‘Extra Care’ Housing Template for Devon

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Funded by

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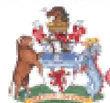

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1 Background

In July 2002 Ridgeway Associates was engaged by Devon Social Services to undertake a research project to:

- ✓ Evaluate the two-year pilot of the Guinness Trust’s ‘extra care’ scheme at Douro Court, Ivybridge; and
- ✓ Develop an ‘extra care’ housing template for use within the County of Devon.

The completed evaluation of the two-year pilot at Douro Court is attached as Appendix 1.

In compiling this template Ridgeway has drawn upon areas of best practice identified through its evaluation of the ‘extra care’ pilot at Douro Court and its extensive hands-on experience of ‘extra care’ housing. It is recognised that individual schemes designated by providers as ‘extra care’ will differ as will the challenges faced by providers when developing a new or remodeled ‘extra care’ project. Therefore whilst we have sought to look at the various scenarios we accept that this is not exhaustive. It should be added that, throughout, account has been taken of relevant current government policies and initiatives such as ‘Supporting People’ and ‘Best Value’.

From the outset it was made clear to Ridgeway that Devon Social Services is fully committed to growing ‘extra care’ housing provision within the County and this is illustrated in their Best value Review of the Accommodation Need of the Frail Elderly (April 2002) which promoted the *‘development of extra-care housing schemes in which the frail elderly can continue to live and be supported as an alternative to residential care’.* It is also clear that other professionals in the County have also aligned themselves with the concept but that some additional impetus and guidance is required to ‘kick start’ the process. In constructing this template Ridgeway first addressed the question: What is ‘extra care’ housing?

2 What is 'extra care' housing?

2.1 Currently there is no official definition of 'extra care' housing. However, it is generally considered to be a form of housing designed for older people whose needs dictate a requirement for housing with care. Older people in this category therefore require care and support services and specific design features incorporated within their homes to enable them to continue to live independent lives. The 'support services' may constitute: personal care; support services (not related to personal care); emotional support or additional security (or a perception of the need for it). The essence and ethos of an 'extra care' development is that it should:

- Promote independence;
- Enable people to be independent for longer;
- Provide choice;
- Provide security;
- Offer the resident 'their own front door' and an assured tenancy;
- Allow people to maintain control of their finances;
- Facilitate companionship and social interaction (where residents wish to take advantage of it);
- Have a preventative influence.

2.2 In many cases 'extra care' housing can obviate the need for residential care and there are also recorded instances where individuals have stepped down to an 'extra care' housing development from residential care (Bartholomeou 1999). Currently the majority of 'extra care' housing is for rent, although residents move into these developments from both rented and owner-occupier accommodation. Recently, however, a growing number of new build leasehold schemes have been developed, for example, the McCarthy & Stone's 'assisted living' developments.

There is not and could not be a 'single model' for 'extra care' housing and there are many examples throughout Britain of the various types of schemes that have been developed to cater for regional requirements

and the circumstances of individual housing providers. The main categories are:

- New build developments;
- Remodelled sheltered schemes;
- Remodelled residential care homes;
- Core and cluster developments.

‘Extra care’ style developments are also often labelled differently and may be variously described as ‘Frail Elderly Accommodation’ or ‘Part 2½ ’ or ‘Part 2½ +’. The services offered and the method of service delivery will also vary and, while some schemes may be stand alone developments, others will also function as a community resource.

2.3 The Design

Essentially an ‘extra care’ housing scheme comprises specially designed or adapted self-contained flats that meet wheelchair standard with a larger than normal amount of communal space. Although this document is not intended to provide a design guide the following gives an indication of the standards to consider:

1. Extensive communal facilities including a lounge, dining room, commercial kitchen, tea kitchen*, specialised bathroom**, social activities areas (craft, computer and library areas), hairdressing facility, shop, office accommodation plus overnight and rest room accommodation for care staff. Accommodation may also be made available for professionals, e.g. visiting GP, nurse, chiropodist;

   **When listing the elements that should be considered for an ‘extra care’ scheme above, a tea kitchen was included. This would be for the use of residents and others since only catering staff should use the commercial kitchen for health and safety reasons.*

   ***Opinions vary on the provision of assisted bathrooms. There is a view that residents lose dignity by using the facility, which is hardly necessary if all flats have walk in showers with seats. Others would argue that there is often a medical need for an assisted bath. To add to the debate, where an ‘extra care’ scheme is utilised as a community resource; assisted bathrooms are often extensively used by health professionals to meet a community need. In this instance, if these bathrooms are*

located in a specific area adjacent to day care facilities, the privacy of residents is maintained. When the facility is in the middle of the scheme, residents comment that the building feels more like ‘residential care’ than a ‘home’.

2. Laundry facility (with washers and driers raised off the ground to facilitate use) plus a washing machine with a sluice facility;
3. Buggy store with electric charging facility;
4. Raised flower and vegetable beds to facilitate gardening by the residents;
5. Some recently built ‘extra care’ schemes are now also offering health and fitness suites and, in one case, an indoor bowling green.
6. Corridors should be wide enough for two wheelchairs to pass with ease;
7. Main external doors should open automatically to aid those with wheelchairs and buggies;
8. Lifts should be large enough for a stretcher/coffin, have a speaking device installed and also incorporate brail symbols;
9. The building should be fitted with a community alarm system to all flats and communal areas;
10. The alarm system should have flashing lights as well as emitting sound to assist those who are hard of hearing;
11. Care should be taken to use contrasting colours on the different floors of the building, and in different areas as appropriate as one in six people over the age of 75 suffer visual impairment. Contrasting colours also assist those suffering from confusion/memory loss;
12. Both one and two bedroom flats should be built. Housing Associations have differing views on the percentage of two bedroom properties which should be built on any one scheme and these range from 10% to 50%;

13. Flats should comprise:
    - Bedrooms with sufficient space standards to accommodate a Hoist or a carer on each side of the bed;
    - Kitchens equipped with storage space suitable for wheelchair users, mid height cooker and fridge;
    - Ample and accessible storage space;
    - Individual meters for utilities.
14. Smart technology:
    - Automatically opening and closing doors and windows can be fitted;
    - Sensors on cookers and passive monitoring (to indicate when a resident is wandering) may also be installed. Sensitivity is required when installing these devices, as undoubtedly the resident will lose some degree of privacy. Therefore this is an area where resident consultation is particularly important. With new-build developments and remodelled schemes it is important to install the enabling infrastructure into buildings during the build /refurbishment stages; physical devices can then be linked in as and when appropriate;
    - High levels of insulation in the building will enable a suitable and controllable heating system in each flat. While older frail people require high levels of heating they also require high levels of ventilation. This also applies to communal areas and in particular the dining facility. Smart technology can also be used effectively to aid this process;
    - Other basic devices such as a 'loop system' for the hard of hearing should not be forgotten.
15. Avoiding an 'institutional feel' to the building
    - This is one of the most important aspects of design and the involvement of users, potential users and front-line staff in addition to the input of the professionals is essential. It is accepted that there needs to be some balance here since adding 'interest' to a building can increase costs. However, we would submit that with innovative

thinking an equitable balance can be struck. To add interest to a building one might consider:

- Ensuring that corridors are not too long;
- Breaking up corridors with small sitting or activity areas where residents can, for example, hold a private conversation or play cards;
- Including a reception / open plan office area in the entrance hall. The benefits are two-fold since the building has a welcoming feel and staff can monitor who is coming and going;
- Making communal areas feel ‘cosy’. Here functionality can be retaining by designing in flexibility – for example by having a room-divider which can be removed to facilitate larger gatherings;
- Enhancing exterior areas by including a covered garden situated within the envelope of the building (frail older residents would particularly welcome this and it would provide an all year round resource for everyone).
- As already noted, features such as the above can add significantly to capital costs but do provide significant ‘added value’.

16. Possible additional facilities:

- A day care facility with a separate entrance (to ensure privacy for the residents) – if on-going revenue commitment can be obtained from the relevant agencies;
- Respite care provision;
- Intermediate care provision.

Note: *these facilities should be designed so that the floor space can be used for flats or other facilities in the future if the original use is no longer required or funding withdrawn.*

2.4 A 24- hour ‘on site’ care team

Moving on to the provision of services, Ridgeway would suggest that a 24-hour on-site care team should be mandatory. The letting of a block contract by Social Services is the key and is an essential element of ‘flexible service provision’. In our experience it is an ‘extra care’ scheme without this provision that will experience difficulties and ultimately will not be able to deliver a service that meets ‘extra care’ standards.

As stated earlier, models of ‘extra care’ housing vary and provision of services is no exception. There are three basic models, namely:

- The care team provided by Social Services (in-house or contracted out);
- The contract let by the RSL to an external care agency;
- The RSL using a Care Agency, which is within its Group Structure.

In practice we have seen all three models working satisfactorily and a decision on the most appropriate option needs to be taken on a case-by-case basis. However, the essential element for all three options is to have in place from the outset a written commitment from Social Services / Supporting People and other Agencies such as Health to fund the on-going revenue costs.

2.5 A Scheme Manager

Clearly the role of the Scheme Manager will differ according to the model of care provision adopted. We have experience of working with more than one model of ‘extra care’ provision and believe that additional tensions can occur when there is a Care Manager / Co-ordinator and a Scheme Manager working in the same building but managed by different organisations. However, where this occurs it is important to define both roles at the outset as this reduces the likelihood of friction and essential elements of the services falling between two stools by not being in the ownership of the Scheme Manager or the Care Co-ordinator (fire alarms, for example). An ‘extra care’ scheme can be a stressful environment in

which to work and we would suggest that the Scheme Manager should be non-resident and work regular office style hours.

2.6 The provision of a meal

We believe that the provision of a meal in a restaurant / dining room is an essential element of 'extra care' housing. For some residents it may be the only social interaction they enjoy and in this respect a meals service clearly plays a part in the 'preventative role' of 'extra care' housing.

Once again the model may vary from provider to provider. For example, the requirement to take and pay for a meal as a condition of tenancy adopted by some providers appears to contradict the aim of promoting 'independence and choice'. However, a commercial kitchen is costly to fit-out in the first instance and the production of say 20 – 40 meals a day is not always cost effective as there is a limit on the price residents will be prepared to pay for a meal. Yet providers are successfully providing meals in 'extra care' schemes across the country. The options for the service are:

- To contract out the service to a commercial provider to prepare and serve meals in the commercial kitchen. On average the cost of a 2-course meal will be in the region of £3.50 to £3.80 per day. From our discussions with residents from various RSLs they seem content to pay this price for a meal if the quality is acceptable; or
- To recruit catering staff and prepare and serve the meals in-house.

Here again the choice will depend on the individual scheme. There are added health and safety issues when employing catering staff yet there is added flexibility since additional meals and options can be offered where providers employ their own staff.

Some 'extra care' schemes provide meals on a 5-day per week basis while others offer 365 day per year service. We recognise that the all year round service will be more costly (particularly in terms of staffing) but the view of the professionals is that 'extra care' schemes can be isolating for the residents at weekends / bank holidays therefore the

365 day per year service is desirable where feasible and if the concept is supported by the residents.

There is, for example, added value in having a commercial kitchen on site because this can service day care facilities, people in the wider community, residents’ guests and community events. Sandwiches and other snacks can be provided and we are aware of some providers who use the facility to produce office lunches to assist in making the kitchen financially viable.

Where there is more than one ‘extra care’ scheme within a given geographical area, one option is to install a full commercial kitchen on one site and a small service kitchen with regeneration ovens for reheating meals on the others. These small kitchens are capable of providing good quality results if properly operated.

2.7 Cleaning of residents’ flats

This service is normally offered to residents within an ‘extra care’ scheme and, as with the provision of meals, it maybe written into the Tenancy Agreement as an obligatory service or alternatively one available for purchase as an optional service. The latter approach clearly enhances choice.

3 ‘Extra care’ models

There are perhaps four main types of extra care development, each one offering its own benefits depending on local conditions:

3.1 New build developments: one could argue this is the most straightforward model as advantage can be taken of best practice adopted elsewhere and all the latest design features can be incorporated. Depending on the availability of land these developments also lend themselves to the ‘community resource’ concept which may well have an inter-generational theme.

3.2 Remodelled existing sheltered schemes: can be a cost-effective method of providing ‘extra care’ schemes where the building has some of the attributes required and where other essential elements can be added to the built environment. However, where extensive remodelling is required and where this will involve either undertaking major building works around residents or decanting them from the scheme a careful cost benefit analysis should be carried out. Consideration should be given to:

- Whether the building is capable of meeting the essential standards required in ‘extra care’ housing;
- What will it cost and how does that compare to a new build scheme;
- What are the likelihood of hidden costs when converting the building;
- How much capital would be raised if the building / land was sold and a new scheme developed on another site.

This list is not exhaustive, but gives a flavour of the sort of issues that require addressing. We have seen examples of many good and poor remodelled schemes and merely suggest that detailed option appraisal and cost benefit analysis is undertaken before committing finance. The essential point is that true ‘extra care’ is not a viable option if the built environment cannot be improved sufficiently to provide the physical requirements of a frail client group.

3.3 Remodelled residential care homes: many of the same issues arise here as in 3.2 above and again it is careful planning prior to committing finance that is essential.

3.4 Core and cluster developments: These developments may be new build or remodelled stock and generally comprise an ‘extra care’ scheme plus a cluster of bungalows or flats on the same site. Residents of the bungalows / flats (built to lifetime homes standard) can use the facilities in the ‘extra care’ scheme either from the outset, e.g. taking a meal and joining in leisure activities, or later on as they become less active. However, the support and care facilities would be available from day one. This type of development may be particularly appropriate in rural areas where the defined need is relatively small and therefore costly on a unit-by-unit basis. The cluster housing may well then be utilised by others in the community, not necessarily older people, but those with an assessed need for care and support. This type of environment may also be appropriate for a mixed tenure development.

All these types of ‘extra care’ developments also lend themselves to community use and as a hub for providing services into the community. In a county such as Devon, where development is likely to take place in small market towns and in rural villages, additional uses for the schemes may make the difference between financial ‘viability’ and ‘non-viability’. The uses we have in mind are, for example:

- Inter-generational use of the communal facilities;
- Provision of a nursery school / crèche;
- Facilities for GPs, District Nurses; Opticians;
- Offering a site for an Automatic Telling Machine (ATM) where the bank or post office pays a rental for the site. This provides a community resource where rural banks and post offices are closing ;
- Providing a base for domiciliary care services into the community;
- Providing educational services on site, e.g. IT classes;
- Providing respite care;
- Providing intermediary care.

4 Who can benefit from living in ‘extra care’ housing?

4.1 People with a range of needs can benefit from living in an ‘extra care’ scheme, for example:

1. **People requiring medium to high levels of care**

   - These prospective residents may be receiving a high level of personal care at home, the costs of which may well have become prohibitive and, additionally, their social interaction / depression / loneliness levels have become such that ‘extra care‘ accommodation would be beneficial to them. They may also be resisting losing their independence – so residential care is not an option they desire;
   - Other prospective residents in this category may be suffering from low level dementia;
   - Other prospective residents in this category may be leaving residential care, either because of the closure of the facility or the remodelling / adaption of the residential care home to an ‘extra care’ facility.

   Note: *in the course of this project it has been suggested to Ridgeway that many residents have entered residential care facilities in Devon while in crisis and evidence suggests that if care needs were assessed today they would be found to be low in many instances. It follows that valuable and costly facilities could be being misused to some extent. It may therefore be beneficial to undertake some analysis in this area to confirm or otherwise these anecdotal perceptions.*

2. **People whose care needs are not consistent**

   - Residents may require high levels of care at one time and little care at other times. This group may include people suffering from MS / Parkinson’s Disease. On more than one occasion Ridgeway has met younger residents living in ‘extra care’ housing who meet this criteria.

3. **People whose care needs reduce to a low level**

- These prospective residents clearly fall into the 'preventative' category. In their previous accommodation in the community they may well have neglected themselves. Often this will include taking poor levels of nutrition and suffering from loneliness resulting in depression. Once stabilised in an 'extra care' environment their care needs are likely to fall considerably. However, their value within the scheme is often assisting others less able than themselves, organising social events and generally participating in the day-to-day life of the scheme. Also, arguably, if they return to their previous home, 'crisis' would reoccur within a matter of weeks. Clearly it is this client group that assist providers in achieving a balanced community but cause concern to Social Services who question whether they should be funding this category of client.
- In evaluating the two-year pilot at Douro Court we found that the model was based on a 'balanced community' formula. It was clear from our discussions with residents that one of their main concerns was that too many people with very high care needs would be offered tenancies and therefore their 'home' environment would become a residential care home by default. However, on the other hand, they also stressed that 'extra care' should constitute a 'home for life' and they should be able to die at home wherever this was feasible. In this instance the model worked as the scheme was categorised as part 'extra care' and part 'sheltered' accommodation. Allocations were controlled via a Local Lettings and Allocations Policy, which had been established and agreed by all Agencies (the Housing Department, Social Services, and the RSL). The policy set out the criteria for entry to the scheme including a cut-off point, for instance, where the care needs of an applicant are perceived as too high, making the letting of an Assured Tenancy inappropriate. Early discussions were also held regarding the suitability of the proposed scheme for tenants with dementia or other mental illnesses. The level of dependency and the appropriate percentage of residents with these difficulties were

detailed in the Local Lettings and Allocations Policy to ensure a proper balance within the scheme. Although the letting of a tenancy in the scheme is a multi-agency decision within the terms of the policy, the landlord made the final decision.

- It is more usual for all the accommodation in a scheme to be categorised as 'extra care' and tenancies should only be offered to residents who have been assessed as in need of the facilities and services offered in the scheme. However, within this the multi-agency allocations panel will wish to ensure that there is a suitable balance of residents within the defined dependency range for the scheme.

5 Why should providers move towards the provision of 'extra care' housing?

Although there are many reasons to explore the possibility of providing 'extra care' housing, in this template document we are concentrating on five areas, namely:

- Meeting the needs and aspirations of today's older people and those in the future;
- Making best use of stock;
- The policy debate;
- Prevention;
- Demographics;
- Cost effectiveness;
- The Supporting People Programme.

5.1 Meeting the needs and aspirations of today's older people and those in the future

The traditional business of an RSL/LA with sheltered stock was developing and managing homes for rent for 'fit' older people. Some schemes would offer a Scheme Manager service while others (probably bungalows / Cat 1 flats) would have only an emergency alarm linked to a local control centre. Much of this stock may well have been built in the 1960s, 1970s and 1980s and is now in need of major refurbishment. Not only does the fabric of the buildings require updating but the needs and expectations of residents will also have changed over the years.

Much research has taken place on peoples' housing preferences as they age and the overwhelming outcome is that people do wish to remain in their own homes for as long as is possible. As a result, people are now moving into sheltered housing later in life, often as a result of major change, such as the loss of a partner or deteriorating health. From Ridgeway's experience it is not unusual for the average age of tenants in

a sheltered scheme to be 75+. Therefore many of them have identified care and support needs when they first take up their tenancies.

Furthermore, the focus of government policy has moved away from the provision of residential care towards people having care services delivered to their own homes. This has resulted in Category 1 & 2 sheltered housing becoming a ‘home for life’, something for which much of it was not designed.

It is the case that many providers have been slow to recognise the changes taking place in their schemes and it is often a Review of the Scheme Manager Service that highlights the additional support needed by residents. Latterly, the work undertaken in splitting housing and support costs within the Service Charge to comply with the implementation of the Supporting People Programme has also served to identify more clearly the actual levels of support provided and inherently areas that need expansion. These are messages that many Scheme Managers have been delivering for some years, often to no avail. The fact remains that a considerable amount of stock exists that is unsuitable for today’s residents and clearly cannot meet the expectations of the future generation of older people. Furthermore, this stock will not meet the standards now being set by statutory bodies.

5.2 Making best use of stock

Ridgeway’s view therefore is that in terms of sheltered housing in England there is:

- Some overprovision of stock in certain areas;
- Stock that is unsuitable / difficult to let due to its physical build standard; and
- Stock that is unsuitable/ difficult to let due to location.

Yet there is an under-provision in terms of ‘extra care’ housing (as now recognised by government) plus, in some areas, a need for accessible Category 1 housing built to lifetime homes standard.

5.3 The Policy Debate

Older peoples’ housing has moved up the political agenda, perhaps spurred on by the ‘bed blocking’ debate. In July 2002 Secretary of State, Alan Milburn made the following commitments in a statement to Parliament:

- A 50% increase in extra care housing places;
- Expansion of all forms of intermediate care;
- Expansion of intensive home care;
- Free community equipment (hand rails, hoists);
- That Local Authorities will be obliged to offer direct payments to people 60+.

The first three of these announcements are particularly relevant to ‘extra care’ housing. Currently further information is awaited on how the expansion of ‘extra care’ housing will be achieved although clearly, from the ‘provider’ point of view, capital and on-going revenue funding will be the key considerations. Additionally it is understood that options being explored include funding via PFI and making use of NHS estates.

In terms of intermediary care these are services that could be offered as part of an ‘extra care’ resource and furthermore Alan Milburn has announced that these services will be free at the point of use. To date, there have been some difficulties in setting up these services where schemes have received Housing Corporation grant. However, in its Older People Strategy (April 2003) the Housing Corporation states:

> *“Two thirds of hospital patients in England are over 65. Better housing and support for older people can prevent unnecessary or unnecessarily long stays in hospital, saving public money and benefiting older people themselves. The same applies to more coordinated and effective processes for matching accommodation to people’s needs. We are working with the Government and housing associations to identify housing association homes that are suitable for accommodating older people who have left*

hospital and are preparing to return to their communities. It is now clear that the Housing Act 1996 does not allow some housing associations to provide some types of intermediate care. Currently, we are working with the Government to devise ways for housing associations to secure intermediate care. We aim to agree a statement with the Government on guide how housing associations can be involved. The statement will also provide useful guidance for housing associations that wish to use their existing specialised housing to offer respite care for older people or their carers.”

Finally, to point three above, the expansion of intensive home care fits well with the model where an ‘extra care’ scheme acts as a hub for home care services into the community, therefore helping to make the provision of care cost effective.

5.4 Prevention

When ‘extra care’ housing was first introduced, ‘prevention’ was not high on the agenda: as a concept ‘extra care’ was seen primarily as a form of housing for frail older people which enabled them to maintain independence for longer. As ‘extra care’ housing has developed we are now able to assess its real benefits in terms of prevention and, in parallel, government policy has also emphasised the need for positive preventative strategies with the terms ‘re-enablement’ and ‘intermediate care services’ being used in policy documents. Traditionally, however, housing and health have been two distinct and separate entities. Yet with ‘extra care’ housing the involvement of ‘health’ is now an important element, although it is fully accepted that, in the past, the partnership was purely between Housing and Social Services, since it was these two entities that established the capital and on-going revenue funding model. The need for collaboration between ‘housing’ and ‘health’ is backed up by The National Service Framework (NSF), which states:

> *"Health and social services should routinely identify the scope for rehabilitation and consider, along with housing authorities, possible alternatives to residential accommodation".*

High on the scale of benefits of the 'extra care' model are:

- Preventing admissions to hospital; and
- Early discharge from hospital.

Our research indicates that admissions can be reduced as common illnesses in the older population such as pneumonia can be treated without admission to hospital, whereas in the community the chances of hospital admission are far greater. The added benefit here is that the older person remains in their own environment so are not exposed to other external infections prevalent in hospitals and benefit from the social interaction of being visited by friends and relatives in their own home.

The 'extra care' housing environment also provides facilities for timely discharge from hospital, so reducing 'bed blocking', and, with additional provision of respite / intermediary care places on site, further progress could be achieved (5.3 above refers).

In terms of early discharge from hospital, the availability of a 24-hour care team greatly enhances this possibility. This is an important and politically sensitive area for Government and proposals to amend legislation so that Social Services Departments can be cross charged if people remain in hospital after a decision has been made to discharge them. If confirmed this will mainly affect older people and will increase attention on the 'bed blocking' problem. It is intended that the legislation will initially affect older people but that it will later be extended to include people with mental health problems (this also has implications for Devon as there is pressure on mental health developments within the County).

It is now becoming well documented that many people become residents of 'extra care' housing schemes when in crisis, which can be as a result of ill health (physical or mental). These problems may be brought on by

isolation, which leads people to become depressed and neglect their health and nutrition. Others may suffer from the reality or perception of insecurity. In these cases, if a tenancy in an ‘extra care’ scheme was not available, the options may well be either to remain in hospital or move into residential care, taking a bed / room which is more urgently needed by others. Taking the scenario of the move into ‘extra care’ housing it may be that the first step could be respite care within the scheme after which people move back into their own home in the community or are assessed as requiring a permanent tenancy in the scheme.

5.4 Demographics

The fact that the Nation’s population is ageing is not disputed and the greatest growth is likely to be among those aged 80 and over. The projected percentage increase in this age category in Devon is 30% by 2006 (North and East Devon and South and West Devon Joint Investment Plans for Older People 2000-2003). The percentage of older people living in Devon is currently 10% and that is 3% above the national average. These statistics provide a clear indication that additional services for older people will be required within the County.

5.5 A move away from residential care

Devon has embraced a policy of a decrease in traditional residential care and has defined a need for a growth in ‘extra care’ housing. In the Best Value Review of Accommodation Needs of the Frail Elderly in Devon County (Joint Review) Vision of the Future - Support People in their own Homes (April 2002), David Johnstone, Director of Social Services stated that:

> “*A significant proportion of LA residential provision is in the delivery of standard residential care*.”

The conclusion of the BV review was that this is **not** the most effective use of resources. So future growth in the provision of ‘extra care’ housing in the County should become a reality. However, ‘extra care’ housing is not a panacea for all needs and so the recommendation in Devon is that

the LA residential services should be dedicated to provide specialist provision such as:

- Re -enablement services;
- Care for the confused elderly, in particular promoting and supporting safe care within the community through outreach, day care and respite services;
- Community Resource Centres incorporating day care services and providing a single point of leisure and lifelong learning;
- Access to a range of community health and therapy services, respite care and domiciliary services.

It is also recognised that further nursing care and provision for those suffering dementia is also required.

5.7 Cost Effectiveness

But is ‘extra care’ housing cost effective? Most research undertaken on this question has come to more or less the same conclusion, namely that ‘extra care’ housing is less costly for the Local Authority but not necessarily so for the Exchequer. But, added value benefits are many and varied and cross the boundaries of housing, health, care and support. Reducing hospital admissions and facilitating hospital discharge can clearly be described as a cost-saving benefit.

Primarily, for certain categories of older people, ‘extra care’ housing is simply a more acceptable form of provision than residential care. However, it is advisable not to reach sweeping conclusions about the full cost of ‘extra care’ provision since it is funded from more than one ‘pot’. However, on the other hand, the benefits derived do bring savings to more than one budget head.

Turning our attention to Devon, there is also a rural dimension in that it is unlikely that, for small towns and villages, the ‘extra care’ housing model with 38 – 40 units can be justified, even though it is precisely this size of development that is most likely to ‘stack up’ financially. However, the move towards multi-agency involvement in ‘extra care’ housing has added a further dimension that allows for income-generating additions to

the model to be considered. So once again we emphasise that joint working plus innovative thinking is the key to successful smaller developments.

However, more work on cost effectiveness of the model is likely to be required when the full implications of Supporting People can be analysed, although in theory the programme should not aversely affect the model.

5.8 The Supporting People Programme

Reference is made to the Supporting People programme in relation to ‘extra care’ housing throughout this template. The SP programme has resulted in some re-alignment in the provision of services between personal care (funded by Social Services) and support (to be funded from the SP grant) and discussion with all Agencies should assist in maximising the opportunities that exist within the Programme.

The SP programme has provided RSLs with an opportunity to define the support element within its service and in some cases introduce 24-hour cover (using support cover overnight). This option is appropriate where residents’ care needs do not justify staff on duty overnight to deliver personal care but where, nevertheless, a support presence is required. This is a particularly appropriate option when a member of a Social Services night team is available to be called in an emergency. It is recognised that not all Social Service departments have night teams and in this case perhaps other services within the community could be utilised.

Other opportunities stemming from the SP programme relevant to ‘extra care’ housing include the provision of additional services such as:

- Support to residents in the community via ‘floating support’ services;
- Support to residents in ‘core and cluster’ schemes;
- Recruitment of specialist staff to assist residents to move from their existing home to an ‘extra care’ housing development;

- Assistance with specialist training.

The SP programme therefore has offered an opportunity for RSLs to develop additional services. However, in the future it will be essential for providers to include the SP teams in any negotiations for new developments and services at the beginning of the planning process.

6 The steps required to develop ‘extra care’ housing

‘Extra care’ housing is markedly different to sheltered housing and therefore a different approach to commissioning and management is required. Where do you start?

6.1 Assessing demand – option appraisal

A great deal of valuable work has been undertaken in Devon to assess demand and a clear need for ‘extra care’ housing has been established. Yet demand will vary from location to location depending on demographics and the current supply and quality of existing sheltered stock and residential care homes. It is therefore essential for RSLs/LAs to undertake an extensive option appraisal of their stock.

In undertaking this work it will be important to establish if the current sheltered schemes / residential care homes will meet the statutory and desired criteria for older peoples’ housing in the future and, if not, whether they can be refurbished to meet these criteria or whether alternative options should be considered. So we would pose three questions:

- What are the needs and expectations of future customers?
- What is RSL/LAs vision for future schemes? and
- Are both views compatible?

Working in line with Best Value principles it is essential that the views of residents, potential residents, stakeholders and competitors are sought in addition to sourcing the following information regarding each scheme:

- Age;
- Size;
- Type of accommodation(s);
- Stock condition surveys (if available);
- Details of planned maintenance schedule;
- Scheme plan;
- Geographical location of schemes;

- Proximity to facilities such as: pharmacy; doctor; shops; public transport;
- Location of schemes in relation to others in the close vicinity;
- Void statistics;
- Waiting list information;
- Age profile of residents;
- 'Care needs' profiles for residents (using the Douro Court model).

Although much of the work to be undertaken is of a technical nature it is important that within sheltered stock Scheme Managers should contribute to this evaluation as they work on the schemes on a daily basis and often have a particularly clear view of the issues.

To complete the work on housing and care needs in the locality further information should be accessed from the appropriate local strategies e.g. housing needs surveys, housing strategies, strategic plans, Best Value Service Reviews.

The outcomes from this work could include possible options such as:

- Minor refurbishment to include facilities to enable the scheme to provide additional services to residents and the community. This may include identifying any additional land on site, which may add to the future viability of scheme, e.g. an opportunity to build additional properties / provide communal facilities/facilities for other professionals (doctors, surgery). Constraints may prevent the scheme being upgraded to 'extra care' specifications but would nevertheless constitute good quality sheltered housing, perhaps with enhanced services provided to residents and the local community;
- Major refurbishment;
- Demolition and rebuild to say 'extra care' standard with possible respite / intermediary care facilities;
- Complete or partial change of use:
    - Continuation of the existing use in part of the building plus short-stay accommodation;
    - Let / sold for use of another client group;

- Demolition and rebuild on site for a similar or different client group;
- Sell site and use proceeds to develop a more suitable site – possibly in partnership with another Agency.

From this extensive analysis a business plan detailing the location and type of possible future 'extra care' schemes can be developed. It is important at this stage to ensure that the model fits the County Strategy.

6.2 Owner occupiers

In meeting the government's objective of offering 'choice' the high percentage of owner-occupiers in the County (80%) leads one to immediately consider tenure options. The problems that develop with age take little account of wealth and many owner-occupiers have a clear need for 'extra care' housing. Therefore it can be argued that if they can afford to buy their 'extra care' home this is a choice they should be able to exercise. It might also be asked why should the public purse fund accommodation that could be funded by the individual? Here there is a clear opportunity to offer mixed tenure developments, namely homes to rent; to buy; plus a shared ownership option. The advantage here is that if, say, one quarter of the properties on any one scheme were sold, this would have a marked impact on capital costs, particularly for smaller developments with inherently higher unit costs. As noted above this is particularly applicable to Devon. Also, another option could be to sell a site to a private developer for 'extra care housing for sale' and cross subsidise a 'to rent' scheme.

Following on with this theme Ridgeway discerns that very little research has been conducted among older owner-occupiers concerning their plans for the future. Consideration could be given to undertaking work on the needs and aspirations of owner-occupiers in Devon. It is our experience that older people, their relatives and friends within the owner-occupier sector have little or no knowledge of 'extra care' housing. Research undertaken for Hanover Housing Association in the mid-1990s also verified

this lack of knowledge among owner-occupiers. Furthermore, professionals have expressed the view that this lack of knowledge has resulted in older people taking valuable residential / nursing home beds when their care needs are low.

6.3 Setting up an Internal Project Team

Internal partnership working is as important as external partnership working. All relevant disciplines within the organisation should be involved in the project planning and implementation processes and their ‘buy in’ to the concept sought. Therefore it is usual to form an Internal Project Group with representation from key areas such as housing management, development and finance - plus, ideally, a Scheme Manager, a board director and a resident. Where an RSL does not have an employee with a care and support background then it may be possible to co-opt someone with the right background from another RSL or, alternatively, expertise could be drawn for other external agencies.

To expand on the point about resident participation we firmly believe that residents driving the decision-making processes during the development of an ‘extra care’ facility is vital. Clearly, Douro Court is a prime example of this.

However, even when developing a new build scheme, sampling the views and aspirations of tenants already living in a sheltered scheme is beneficial. If the plan is to develop a scheme incorporating a ‘community resource’ in a rural location a wider consultation process is required. Involving the Parish Council can be a useful first step prior to wider consultative processes.

The first major task for the Group will be to draw up Risk Assessment Criteria. It is likely that such a document is already in existence for development purposes and this may simply require extending to cover the additional elements specific to an ‘extra care’ scheme. As well as fulfilling its primary purpose a well constructed risk assessment document can also

provide a valuable project management tool, taking the RSL step by step through the development and commissioning processes. When developed, the Risk Assessment Criteria should be approved by the Corporate Management Team and the Voluntary Board and, at this stage, a Risk Assessment Panel will normally be chosen, comprising members who can authorise development and spend on the project. In our experience these staff are normally members drawn from the Corporate Management Team. Without their agreement the project cannot progress and thus the project team will need to seek their approval at each of the milestones identified in the Criteria.

6.4 Undertake a design and development feasibility study

This study will identify scheme costs and issues for the models identified in the business plan. The candidate schemes under consideration can be categorised as high, medium and low priority so narrowing down the number of schemes that are under consideration during the early stages.

6.5 Partnership working

‘Partnership working’, ‘joined up thinking’ and similar phrases have peppered government policy and debate over recent years. However, in terms of ‘extra care’ in the schemes that are not operating effectively, the root cause can often be identified as being a lack of engagement between the partners within a scheme and poor clarity for the aims they originally agreed for the enterprise. It is probably fair to state that many professionals are still not clear about the service offered by ‘extra care’ housing and how it might link into their health and care agenda.

Another ‘partnership factor’ is that the creation of an ‘extra care’ housing scheme in an area can affect the way in which other professionals use their time and resources. To illustrate, here are two examples:

- The district nurse will spend a significant amount of time on the scheme. This is good as it saves time driving between clients’ homes in the community, but the Manager will have to reshape his/her rotas and adjust budgets;

- The introduction of a treatment room is an excellent facility on a scheme but who stocks it? These are issues to be settled during the development stage as the appropriate department can arrange to budget for and service the facility.

Towards maximising the potential for effective partnership working it is vital to set up from the outset a liaison team comprising representatives from the local Housing Department, Social Services, the Supporting People team, the Primary Health Care Team, GPs and District Nurses, plus any other representatives that are appropriate to the proposed development.

6.6 The financing of 'extra care' housing

When consideration is given to constructing new build or remodelling existing stock to 'extra care' standards the ultimate decision to go ahead will depend on whether the scheme appears financially viable from both the capital and on-going revenue points of view. In terms of capital the cost of the land, grant aid obtained etc all contribute.

6.6.1 Funding the capital programme – the essential elements:

- Minimise the cost of land and if possible source free or subsidised land;
- Obtain Social Housing Grant (SHG) from the Housing Corporation. The Corporation has stated that they will only invest in developments where people need support that are consistent with the local Supporting People Strategy;
- When remodelling explore the possibility of obtaining funding from the Housing Corporation who have stated that, *"We will now consider funding the remodelling of sheltered housing".* They have included a range of criteria and these can be found in the HC's Strategy for housing older people in England (HC April 2003)*;*
- Look to achieve cross-subsidy;
- Raise funds from other sources, e.g. 'health' monies;

- Source charitable funding. This is an area not heavily exploited in the UK but it can provide substantial opportunities.. This type of fund raising should commence before the building stage since it is more attractive if the donor(s) can monitor the project as it emerges. The other alternative is for the users of non-housing related facilities based on the scheme to pay a rent to the RSL to cover the cost of the loan;
- Identify the amount of private finance required.

At the end of this process it is essential that the cost of borrowing is minimised to ensure that the rent and service charge payable by the resident is ‘affordable’ and accepted by Housing Benefit and Supporting People departments.

6.6.2 Revenue funding – the essential elements:

As suggested above a 24-hour care team is an essential element within an ‘extra care’ housing scheme and this has tended to be funded by Social Services. As mentioned earlier in this document Supporting People Grant now has a part to play in revenue funding, as do other Agencies. Although when a scheme is remodelled to ‘extra care’ standards some RSLs will front fund some of the revenue costs while care needs are rising, this is not the case across all RSLs. In terms of a new build scheme front funding should generally not be necessary.

Funding the 24-hour care is an essential element in any scheme and Ridgeway would recommend that clear written guidelines and responsibilities are set with Social Services, Supporting People and all other Agencies involved with the funding of the scheme prior to embarking on the project. Clearly, a Risk Assessment Panel should not approve a scheme until these written guarantees are in place.

Funding will always be an issue and we have in the past explored models where residents agree to pay the equivalent of their Attendance Allowance as part of their rent. To date this model has

worked well but one must always be cautious over non-means tested benefits as national policy can change. However, RSLs should ensure that benefit checks are made available to all residents taking on an ‘extra care’ tenancy. There is a view that ‘Supporting People’ is causing service charges (which, as mentioned, should be agreed in advance with both Housing Benefit and Supporting People departments) to rise which adversely affects those residents not eligible for benefits. Therefore claiming non-means tested benefits becomes even more important.

6.7 Assured Tenancy Agreements

It is important for RSLs to develop an ‘extra care’ Tenancy Agreement defining the services offered to residents. If the scheme is new build the sign up procedure is straightforward. However, if the scheme is to be remodelled and existing tenants will be elevated to ‘extra care’ then changing their Tenancy Agreement is an extensive exercise, which can take many months and is likely to require Board approval. This is a housing management task and should be programmed into the Risk Assessment Criteria.

6.8 Nominations

Appropriate allocations policies have been considered in this document, as the long-standing principle of offering a tenancy to the person at the top of the list is not applicable for ‘extra care’ housing. Detail regarding nominations and the adoption of a ‘local lettings policy’ is set out in 4.1 above.

6.9 The Care Contract

As outlined in 2.4 above, there are three basic models that can be adopted when providing a 24-hour care team, namely:

- The care team provided by Social Services (in-house or contracted out);
- The contract let by the RSL to an external care agency;

- The RSL using a Care Agency, which is within its Group Structure.

The decision on which option to adopt should be made in liaison with Social Services the Supporting People team and other partners. We would stress once again that a written agreement, signed by all parties, detailing the model is essential. The option chosen will also affect staffing of the scheme and where the contract is let by the RSL there is likely to be a staff training issue as managing care contracts is outside most housing organisation’s core business.

6.10 Catering and Cleaning

The options for catering and cleaning on the scheme are discussed earlier in this document. It is our experience these activities run smoothly in ‘extra care’ housing schemes where care is taken to set them up properly in the first place. Risk assessment is the key in both cases. In particular the legislation around the provision of meals should be adhered to and expert advice obtained where required.

6.11 Promoting the scheme

It is our experience that promotion (marketing) of the scheme, whether new build or remodelled, is essential. The essence of ‘extra care’ housing is joint working so it is important that all the relevant professionals are aware that the facility will be available to them, and when.

6.12 Letting the Scheme

It is important to recruit / identify the Scheme Manager at an early stage so that he/she is involved in the allocation process from the outset. The potential residents are ‘frail’ and need considerable support during the decision-making and moving process.

Prospective residents visiting the flat can also be an issue with new build schemes so allocating a ‘show flat’ in an area of the development during the latter stages of the build process is helpful. Some RSLs furnish these flats.

6.13 The move

Schemes are in existence where a specialist member of staff is recruited to purely ‘assist with the move’ from one home to another. It can be traumatic experience when young so the apprehension / worry for someone of 80 or so is immense.

Note: there are instances where this service is being funded by the Supporting People programme.

The actual moving-in process also needs to be managed progressively, since it is clearly unrealistic for a significant number of frailer older people to move into a development on one day. Therefore the associated loss of rental income needs to be costed as part of the project.

6.14 Other facilities

We have discussed the provision of other facilities such as day centres / respite / intermediary care being included within the scheme. The use of the scheme as a community resource and its use as a hub for domiciliary care staff servicing the community have also been mentioned. Again these all require intensive joint working but, as shown at Douro Court, they can be very successful. In this template we stress early and detailed planning. The major issue to be overcome is capital and on-going revenue funding (discussed earlier) and in our experience joint working and innovative thinking usually provide the key.

We have also mentioned inter-generational use of the scheme and this would seem particularly appropriate in Devon with its small market towns and rural villages. For example, if the facility is used to host a crèche as well as a day centre could the transport for the day centre also be used for the children? Space could also be rented for evening classes (draw education into the project group); perhaps some of the residents would attend.

7 Conclusion

In conclusion we would reconfirm our view that the various models for ‘extra care’ housing, both rented and for sale, will constitute a significant tranche of housing for older people in the future. The essence of developing successful ‘extra care’ housing is careful planning and joint working. While the model itself offers the user added independence and choice plus a quality service.

Developing 'extra care' housing

- A Short Guide -

N.B. This guide should be used in conjunction with the Ridgeway Associates' 'Extra care' Housing template for Devon (2003)

Step 1 - Inception

- Assessing demand
  - Undertake an 'option appraisal' (see 6.1)
- Consider tenure options (see 6.2)
  - Rented
  - Shared ownership
  - Owner occupation

Step 2 - Planning

- Set up an internal project team (see 6.3)
  - Multi discipline
  - Residents / tenants
- Set up a Risk Assessment Panel (see 6.3)
  - Include officers who can authorise spend
- Devise a Risk Assessment Criteria (see 6.3)
  - Set timescales
  - Identify milestones
- Design and develop feasibility study (see 6.4)
  - Prioritise targets

Step 3 - Development

- Partnership working (see 6.5)
  - Housing Department
  - Social Services
  - Primary Health Care Team
  - GPs / District Nurses
- Financing 'extra care' housing (see 6.6)
  - Funding the capital programme
  - Revenue funding
- Tenancy Agreement (see 6.7)
  - A new 'extra care' Tenancy Agreement
  - Amending the current Tenancy Agreement
- Nominations
  - A Local Lettings Policy (see 3)
- Contracts
  - The Care Contract (see 2.4)
  - Catering and Cleaning Contracts (see 2.6 / 2.7)
- Promoting the scheme (see 6.11)
- Letting the scheme (see 6.12)
  - Recruiting the Scheme Manager
  - Assisting with the move (6.13)

Appendix 1

Douro Court

'Extra Care' Centre, Ivybridge

An evaluation of the two-year pilot

Prepared by Ridgeway Associates for

Devon Social Services

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1 Background

In July 2002 Ridgeway Associates was engaged by Devon Social Services to undertake a research project to evaluate the two-year pilot of an ‘extra care’ scheme at Douro Court, Ivybridge. The scheme is owned and managed by the Guinness Trust (GT).

There are various models of ‘extra care’ housing and in essence Douro Court was built some 13 years ago to Category 2.5 standard with the additional features such as an assisted bathroom and commercial kitchen which made its conversion to ‘extra care’ without extensive remodelling a viable option.

Of the 31 flats at Douro Court, 20 are now classified as ‘extra care’ and the remaining 11 remaining as sheltered flats for less dependent older residents. Prior to the pilot residents’ assessed care packages were individually contracted whereas with the introduction of the pilot a block care contract was put in place with the Guinness Trust managing the contract which was let to an independent care provider.

In order to provide 24 hour cover on the scheme, from day one grant monies from the JIP partnership, Social Services and GT front funded the budget deficit for the duration of the two-year pilot, which allowed sufficient time for dependency levels in the scheme to rise to the point where night cover became financially viable. Then, at the end of the pilot period Social Services took financial responsibility for the ‘extra care’ places. During the pilot the Supporting People programme also become a factor in the equation and some costs have now been defined as ‘support’ rather than personal care.

2 Methodology

In undertaking this evaluation Ridgeway focused attention on: those individuals whose vision and commitment drove the project forward; the users of the services offered on the scheme; staff of the Agencies involved in the project and, front line staff. To achieve this the following tasks were undertaken:

- Face-to-face / telephone interviews with professionals from housing, health and social services. Staff included were those that influence policy, managers and, front-line staff;
- Face-to-face interviews with users of the services provided at Douro Court;
- A focus group with service users.

As well as conducting interviews across the County, Ridgeway found the days spent at Douro Court provided considerable added value since we not only became familiar with the physical attributes of the scheme but also were able to assess the atmosphere, community spirit and interaction between residents and other users of the facilities.

During our visits to the scheme we also attended a Project Group meeting. This is a multi-agency group with the membership comprising representatives from: the residents (two), the Care Provider, the Guinness Trust, Health, Social Services and the Voluntary sector.

As a comparator we also visited a new build 'extra care' scheme in the north of the County where the provision of services differed from that of Douro Court. In preparing this document we have also drawn on this experience and also that gained while working with other 'extra care' housing providers over a number of years.

3 Evaluating the pilot

As indicated above Ridgeway believes that this pilot has been a success but, like any other new venture, it has experienced teething problems. The primary issue was the fact that the cost of running the services at Douro Court proved to be higher than at first anticipated. However, this major obstacle was overcome through the:

- Commitment of the Agencies involved in the scheme to front fund the project; and
- Ability of the staff at Douro Court to drive the project forward and increase income through providing additional services to both residents and the community as a whole.

Douro Court has a day centre facility, a luncheon club, offers respite care, care services via a ‘costed menu’ and lets office space to another Agency, all of which has helped in balancing the budget during the pilot period. Now, with a good balance of dependency levels within the scheme, a three year contract has been signed with Social Services / Supporting People departments thus securing the scheme’s medium term financial future.

Throughout this two-year pilot Douro Court has enjoyed a great deal of publicity and media attention. Television crews have visited the scheme and thousands of words have been written about the transition of the scheme from sheltered housing to an ‘extra care’ centre. Although it is vital to promote schemes such as Douro Court we ascertained that there was perhaps too much ‘hype’ and audiences became bored; *‘not Douro Court again’* was said to have been heard several times, although we perceived that the residents had thoroughly enjoyed the attention. Because of these factors, in this evaluation, we have attempted to avoid covering ‘old ground’ but instead have concentrated on developing an evaluation supported by the feedback of:

- Those who have worked towards making Douro Court a success; and
- Residents and members of the community of Ivybridge who benefit from the provision offered by the scheme.

In this main body of the evaluation we review the specific areas of major significance that we have drawn from our fieldwork.

1. Ethos

The majority of factors contributing to success at Douro Court can be identified as tangible. However, Ridgeway would submit that it was the less tangible aspects of responding to the Best Value principles of ‘challenge’ and ‘continuous improvement’ that were the key elements in the success of the project; as expanded later in this document. An illustration of this is the attitude of those instrumental in the success of the scheme who, rather than resting on their laurels, continue to question service delivery standards and also put forward suggestions for improvements in the built environment. We believe that it is this ethos that has driven the scheme forward. The factors contributing to this include the commitment to multi-disciplinary working, the personalities of those involved and the ability to side step bureaucracy and so achieve the aims of the project.

2. Managing change

In setting up this pilot it was clear to all concerned that the residents would undergo major change, an experience which older people find particularly difficult to accept. This has been overcome by fully involving the residents in the planning and execution of the change processes with support from a representative from Age Concern. As a result, the clear message received was that the residents feel they have ‘real involvement’ in the decision-making processes.

It seems that the residents have two concerns for the future, namely:

- That their ‘home’ does not come to resemble a residential care home because dependency levels are allowed to escalate; and
- That they do really have a ‘home for life’ and will not be forced to move to other provision.

The above expectations may appear to contradict each other but this is human nature. It is difficult to ‘square the circle’ to meet the concerns of residents but in attempting to achieve this Douro has set criteria that promises

the creation of a balanced community within which there are sufficient active residents. The introduction of a Local Lettings Policy giving the multi-disciplinary lettings team the discretion not to take the person at the top of the waiting list has been the essential factor in managing this balance.

Professionals associated with Douro Court have stressed, however, that the above policy has not prevented them accommodating highly dependent people within the scheme, including those with cognitive problems. An additional management tool, namely a dependency matrix, has been introduced to check overall dependency on the scheme. One of our interviewees suggested that a more positive slant could be introduced by changing the name to an ‘independence matrix’.

We cannot over emphasise how important the balanced community concept is to residents since much of the enhanced quality of life they achieve at Douro Court is via social interaction both inside and outside the scheme. There is an active Social Committee at the scheme and both the able and less able can participate in the events that are organised. It should be noted that the availability of the scheme’s own transport is a vital resource. Demonstrated here is an innovative example of joint working, as the transport is made available via a contract shared between the Education Department and Devon Social Services. Under this arrangement Douro Court is able to use the minibus after 4.15pm during term time and has sole use during the school holidays.

In terms of ‘a home for life’ residents have seen evidence of additional care being given to frailer residents to allow them to die in their own homes. However, nothing is ever perfect and there has been at least one instance where a resident has had to move on to nursing care. However, no residents have moved into residential care provision since the pilot was introduced.

3. Flexibility

The whole essence of an ‘extra care’ environment is flexibility and while at Douro Court, as in other ‘extra care’ facilities, residents have individual care

plans, because their care and support needs vary from day to day the block contract system allows for them to receive more or less assistance on demand. Naturally individual care plans themselves will need to be varied at times but we were given the impression that the process evolved more easily and was ‘less bureaucratic’ than generally found in the community and this process was much aided by multi–disciplinary working.

The non – ‘extra care’ residents are entitled to one week of free care if the need arises after which they pay for care. If problems continue they will be assessed by Social Services in the normal manner and if a care package is established they will fall into the ‘extra care’ category. This arrangement is a prime example of residents influencing the service since during the consultation process they pointed out that, under the old system, the Warden provided care as an interim measure until statutory care arrangements were put in place. Therefore they rightly argued that since they were already paying for this service within the service charge, allowance needed to be made for this and therefore compensation in the form of free care for one week was jointly agreed to be equitable.

In terms of the Care Contract, Sanctuary Housing holds this and Sanctuary’s Care Co-ordinator is based in the open plan office on the scheme. Unlike in the community, the experience at Douro Court has been that there is little turnover of care staff. The staff appreciate working in one place, being offered block hours and the opportunity of building up a relationship with their clients.

4. Managing care needs

Initially problems were experienced following the change in the way care was being delivered on the scheme. At the outset, care needs were low and care staff less busy and an ethos arose where the residents called the care staff *‘to pick up a hankie’*. As care needs grew this became impossible to service and staff and residents agreed a formula for ‘pop-ins’. Introduction of this formula resulted in the number of pop-ins reducing from 1,745 to 250 in one month.

Residents are allowed up to three free ‘pop-ins’ per day as part of their care package. They are then billed for 15 minutes for every five ‘pop-ins’ thereafter. While residents are not billed for night calls if they insist on being got up and dressed while the night shift is working, for example, at 6am, they are billed for 30 minutes.

This system fits well with the menu of charges for care / support which has been drawn up. It enables residents to purchase additional services such as bathing, shopping, housework and escorted outings, namely those services that are not covered by the block contract. Residents resented these charges at first and the view is that some still do. To ease the issues that arise from this it is important that clients sign a timesheet confirming receipt of the extra services delivered. We understand that this is an area where some improvement in practices is required.

Residents have the opportunity to, for example, ask for an assisted bath at a certain time on a certain day and generally their aspirations are met. However, the view is that they are often not willing to be flexible. This does lead us to raise the question of ‘equality of service for all’ as the picture out in the community is usually somewhat different when compared with the Douro Court service!

Ridgeway considers that the introduction of a chargeable ‘menu of services’ is a positive feature of this pilot. It offers choice to the residents and has a positive influence in avoiding the ‘dependency culture’ found in many residential care homes. However, it is important to ensure that residents

apply for Attendance Allowance as soon as it becomes applicable. It appears that a culture of spending Attendance Allowance on these additional services has been positively encouraged within the scheme. The view is that the take up is good, probably because the services are visible and the carers are based on site.

5. Dependency / Prevention

Ridgeway found that the responses from some of the professionals interviewed on the issue of ‘extra care’ housing proving to be a positive factor in influencing ‘prevention’ and ‘minimising dependency’ of particular interest. While this aspect of the model was a central part of the ‘vision for Douro Court’ for some, it was seen as an ‘unintended consequence’ by others. Clearly, the benefits are evidenced at Douro Court. Residents not only receive care but also benefit from the social inclusion. In our view this is much enhanced by the fact that the scheme is now a ‘hub’ for other activities.

- Crisis often prompts older people to move into residential care and this can involve:
- The need for night care when neither they themselves nor the Scheme Manager (if they live in sheltered accommodation) can cope;
- The inability to cope at home after leaving hospital;
- A feeling of isolation leading to depression and neglect.

In any of these cases Douro Court can prevent the move into costly and scarce residential care and preserve the resident’s independence. In addition, in some instances, once stabilised, the resident’s care package actually reduces. Ridgeway was given instances of this by both staff and residents and, listed below are some of the perceived benefits of living in a facility such as Douro Court:

- Confidence is boosted because help is at hand and, as a result, mobility improves and the resident can take an active part in life of the community;
- Self esteem is boosted;
- Social skills are regained;
- Re-enabling / enabling by staff creates additional independence;

- Staff notice both gradual or sudden deterioration in health and timely action can be taken.

However, the success of the scheme in this area brought with it a dilemma. From a Social Services’ budget point of view, if care needs reduce, should the resident be supported in ‘extra care’ when they no longer need it? However, this has now been resolved as the balance in dependency level is being redressed as vacancies occur.

Prevention, particularly as a means of avoiding bed blocking, is high on the government’s agenda. Here, the evidence is that, once again, the Douro Court model has provided positive benefits because the flexible nature of the care allows many patients with for example, influenza or pneumonia to be cared for in their own home. Also, on the other hand hospital discharge is facilitated because of the 24-hour on-site care team.

Clearly, those involved with Douro Court can see how effective the scheme is in terms of prevention but to date no formal analysis has been undertaken. Ridgeway believes that this would be valuable: for example if ‘health’ are to contribute financially towards ‘extra care’ housing they would wish to know how many ‘bed days’ they can save. However, we understand that although approached, health services were at that point in time unable to commit to such research.

6. A service to the community

As detailed above, Douro Court is more than a basic ‘extra care’ scheme as it also provides services for the community. The results from this section of the evaluation proved to be diverse. In talking to users of the services it emerged that they enjoyed the facilities and found the staff to be friendly, kind and that they also put themselves out to help in any way they could.

The Day Centre user we interviewed enjoys the company, the activities, e.g. cards, bingo and commented that; *‘I don’t know how people manage without places like Douro Court’*. It was also interesting to note that the respondent

appreciated the fact that while she was at Douro Court her carer (husband) was able to have some time to himself. This is another instance of ‘added value’ derived from the scheme. We also gained further evidence of user participation and influence through the setting up of a Day Centre Committee.

Those who used the Luncheon Club considered the meals to be excellent; the choice of menus was regarded as good and one interviewee stated : *‘if you do not like what is available, the cook will provide you with an alternative’.* These users of the service also highlighted ‘added value’ in terms of the service that the dining room facility offers:

- Users of the service gain an insight into life at Douro Court, which is potentially useful since they may then choose to become a tenant in the future;
- Social opportunities exist not only for those who come to the scheme for a meal but also those who live on the scheme Some interviewees actually felt it was more advantageous for the residents than for incomers;
- The opportunity to take away frozen meals for use on other days.

So while the feedback from the users was very positive, we experienced a somewhat different view from the staff and professionals involved with the scheme. The following points may appear critical but the manner in which they were delivered leads us to believe that it is the wish to ‘continually improve’ the service that drives the comments received. And no doubt some of the items mentioned will already be pencilled into next year’s business plan. A prime aim was to broaden the menu of services offered to the community, for example to:

- Provide an information service;
- Broaden the remit of the Day Centre to include rehab;
- Open the Luncheon Club to a wider range of clients, therefore broadening the mix of ‘abilities’.

Another aim was to increase usage of the building as a multi-agency resource by:

- Introducing preventative work by District Nurses so as to identify the early onset of problems;
- Providing a resource for GPs;
- Using Douro Court as an outreach facility for providing care into the community;
- Creating an inter-generational resource.

Although Ridgeway's remit was to evaluate the pilot we would submit that although the points made are valid and positive, in fact the 'built environment' of the scheme limits significant expansion. There are already tensions in that the layout of the building is not ideal for the purposes mentioned above. The residents also appear to feel, to a certain extent, that they have lost some privacy now that the scheme is more heavily used by the community. It is unfortunate that the only lounge available for residents' sole use is very small. Also, concern was expressed that the scheme would not be able to cope with a resident suffering from dementia, as the front door has to be left open for 'the Day Care Centre'.

Ridgeway appreciates that there are on-going discussions regarding the expansion of the scheme and if a discrete suite of facilities for the community could be constructed (with the residents able to participate in the activities provided) this vision of expansion could be realised.

Views were expressed on how to improve the services and facilities with some minor adaptations to the building. These included:

- Creating a venue that is stimulating for its users – the restaurant / day centre was seen to be 'institutional' in appearance;
- Increasing the size of the Day Care facility by building a conservatory, allowing for the creation of areas where people can hold a private conversation;

- Introducing a 'buddy system' for newcomers to the facilities as some people may not have the confidence to participate initially – particularly those who have lost a partner. It was noted that the Health Care Assistant introduced her clients to the scheme, but because this does not happen with everyone, it was seen as an area for improvement.

The conversion of a Scheme Manager's flat into respite accommodation was considered to be an excellent idea and an effective use of space. But from a servicing point of view mixed messages were delivered, for example, care staff were on the one hand concerned about disturbing other residents staying in the respite flat, particularly when one resident required a number of visits at night. On the other hand it was felt that the communal facilities provided in the flat helped to prevent loneliness for the respite residents in the evenings and at weekends.

7. Areas where the service could be improved

Again the majority of these messages came from the professionals and staff rather than the residents. One pertinent quote was "*We need to promote a more exciting and stimulating venue".* It is probably fair to comment that in appearance the communal areas on the scheme border on the 'institutional', the new reception area being the exception.

In terms of catering, the unanimous view of the users was that the service was excellent. They praised the quality of the meals and the variety of food on offer. However, the question of extending the service from 5 to 7 days per week did arise on more than one occasion as did the fact that the kitchen is closed on public holidays and Trust days (extra holidays for staff employed by GT). In particular the professionals felt that when the catering facility was closed the scheme was an isolating and lonely place for residents. This does not fit with the recognised 'extra care' model where the catering facility is available 365 days a year. While it is clear that staff would like to extend the service, decisions are 'resident led' and currently the vote is just 50/50 for an extended meals service. So the view is that until the majority of residents are in favour of extending the service it should remain as is.

However, in Ridgeway’s view catering is one of the few areas of the service at Douro Court which requires attention. Success in attracting additional customers to the dining room has put additional strain on the catering staff. Cover for sickness and annual leave has also become a problem. Cover is provided by the care staff but they also have a heavier workload now that dependency levels have risen, so they find it more difficult to assist. Also, not all of care staff possess food hygiene certificates and should not be asked to provide cover in the kitchen. A move to a 365-day service would enable GT to:

- Employ additional staff and so cover absences / leave entitlement;
- Give consideration to providing teas as well as lunches;
- Give consideration to adapting the facility to provide a cafeteria style venue;
- Take steps to remove institutional practices such as setting aside separate tables for residents .

8. Staffing and staff facilities.

Clearly with dependency levels rising the pressure on care staff is greater. However, we are aware that this has been addressed as part of the new contract with Social Services and the Supporting People department.

Over the period of the pilot there have been some challenging issues over roles and responsibilities and considerable effort has been made to hold joint meetings between housing and care staff to resolve these. The introduction of the open plan office is recognised as a step forward as it cements multi-disciplinary working and aids communication. The down side is that there is no private meeting room, which could be booked when:

- Work of a confidentiality nature needs to be undertaken, e.g. setting up care packages;
- Undertaking appraisals / interviews.

In taking on responsibility for managing the care contract GT experienced a steep learning curve and in particular the internal budgeting system could not cope with the complexities of managing the care contract. These issues have now been resolved and effective management tools introduced to monitor budgets and service provision.

9. Ongoing training

As expected staff identified issues where they felt that on-going training would improve service provision on the scheme and these included:

- Work on care plans;
- Promoting re-enabling / enabling;
- Focus on quality of life;
- Promoting independence;
- Medication;
- Manual handling;
- Food hygiene;
- Respecting privacy.

In terms of the final bullet point, residents expressed a view that some care staff did not respect their privacy. They considered that *‘care staff should knock at the door of their flat and wait for a response, not let themselves in and shout’.* Although this may be a rare occurrence this type of institutionalised behaviour undermines the concept of ‘extra care’. However, regular training reminding staff about these issues can remedy the problem.

10. Other Issues

Our experience in this field has shown that medication in an ‘extra care’ environment is always ’a tough nut to crack’. How do you promote independence yet on the other hand ensure that a confused resident is taking their medication? These same issues have arisen at Douro Court and now two staff operate a medications trolley for those residents who are unable to cope with their own medication. Ordering of medication is undertaken for the ‘extra care’ residents only. The care staff identify the medication required

while the physical ordering is undertaken by GT staff. Some staff believe this system requires review to improve efficiency.

4 Conclusion

In conclusion there was a steep learning curve for all the parties concerned with this pilot and close multi-agency team working has clearly assisted in overcoming this and so contributed to making the scheme a success. We include within this team working those residents who have played an active part in the project groups and influenced the transition of the scheme. In hindsight, the Scheme Manager wished that she had set up the project team even earlier *'So everyone signed up to the same vision for the scheme at the outset'.*

We have no hesitation in saying that the service provided today is of higher quality and is more comprehensive than prior to the pilot. But is it cost effective? Most research undertaken into the cost effectiveness of 'extra care' housing has come to similar conclusions, namely that 'extra care' housing is less costly for the Local Authority but not necessarily so for the Exchequer. But, the added value (benefits) are many and varied and cross the boundaries of housing, health, care and support. Those achieved at Douro Court include:

- Preventing admission to residential care;
- Prevention of admission to hospital;
- Facilitation of discharge from hospital;
- The creation of a community resource which minimises / prevents crisis;
- Easing the strain for carers in the community;
- The opportunity to monitor residents' health on a daily basis and take timely action when deterioration is noted.

So what of the future? As indicated above Douro Court may well expand and offer a wider range of services to the community. Additional land would allow it to add on a dedicated suite to facilitate this, plus perhaps an EMI wing and 'extra care for sale' housing. This would constitute a further step-change for the scheme and would require staff to build on their consultation

skills and capacity to form multi-disciplinary teams. But at the end of the two-year pilot those involved have a firm foundation to work from.