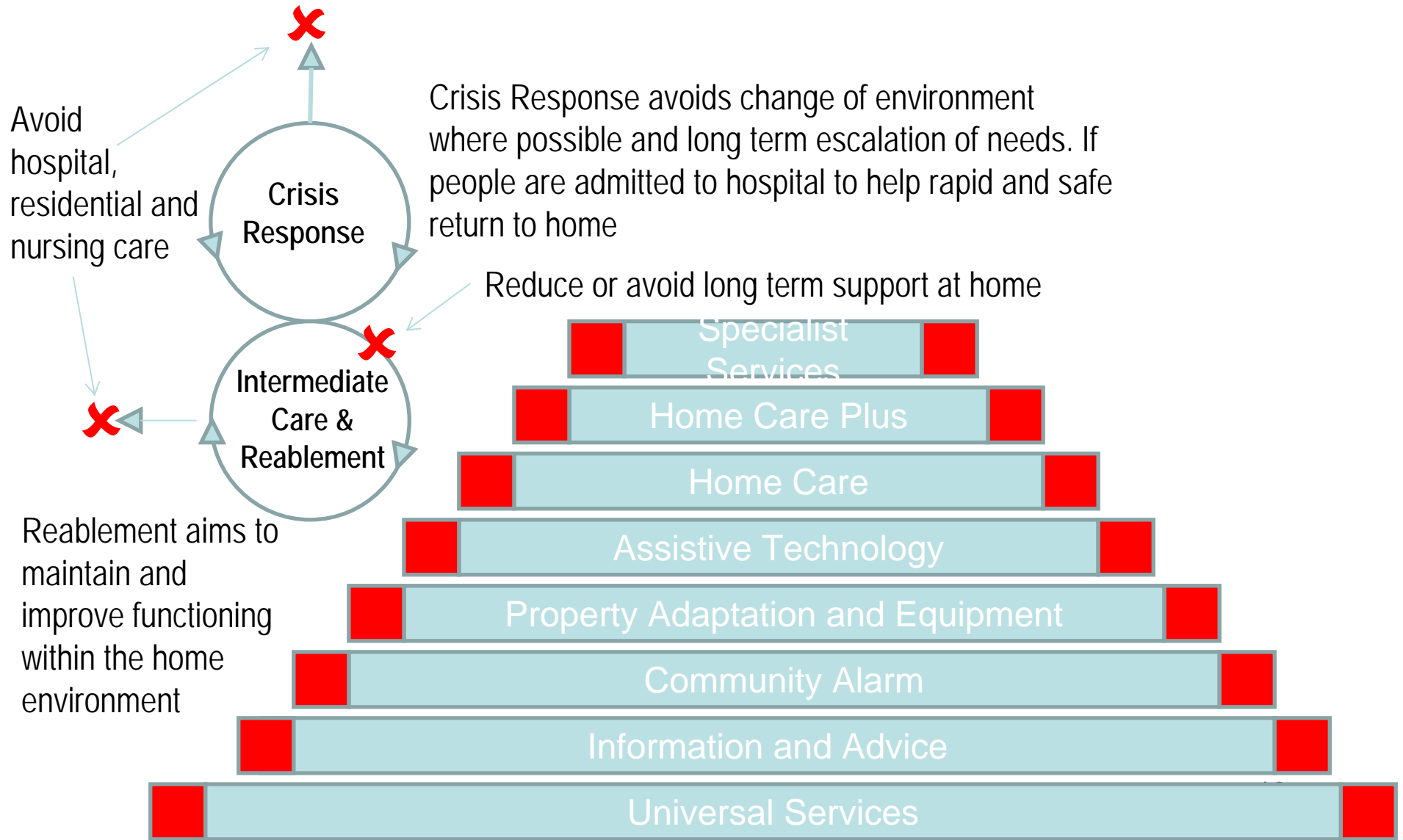
# Refreshments



# How housing fits into the bigger picture

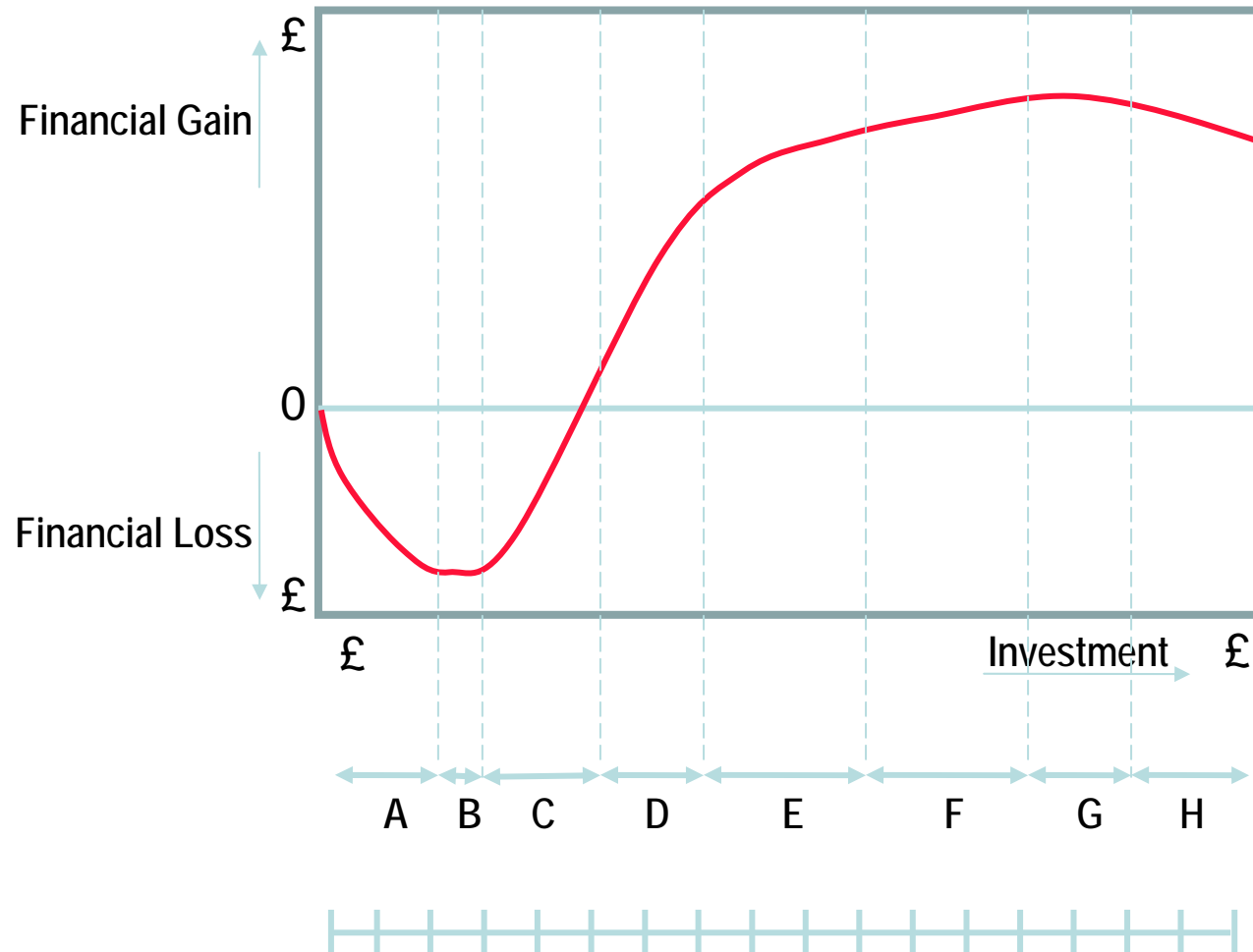


**National Strategy for Housing in an Aging Society (Feb 2008)**

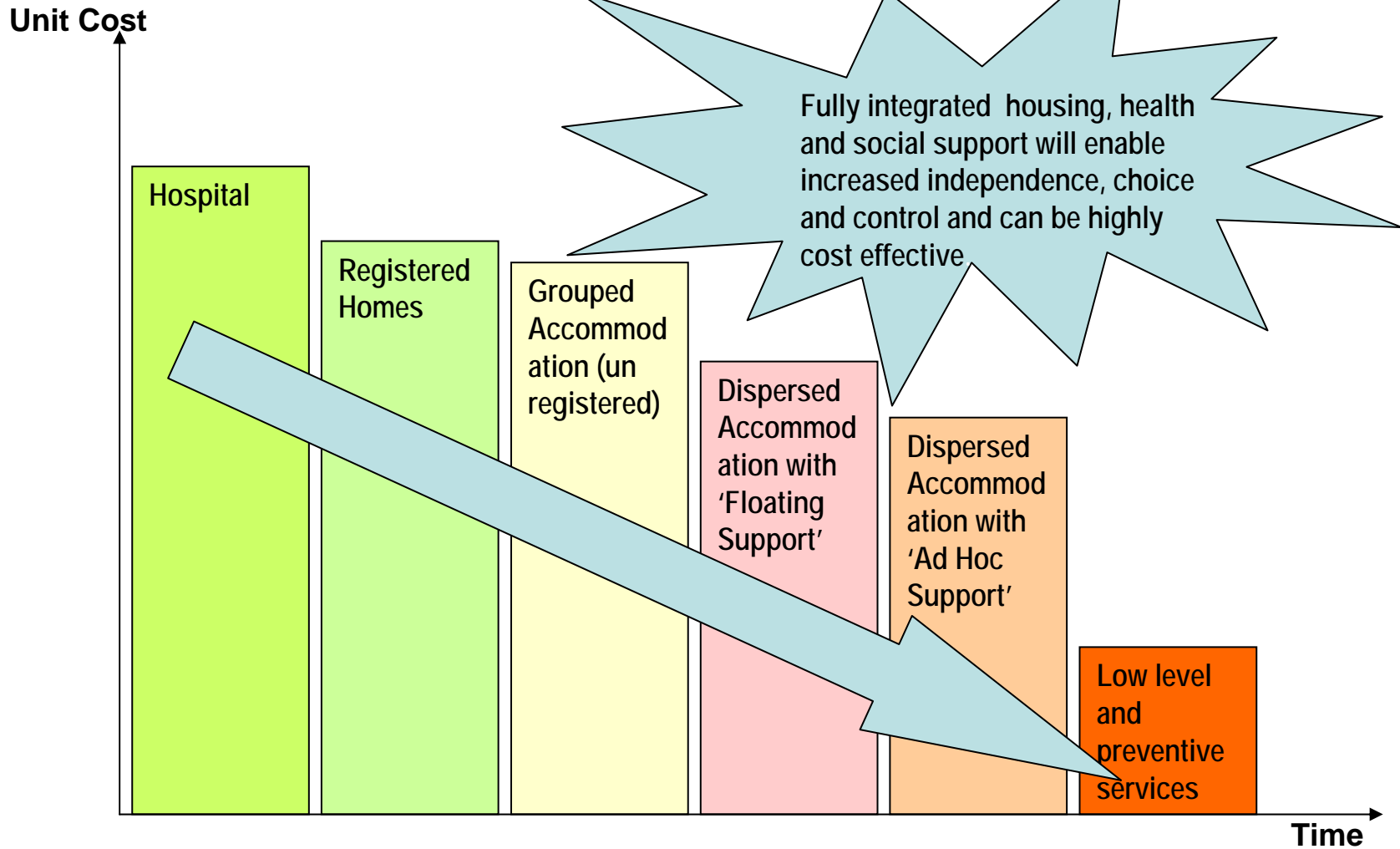




# Diminishing Returns to Investment



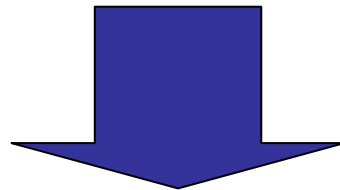
# Housing and efficiency



**Lowering dependence, increasing independence, improving efficiency**

## Unsuitable housing or a lack of support at home:

- Leads to support needs escalating
- Can contribute to “trigger events”
- Often delays discharges from hospital
- Reduces confidence that individuals can remain at home safely



**Leads to overuse of residential care,  
increased NHS activity and reduces  
choice and control**

# Re provision of Residential Care has been discussed for a long time



- Royal Commission on Long Term Care (1999) supported the replacement of traditional RC with extra care housing to provide better outcomes for individuals in a cost effective way.
- Residential and Nursing homes and other ‘grouped’ institutional care (reminiscent of hospitals and work houses) defined people as “problematic” and described them as “reluctant guests on other people’s territory”.
- What is extra care housing for?
  - Is it to add to the range of options along a continuum of RC and conventional sheltered housing? or
  - To offer an alternative so that a substantial part of what is currently provided as RC becomes redundant?

# Current Results - Use of Resources Data



Wiltshire

Somerset

North Somerset

BANES

<b>Use of Resources Indicator:</b>	Now	▶▶	Now	▶▶	Now	▶▶	Now	▶▶
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Occupied bed days of those aged 75+ associated with 2+ emergency admissions per 1000	1731		1551		1560		1620	
Number of individuals aged 75+ with 2+ emergency admissions per 1000	51		58		55		59	
% of patients 65+ discharged to Res care	2.6%		2.2%		5.0%		2.2%	
% of OP gross spend on ACM	19%		14%		8%		16%	
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% of OP gross spend on Day/Dom Care	31%		29%		31%		27%	
CSCI efficiency gains 2007-8	0.7%		1.5%		1.7%		0.8%	
CSCI efficiency gains 2008-9	1.0%		1.2%		1.9%		0.6%	

# Drivers for Change

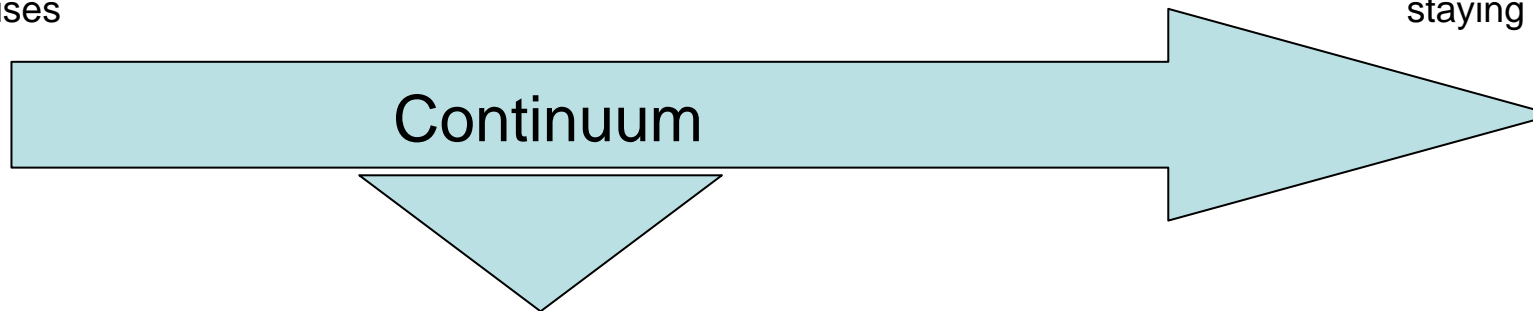


- **Changing needs.**
  - Increased needs due to demographic changes.
  - Mixed profile of needs.
  - Changed needs profile due to allocation policies.
- **Changing expectations.**
- **Supporting People.**
- **Value for Money and changing commissioning patterns.**
- **Specific Issues relating to resident scheme managers.**
  - Working Time Directives and other legislation.
  - Confusion over the role of housing related support versus care.
  - Difficulty in recruiting resident scheme managers.
- **The Transformation Agenda.**

# The range of housing models

Housing and support 100% in same purpose built premises

Housing and support 100% in community with people staying at home



Can vary many aspects of design. For example:

- Ownership of the housing environment e.g. rented, owned,
- Place where support is delivered e.g. in own home, in purpose built place
- Base delivery staff operate from e.g. support people in a scheme only, out reach
- Who delivers the support/ who controls support e.g. integrated team, specialist teams
- When support is available e.g. 9 til 5, 24/7, by appointment, when called by AT
- The population supported e.g. residents of a scheme, all members of a community
- Extent to which support is fixed or variable
- Etc, Etc.

# Supporting People - Cost Benefits of Housing Related Support, Cap Gemini (2009)



- Report concluded that the revenue cost of providing housing related support services to older people was £328m; benefit to public spending £1,726m so giving a new benefit of £1,398m
- For an older person living in sheltered housing the average cost of SP support was £440 pa
- If SP were to be removed the cost to other services would increase by £550 made up of:
  - £428 increased cost to social services
  - £55 increased costs relating to hospital admissions
  - £67 increased other costs
- Extra care housing and support offers the opportunity to draw down this funding stream along with others such as housing benefit, ILF etc.



## Costs and estimated benefits per annum of Supporting People services by client group



Client group	Cost (£m)	Net financial benefit (£m)
People with alcohol problems	(20.7)	92.0
Women at risk of domestic violence	(68.8)	186.9
People with drug problems	(30.1)	157.8
Homeless families with support needs - settled accommodation	(32.5)	(0.5)
Homeless families with support needs - temporary accommodation	(17.5)	28.5
Single homeless with support needs - settled accommodation	(130.1)	30.7
Single homeless with support needs - temporary accommodation	(106.7)	97.0
People with learning disabilities	(369.4)	711.3
People with mental health problems	(254.4)	559.7
Offenders or those at risk of offending & mentally disordered offenders	(55.4)	40.3
Older people in sheltered accommodation	(198.2)	646.9
Older people in very sheltered	(32.4)	123.4
Older people receiving floating support and other older people	(97.3)	628.0
People with physical or sensory disability	(28.4)	73.3
Teenage parents	(24.9)	(18.3)
Young people at risk - settled accommodation	(94.9)	26.6
Young people at risk - temporary accommodation	(38.1)	26.7
Young people leaving care	(12.7)	(0.7)
<b>Total</b>	<b>(1,612.4)</b>	<b>3,409.4</b>

# Examples of Extra Care Options and Models – “A starter for ten”



- **Village Model** - A mixed community of both active older people and frailer older people with high care and support needs
- **Scheme Model** - A complete service where housing and support is provided by same scheme provider (scheme model).
- **A Partnership Model** - Housing is provided by one provider and support by another provider (public, private or third sector).
- **In-reach Model** - A model in a setting that also provides a range of services for older people in the surrounding community including dining, social, recreational.
- **Out-reach Model** - Support provided from a base such as a residential home (core and cluster model), a resource centre (community model) or sheltered housing scheme (hub and spoke model).
- **Virtual/ Virtual Village Model** - Care and support provided by mobile service across specific geographical area (defined by response times rather than size) delivered to that population in their own homes including virtual extra care provision (where benefits of ECH are delivered to people in their own home)

# The 'Village' model

## Hartrigg Oaks, York



- One of first village communities, developed on outskirts of York by Joseph Rowntree Trust to provide residents with full and active lives supported by care when needed.
- Approach of scheme to frailty in old age is progressive.
- Provides communal eating and leisure facilities and social opportunities.
- Individuals purchase a bungalow when in good health; care and support provided in own bungalow linked through an alarm system to The Oaks Centre.
- When care and support needs increase, in excess of 21 hrs a week, individual can move permanently to one of the rooms with en suite facilities in “The Oaks” residential facility but with full access to the wider village community.

# Extracare Charitable Trust model

## – Scheme model with “In Reach”



- ExtraCare Charitable Trust formed in 1988 and operates 30 supported housing schemes and retirement villages throughout the Midlands area and the North (8 in Wolverhampton)
- Trust’s roots are in the re-provision of NHS long stay units for older people providing substantial experience of higher end dependency.
- Emphasis on lifestyle and opportunities for learning and growth in old age alongside flexible approach to care provision.
- Very sheltered model is partnership between registered social landlord, care provider and local authority who retain 100% nomination rights if free land given.
- Each scheme consists of typically 40-50 self contained flats held on assured tenancy agreements that give a legal right of occupation and offers:
  - Social club with social, learning and healthy living activities plus Cafe/restaurant. for people in scheme and for the local community ( in reach).
  - 24/7 dedicated on site care team, to provide flexible response to tenants needs (average package = 10-12 hrs per week; schemes monitored by allocations team to ensure no disproportionate number of people with high level needs).
  - Preventative, rehabilitative, person centred approach.

# Extracare Charitable Trust model Wolverhampton - Impacts



- Wolverhampton has 8 very sheltered schemes providing over 400 units.
- **Impact on where people live:**
  - Investment has had an impact on residential care numbers reducing over a 10 yr period from anticipated 1,050 to 588 ( 814 people 65+ in1997).
  - Indicates that 400-500 older people were maintained at home through reconfiguration of very sheltered housing, intermediate care and respite care.
- **Cost effectiveness:**
  - Broadway Gardens was initial element of LA's total re provision of RC homes. Evaluation of 36 tenants after 2 years showed that if they had received the same level of care as prior to the scheme care costs would have been 50% higher so producing £123,000 savings over the two year period.
  - Langley Court has shown savings of £93,132 (48%)
  - Bridge Court has shown savings of £108,888 (24%) N.B. Savings from Bridge Court would have been 33% if Supporting People funding had been excluded.
  - Net average cost to social care of support to older person in scheme = £125 pw compared with residential care net average cost of £250 pw or average care package of £190 pw (not including 24/7 support).
  - People with £16,000 capital pay flat weekly fee (£105); people who receive attendance allowance pay at least 85% to scheme provider.

# Extracare Charitable Trust 'village' model, Berryhill, Stoke- on-Trent – Optimum Size



- Developed after Broadway Gardens to offer a 'village' approach.
- Increased conventional size of traditional sheltered schemes on the basis that:
  - A larger development allowed greater investment in high quality communal facilities for tenants and local community.
  - Enhanced the viability of activities and services that drew upon the expertise of residents.
- Trust now regard 250 unit schemes as the norm i.e. it is important to think about service size from the perspective of quality and economies of scale

# Extracare Charitable Trust 'village' model, Warrington –The question of tenure?



- Example of larger scale developments providing units for sale for owner occupier market; 20% moving towards 50%.
- Success of schemes depend on volunteers among residents to sustain them mixing a relatively high proportion of people with little or no current care needs with smaller numbers with medium to high needs so developing social capital within each community and offering valuable peer support.
- Evidence from the Trust and an evaluation from Keele University indicates that such schemes can reverse dependency for some residents and support a proportion of residents with high level service needs.

# The 'scheme' model Wokingham - Extra Care Sheltered Housing



- Mixed dependency population; around 1/3 having care needs in excess of 18 hrs pw; 1/3 low care needs; 1/3 no current care needs.
- Aggregate care needs at least 240 hrs p.w.
- Manager based on site provides support and co-ordination; 24/7 on site care. Facilitated recreation, social and cultural programme.
- Offers en suite 1 bedroom accommodation plus:
  - Restaurant,
  - Craft rooms,
  - IT suite,
  - Exercise suite,
  - Day opportunities.
- Scheme design:
  - Encourages orientation,
  - Has infra structure for AT,
  - Additional storage space.



# The 'hub and spoke' model Flourish Homes



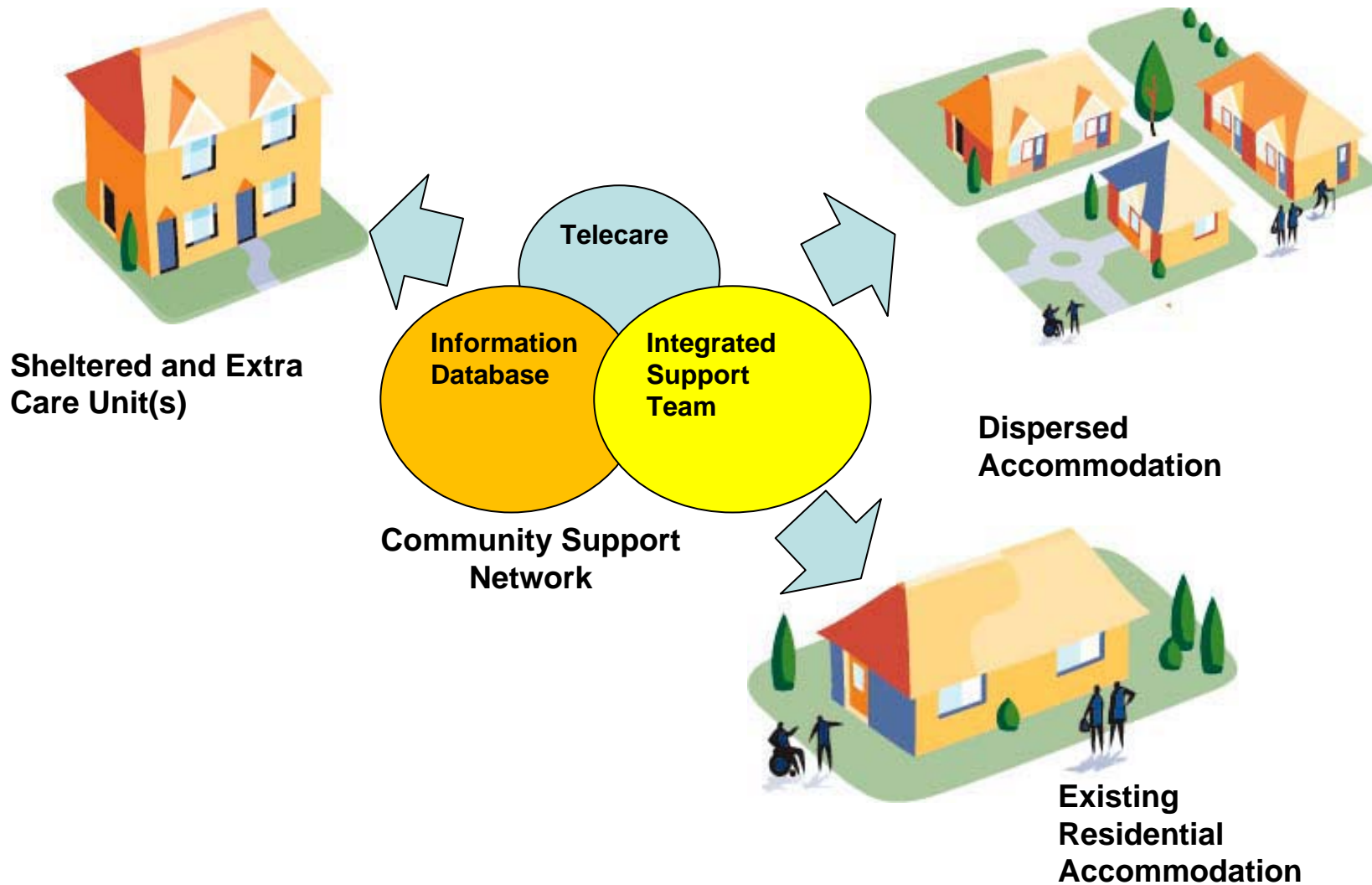
- Housing provider in central Somerset offering range of hub and spoke services that include:
  - 21 sheltered housing schemes.
  - 4 extra care schemes.
  - Floating support to people in their own homes.
- Individual needs assessments with a banded system of support including AT, daily phone contact, regular support visits.
- Also provides 2 innovative services:
  - 'Road to recovery' short term housing support service for hospital discharge.
  - 'Smooth move': helping older people move to SH from large homes.
- In addition activity co-ordinators work with vol orgs, health and social care & colleges to organise activities in communal halls including internet shopping, 'flexercise' classes and healthy eating classes.
- Achieves a flexible cost effective approach to providing support that people can dip in and out of as needs change with in reach to community.

# The 'virtual care village' model Cumbria County Council



- Care and support provided by mobile service through block contracts across a specific geographical area defined by response times rather than size delivered to that population in their own homes including extra care provision.
- Alarm provider uses telecare database to provide vital information to care workers via mobile phones 24/7; telehealth used to monitor LTC.
- Extra care schemes provide on site waking night service and a base for mobile night time care team.
- Developments include housing visitor, housing warden and floating support.
- Drivers include making existing extra care housing more efficient and better management of risk in communities given demographic pressures and rural locations.
- Potential to develop shared information systems and client data base, development of co-ordinated handyperson service and 3<sup>rd</sup> sector support services e.g. Alzheimer's Society Family Support, Carers Assoc.

# Service Elements - Virtual Care Village Model



# Virtual Extra Care/ Enhanced Domiciliary Care

## - North Warwickshire



- Existing daytime home care service + new night time home care workers operating on short term contracts from a Residential Care Home, Bracebridge Court, offering 24/7 cover to a defined rural community within a 14 mile radius. Under home care regs.
- Eligibility to cover those assessed as needing Residential Care or respite, or temporary social care needs e.g. hospital discharge, reablement etc.
- Bracebridge offers respite and telecare familiarity for short stays and as a local community resource.
- Service linked with housing management staff, community nurses, 3<sup>rd</sup> sector and locality commissioners for continuous review.
- Unit costs based on estimated 20 service users = £7,950 pa. or £150 p.w.
- If scheme extended to additional users, unit costs will decrease.
- Scheme offers an extra care cheaper alternative to residential care and benefits for users at being able to stay in their own home and community.
- Possibility of linking to 'virtual wards' in future.

# Crisis Response Services Are Essential



## What is crisis response?

- A crisis intervention team (Domiciliary Support, Social work, Nurses, Therapists)
- Designed to respond within 4 hours to any health or social care crisis
- Acceptance criteria – 18yrs /over, either a Salford resident or patient of a Salford GP
- Provide combined social care, therapy and health care in a patient's own home

## How does it work?

- Single entry point (SEP)
- Assessment in persons own home, A&E or Emergency Assessment Unit within four hours
- Tailored health, therapy, social package
- Team work with the individual to manage the crisis and start return to previous independence
- Links made to other community services to continue re-ablement as required.
- Maximum length of stay 14 days, average 5 days

**Benefits - Projected Reductions in Activity and Benefits per annum in Devon, Health benefits highlighted in Red, Social Care benefits in Blue. Worst case scenario.**



	<b>Reductions in Activity</b>	<b>Benefits</b>
Avoided Ambulance Call Outs	2,414 (25% of all RR episodes)	£398,475
Avoided A&E attendances	966 (10%)	£73,416
Avoided Community Hospital admissions	1448 (15%)	£1,738,800
Avoided acute admissions	683 (7%)	£1,236,770
Avoided Funded Nursing care contributions	125	£57,641
<b>Total Health Benefit</b>		<b>£3,505,002</b>
Avoided Direct admissions to care Homes (7days)	108 (1%)	£28,980
Delayed (6mnths) admissions to care Homes following hospital stay	62 (28% are nursing Homes admissions) 1.6 – 3% of hospital discharges Acute admissions for elderly	£480,916
<b>Total Social Care Benefit</b>		<b>£509,896</b>
<b>Total Health and Social care Benefit</b>		<b>£4,014,898</b>

# Role of Assistive Technology



- 1. To convey information to the public**
- 2. To support assessment /review process to ensure greater accuracy and therefore 'fit for purpose' care or support plans**
- 3. To provide a wider choice of service options in a care or support plan (complement or substitute for traditional service models):**
  - promote self care e.g. medicine management
  - support memory services
  - to anticipate and pro actively manage risk to prevent deterioration or crisis
  - to alert to a crisis e.g. a fall
  - to provide support to and efficiencies in supported living accommodation e.g. reduction in night sleeping staff

# Group Work 1: What are you already doing well?



- Discuss and note down:
  - What is working well and can be built on?
  - What results demonstrate what is being achieved?
  - How would we like results to have changed in 1, 2 and 3 years time



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## Group Work 2: What are the main opportunities to improve?



- Thinking about the range of options available discuss and note down the main opportunities to improve?  
These could be:
  - Building on existing good practice
  - Starting to do something new
- How would we expect results to have changed in 1, 2 and 3 years time if we are successful?

## Group Work 3: What might stop us using the opportunities identified?



- Discuss and note down the practical barriers to progress
- Ask Why each barrier exists and repeat the process until you feel you have reached to “root cause”

## Group Work 4: What we will do ourselves and with partners?



- So far you have Identified:
  - Strengths to build on
  - Opportunities to improve and
  - Barriers to progress
- Now identify how you can realise the opportunities including how joint working could help

## Next steps



- Please identify the first 2 or 3 things you will do to start taking advantage of the opportunities identified
- Discuss what support (external and by peers) would be helpful in the future