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Extra care housing for older people

An introduction for commissioners

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READER INFORMATION

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1 Introduction

What is extra care housing?

Very sheltered housing, extra care housing and a range of other terms are used interchangeably to describe a style of housing and care for older people that falls somewhere between established patterns of sheltered housing and the accommodation and care provided in traditional residential care homes. The proliferation of jargon and brand names in this area makes it difficult to achieve precision in identifying the facilities and services actually provided in any particular scheme. This difficulty extends to identifying the arrangements for care delivery and management, or the mechanisms for funding the various elements of the service.

The emerging role of primary care trusts and, where they have been established, care trusts has given a new dimension to planning and commissioning services at the interface of health and social care. Extra care housing has come to be seen as having the potential to be an important element in integrated approaches to the housing, health and social care needs of an ageing population. The Department of Health, Office of the Deputy Prime Minister and the Housing Corporation have co-ordinated their efforts to provide a constructive policy framework within which strategies can be developed and options appraised.

The role of the Change Agent Team

Among the initiatives taken by the Change Agent Team at the Department of Health in encouraging and supporting joint approaches to a range of issues has been the creation of a housing learning and improvement network. At the conference to launch the network delegates asked for more information on very sheltered or extra care housing.

The purpose of this document is to provide an introduction to the field for those from a variety of professional backgrounds and organisations who may be working together to commission new patterns of provision. It does not claim to be definitive or to provide the final word on the various issues involved. In such a rapidly changing field that would hardly be possible. It does offer a relatively concise account of the background and issues from which to start local collaborative work and details of the Department of Health's grant funding for extra care, made available under the Access and Systems Capacity Grant (2004-2006).

2 The history of sheltered housing

In order to understand where extra care or very sheltered housing has come from we need to take account of the development of sheltered housing in England. The model that we now recognise as conventional sheltered housing began to emerge shortly after the Second World War. Growth during the 1950s was relatively slow, with perhaps 28,000 people living in sheltered housing by 1960. Most of the accommodation, in flats and self-contained bungalows, came from local authorities.

The first priority of post-war housing policy had been the clearance of damaged or unfit housing and the building of family accommodation. By 1960 the lack of balance in existing programmes was beginning to be recognised and greater emphasis was placed on providing accommodation for older people. Official government policy began to encourage housing departments to build "accommodation mid-way between self-contained dwelling and hostels providing care" (Ministry of Housing and local government design bulletin 1958). The design guidance – accommodation for a warden, alarm system and a communal sitting room – reflected this 'hybrid' concept.

Early models of sheltered housing

This guidance set the tone for the next 30 years. First, it suggested a model of housing which combines self-contained accommodation with communal facilities. Second, it advocated a particular model of community care that ensured that people move along a continuum of built provision as their need for care increases. The first of these two assumptions remains influential in the design of most schemes, including those intended to be extra care. The second element is challenged by some champions of the development of extra care housing. By adding additional facilities and services to the conventional model of sheltered housing it is argued that people can receive rising levels of support while remaining in place, so they don't need to change their housing context as they move along a continuum of care.

A joint circular from the Ministry of Housing and Local Government and Ministry of Health in 1961 introduced the idea of a 'balanced population' of tenants. The idea is based on the assumption that fit people in a scheme help those who are frailer and that the total support needs of all the tenants should not exceed the capacity of the warden service. This notion has been consistently challenged. A 1983 report[1] contended that it introduced a fundamental contradiction into the concept of sheltered housing. If this was indeed to be seen as a form of provision that gave something additional to those who needed it, sheltered housing could only be allocated to those with an appropriate level of need. Allocation solely to those with high levels of need would make the warden's role untenable in the models of sheltered housing operating in the early 1980s. If to achieve balance those with lower levels of need were introduced into a scheme this must be an inappropriate use of public funds.

1 *Sheltered housing for the elderly: policy practice and the consumer* (A Butler 1983)

Arguing from a quite different premise – that the demand was so great among those with high levels of need only an irresponsible provider could allocate available places to those whose need was less pressing – a later study[2] advocated an end to the notion of a 'balanced community'. In more recent work on sheltered housing in general and the role of the warden in particular this abandonment of the concept of balanced community is taken as read. A 1998 report for the Metropolitan Housing Trust[3] takes a more consistently dependent tenant population as the starting point for defining a new role for the warden that is not as a 'hands-on' carer but as a professional partner in the allocation, assessment and care delivery system.

Category 1 and 2 schemes

A Ministry of Housing and Local Government circular set the pattern for the continuing rapid growth in sheltered housing provision in the 1970s, introducing the distinction between Category 1 schemes for more active elderly people and Category 2 schemes for the less active. This distinction still influences current designs and language, although the Housing Corporation is looking at new definitions. Category 1 schemes were seen as grouped self-contained housing, designed especially for older people. Category 2 schemes included communal facilities, warden accommodation and office, an alarm system, a guest room, laundry facilities and a common room. It is this style of provision that we have referred to as 'conventional sheltered housing'.

During the 1990s policy and investment decisions at national and local levels began to be influenced by the general perception that in most parts of the country there was a sufficient supply of conventional sheltered housing but that opportunities existed to add to the stock of extra care housing. This was substantiated in a 1994 study for the Department of the Environment[4] that concluded that there was "a significant unmet need for very sheltered housing and a potential over-provision of ordinary sheltered housing".

Difficult-to-let sheltered housing

The rising popularity of extra care housing coincided with a growing awareness among providers that conventional sheltered housing was beginning to run into difficulties. After two decades in which demand had consistently outstripped supply they began to encounter a fall-off in demand for some of their schemes. The reasons for this were self-evident; many schemes were old, unattractive, in areas where local shops and other facilities had disappeared and access to transport was no longer easy. Many offered very small, bedsitter accommodation. Some had shared bathrooms, a few even shared toilets. A number, especially those in the ownership of local authorities, lacked lifts and were generally inaccessible to potential tenants considering a move into sheltered housing at a later stage in their lives than had generally been the case in the 1960s and 1970s.

2 *The future of sheltered housing – who cares? Policy report* (P Fletcher, NFHA/Anchor Housing Trust 1991)

3 *Sheltered housing is changing – the emerging role of the warden* (J Hasler & D Page, Metropolitan Housing Trust 1998)

4 *Living independently: a study of the housing needs of elderly and disabled people* (P McCafferty, 1994)

Preliminary analysis of the situation by the Anchor Housing Trust[5] was confirmed by a 1995 study of difficult-to-let sheltered housing[6]. Among the strategies identified to help providers of sheltered housing tackle the problem was bringing care services into the scheme and allocating flats to frailer old people. In its 1996 *Appraisal Guide for Sheltered Housing* the National Housing Federation suggests that improving services may form part of a strategy to improve letting, such as providing meals or a bathing service. It also suggests upgrading the scheme through such more substantial measures like ramp access, providing hand and grab rails, fitting appropriate door handles and taps and installing showers.

The need for appraisal

This approach has its dangers without a thorough appraisal of the purpose of the scheme and the needs of those it is being targeted to serve. As the Anchor Trust study points out: "The concentration on features rather than purpose can mask a relative lack of clarity about who sheltered housing is for and whose need it is trying to meet."

This is a view endorsed by the Audit Commission, which referred in a 1998 report[7] to the current pattern of sheltered housing as "entirely historic and not related to any identifiable levels of need or demand". Analysis of experience in 47 local authorities led the Audit Commission to the conclusion that: "None of them conveyed a clear vision of the future role of sheltered housing. There is little evidence of joint working with social services and local registered social landlords to include sheltered housing in a wider strategic approach to services for older people. Working in isolation from the social services assessment process, housing authorities are less able to identify the needs of older residents across all tenures and develop and allocate sheltered housing accordingly."

Developing a strategic approach

This perceived lack of coherence has presented a challenge for those now seeking to develop strategic approaches that cross the boundaries of housing, health and social care. These include the mapping exercises and focus on establishing levels of need advocated by the Government's new *Supporting People* programme, which aims to provide high quality housing services to vulnerable people through local partnerships.

Assessment processes and allocation procedures for different styles of provision are seen not to be related to one another, leading to overlap or gaps in provision. Establishing a single and consistent set of priorities for investment and revenue funding is driving the attempt to relate these elements of the accommodation and care economy to one another in a more consistent fashion.

5 *Difficult to let sheltered housing, an exploratory study for Anchor Housing Association* (M Miscallef, Anchor Housing Trust 1994)

6 *Difficult to let sheltered housing* (A Tinker, F Wright & H Zeilig 1995)

7 *Home alone – the role of housing in community care* (Audit Commission 1998)

3 The emergence of extra care housing

As tenant populations grew older, and the age for first admission to sheltered housing increased, providers began to recognise that the needs of their tenants could not be met within a conventional sheltered housing scheme with a traditional warden service. While a traditional warden service and peer support among tenants could cope with one or two frail tenants in a scheme over a long period, or a slightly larger number for short periods, a situation in which a significant proportion of tenants needed care services posed difficulties. Care often seemed to come into the scheme in an uncoordinated, almost haphazard, way and the warden was left to cover the care gaps.

From the early 1980s some providers began to develop schemes in which more coherent arrangements for care were negotiated with social service authorities and some additional facilities were introduced into schemes. Some experimented with the provision of meals, others considered providing facilities for assisted bathing, treatment rooms and other specialised facilities. These were known by a variety of titles including 'category two and a half', placing them somewhere between conventional Category 2 sheltered housing and residential care Category 3 homes. These schemes, some new-build and others developed by converting existing sheltered housing, were the first examples of extra care housing.

In the early 1990s extra care housing began to attract attention as responding to the needs of an ageing and frail population moved up the public agenda and the search for less institutional settings for care gathered pace.

Variations in provision

Research for the Department of the Environment[8] found that extra care housing varied considerably in design, particularly in terms of the type of accommodation. Some schemes were registered with the local authority under the Registered Homes Act 1984 as residential care homes, thus providing full meals and personal 'hands-on' care. Others offered meals but more of a 'home help' style of care. Some schemes provided all the care staff themselves while others used staff employed by the local authority to bring the care element into the scheme.

Sheltered housing in general, and extra care housing in particular, began to establish itself as a desirable element in providing accommodation and care for frail older people. In good practice guidance issued in 1997 the Department of Health gives examples of sheltered housing where a housing department wished to improve use of sheltered stock and a social services department wished to develop an alternative to residential care provision. This resulted in the refurbishment of a sheltered block to provide accommodation for frail elderly people, with a resident warden who liaised with care workers provided by the social services department.

8 *An evaluation of very sheltered housing* (A Tinker 1989)

Specialist registered social landlords, such as the Hanover and Housing 21 housing associations, have promoted particular approaches to extra care housing and set out design criteria for buildings, management and care systems.

Arguments for re-provision of residential care

Martin Shreeve, former director of social services for Wolverhampton Metropolitan Borough Council and past chair of the Association of Directors of Social Services older persons' committee, has advocated the wholesale re-provision of residential care through the development of purpose-built extra care housing schemes. Wolverhampton has a programme in place to achieve that re-provision and change the use of a small number of residential care premises to provide resource centres for community-based support, rehabilitation beds, respite care and other specialist uses.

Support for the strategy of replacing residential care home provision with extra care housing comes also from the Royal Commission on Long Term Care[9]. Their support for extra care housing draws on the perception that it is both more cost-effective and provides a better quality outcome for service users. The research material[10] provided to support the Commission's findings and recommendations reflects the variety of past and current provision and makes no serious attempt to discriminate between them.

For some, the advocacy of extra care housing is grounded in the desire to establish a new and more appropriate culture out of which accommodation and a context for the delivery of care may be provided. The foreword to a report[11] on the experiences of people living in Hanover Housing's extra care development points out:

> "Forms of residential provision for older people based on health and social welfare models – residential care and nursing homes, long stay units, almost all facilities offering grouped care – cannot avoid referring back to the hospital and the workhouse in the way they operate. Both these institutions, however benignly they were managed, defined people as essentially problematic; their inmates were – in the case of hospitals still are – reluctant guests on someone else's territory."

This makes the claim for extra care housing that it should not simply sit somewhere between conventional sheltered housing and residential care but should replace the latter as a more appropriate style of provision. We need to explore what extra care housing is for: Is it simply adding to the range of available options, filling a gap in the continuum or does it offer an alternative, which will mean a substantial part of what is currently provided as residential care will become redundant?

9 *With respect to old age: long term care – rights and responsibilities* (Royal Commission on Long Term Care 1999)

10 *Alternative models of care for older people* (A Tinker 1999)

11 *A view of the future – an evaluation of Hanover residents' experience of extra care* (J Bartholomeou 1999)

4 Government policy on sheltered housing

The cornerstone of the development of a pattern of provision within which people might expect to be cared for within their own homes rather than in an institutional setting was laid in the NHS and Community Care Act 1990. After a decade the aspirations of that legislation have still to be realised, not least because it has proved difficult to liberate resources from institutional provision to fund new services.

A focus on independence

The NHS Plan recognised the importance of enhancing quality of life, not just increasing its length, and the Department of Health's planning priorities framework focuses on dignity and independence. Within the framework is an imperative to develop preventative strategies and services that will reduce the risk of illness and disability, and encourage working with older people rather than for them. Strategies should emphasise remaining capacity for independence and self-care, rather than accelerating dependency.

The 1998 White Paper *Modernising Social Services* points the way to a pattern of service that is "convenient to use, can respond quickly to emergencies, and provides top quality services". It also suggests further expansion of support to allow people to remain in their own homes.

While the Royal Commission into Long Term Care's 1999 report[9] was mainly noted for its recommendations about costs, its findings were much wider and provided examples of patterns of care, commending them as alternatives and additions to existing provision.

Opportunities for funding alternative schemes

The changes to the funding of support services, brought into force through the *Supporting People* programme, provide opportunities for funding alternative services in a strategic way. Where the mapping exercises that have been undertaken to provide baseline information for *Supporting People* at a local level are complete they will include information about specialised housing for older people. Shadow strategies developed to guide the initial funding decisions of Supporting People boards will provide a starting point for wider discussion. The housing context within which a future pattern of accommodation and care may be set is to be found in the strategic framework developed by the DETR and Department of Health in 2001[12] This wants to see the majority of older people remaining in their own homes but with access to services that make this possible. The document recognises that in the future most older people will be home owners, and this will have an impact on the assistance they require and the way in which services are delivered to them.

12 *Quality and choice for older people's housing – a strategic framework* (DETR/Dept of Health 2001)

Overall, the relationship between central and local government is changing. While central government accords a degree of discretion to local authorities in the management of their own affairs they measure outcomes through a range of performance indicators. The future allocation of resources will increasingly be determined by performance against these indicators, including performance indicator B11, which looks at whether authorities rely too much on providing intensive care in institutional settings, in comparison with the amount of support offered to older people in their own homes.

Implications of the National Service Framework

The National Service Framework for Older People sets out standards of care, commits the Government to ending discrimination in health and social care on grounds of age, and aims to promote active, healthy life in old age. Four standards have particular implications for the design and delivery of accommodation services, and for the role of such services in helping deliver the National Service Framework. They are:

- Rooting out age discrimination
- Person-centred care
- Intermediate care
- Promotion of health and active life in old age.

The Best Value regime also has implications for sheltered housing. All areas of public service now have a statutory duty to establish best practice, seek value for money, engage in continuous improvement and involve service users and carers in the design and evaluation of services, and this is becoming core to the process of developing and managing services.

The impact of the Care Standards Act

For operators of residential care and nursing homes in both the private and public sectors, the Care Standards Act 2000 is bringing major changes. Many smaller providers are leaving the market. Local authorities, faced with the need for major reinvestment, are considering transfer to voluntary or commercial organisations and re-provision, often with extra care housing. There are a number of issues to be addressed by those who pursue this course; without clear plans for future capacity and service differentiation, problems may be merely exported to the private or voluntary sector rather than being constructively addressed. The status of extra care housing that is part of any re-provision exercise, in relation to registration with the Care Standards Agency, may be unclear. However the National Care Standards Commission has produced guidance and a toolkit to clarify arrangements[13].

13 National Care Standards Commission website www.carestandards.org.uk/faqs/assesstool.htm

The role of sheltered schemes

The DETR/Department of Health framework[12] puts forward a positive view of the role that sheltered housing with appropriate care provision can play :

> "In the private sector, there is evidence that some older people often consider an early move to schemes that offer care and support services on site, should these become necessary. Moving to good quality sheltered housing in the public and private sector is a positive experience for many older people. It enables older people to retain their independence in a home appropriate to their needs while receiving support, security and company. In some situations where providers have reinvented their approach to sheltered housing it can provide a home for life."

However it warns:

"There is evidence that there is a shortage of small, suitable housing for older people and that in some cases sheltered housing has met a housing gap irrespective of the support offered. It is clear that the role and purpose of the range of sheltered schemes needs to be both clarified and promoted within the health, housing and social care agendas, given its preventative role."

The document concludes that key outcomes should be:

- A greater focus on solutions that enable people to stay in their own homes for as long as possible, or live in a home that best suits their needs and aspirations;
- Facilities to enable older people to use their own resources effectively to improve their housing;
- The enhancement of technological solutions which help older people to feel safe and secure at home; and
- Joint planning of new provision which takes a more strategic, 'whole systems' and 'citizenship' approach to meeting needs.

It sums up:

> "There are clearly important issues revolving around the need for flexible service provision for older people across all tenures, whether they choose to remain in their own homes or move to more specialised accommodation."

Strategic guidance

The Office of the Deputy Prime Minister and the Department of Health have issued joint guidance on the preparation of older people's strategies that link housing to health, social care and other local strategies. Its principal intention is that local authorities and primary care trusts be able to deliver housing-based solutions to locally assessed needs.

5 Different approaches to extra care housing

Advocates of various new models of sheltered housing come from different starting places. In addition to the influence of statutory providers, private sector developers and managers have brought forward models that offer access to care in the context of specialised housing. There are conflicting agendas from stakeholders, whether declared or not. Extra care housing is put forward as a means of addressing all these agendas but this may be partly because stakeholders mean different things by the term.

Within social service departments, the primary objective is to establish the context for a number of key values, which are frustrated by the experience of residential care or gaps in care for people in their own homes. These values help define a new model for life in old age that is characterised by encouraging the maintenance of independence, facilitating lifelong learning, providing security, offering empowerment and encouraging participation. For some the extra care model answers the question of how to move on from the restrictions of residential care and make sense of sheltered housing.

Cost effective solutions

In other cases the focus is on cost-effectiveness. Does extra care housing offer good value for money when compared with the provision of accommodation and care for older people in their own homes, in conventional sheltered housing or in residential care? The answer depends on the definition of the client group for whom the provision is intended. If extra care housing is populated by older people who overall do not need the level of care built into the arrangement, then it is difficult to justify on cost grounds. Schemes that grow out of a desire to protect or enhance the future viability of a conventional sheltered housing scheme may struggle to demonstrate that they represent value for money. Re-provision that accommodates and cares for those formerly in residential care, or those who would otherwise have been allocated to residential care, will find it easier to justify the levels of care capacity associated with extra care housing.

Converting conventional schemes

Some housing providers seek to maintain the viability of their existing stock by changing its function to extra care housing. This may be intended both to enable a higher proportion of an ageing tenant population to remain in their current accommodation, and the potential of letting to a more dependent group within the community. The dilemma here is that it is often the oldest and least suitable stock that is suffering difficulties with letting and is therefore identified for conversion. There is a temptation to minimise the amount of work needed to modify the physical arrangement of schemes while 'badging' them with the same label as a purpose-built extra care scheme. An example would be a conventional sheltered scheme operating for more than six years as extra care, but without a lift and no plans to convert baths to showers.

Concern to facilitate transfers of care in a timely way that makes best use of health services and facilities has drawn health bodies into the consideration of extra care housing as a possible alternative destination to either nursing or residential care when a return into general housing is not feasible. Primary care trusts and care trusts are coming to see this style of provision as adding options to their commissioning plans with a direct impact upon transfer issues facing acute trusts.

Different agendas may be met by widely differing outcomes. For example, relatively minor improvements in a conventional sheltered housing scheme may greatly improve its lettability and in the short term allow some tenants to avoid a move to an institutional setting. Such a limited programme of changes will not meet the more ambitious agenda of those who wish to create an enabling environment within which older people may not only enjoy independence but also find some enrichment of their quality of life and opportunities for personal growth.

6 Defining features of extra care housing

No single definition of extra care or very sheltered housing has yet been established. Indeed there are those who would argue that at this stage in its development it is helpful that the boundaries should remain blurred. However any definition for extra care housing will generally refer to a combination of facilities and services. To varying degrees the alternative models offered by the principal providers are all set out in this way.

Key characteristics

A review of nine extra care schemes in Peterborough and Cambridgeshire[14] identifies the following 'defining characteristics':

- Self-contained accommodation;
- Equipment for care;
- Care staff, probably including 24-hour cover;
- Catering;
- Communal facilities;
- Social and religious worship;
- Provision of an appropriate level of care for tenants;
- Help with domestic tasks and shopping;
- Some wider activities and services.

The difficulty with this list is that all the elements, except perhaps equipment for care and care staff, especially if providing 24-hour cover, are available to tenants of conventional sheltered housing either through their housing provider or access to community support services from social services.

An earlier report for Housing 21[15] offers a more detailed list:

- Self-contained flats with full kitchen and bathroom facilities to mobility and, usually, wheelchair standards;

14 *You have your own front door* (Cambridgeshire County Council 1999)

15 *Remodelling sheltered housing* (E Trotter & M Phillips, Housing 21 1998)

- Staff facilities including office and sleep-over;
- Barrier-free spaces which are accessible, aid mobility and are fully equipped, with lifts to all floors or as many floors as possible;
- A range of service areas for hairdressing, laundry and chiropody, etc;
- Communal areas including day rooms, catering and dining facilities, offering communal meals or café services;
- Guest facilities;
- Good links to the local area;
- Staff on site responsible for the building, management and the co-ordination of care and support services;
- Privacy for residents combined with services to the local area.

Variations among providers

The Housing Corporation identifies carer facilities – staff room, toilets, changing room and sleep-over room – as essential features. Hanover would add a shop, generally open part-time and often provided by a local supermarket, and emphasise the importance of providing a suitable store and charging area for pavement scooters. The view of the Anchor Trust is that adequate laundry facilities within flats mean a separate laundry is unnecessary, and neither is a shop. Extracare Charitable Trust would put emphasis on social, educational and recreational facilities, which could also be used by older people drawn from the surrounding community.

The manager's role

The models offered by different providers also vary in how they define roles, particularly that of the scheme manager, and arrangements for the delivery and management of services. Extracare Charitable Trust and Anchor Trust advocate integrated roles in which one person supports a tenant's range of needs, including personal care, cleaning and domestic tasks and social activities. This is seen as being closer to the all-round support provided by an informal carer.

These two providers also prefer to integrate the management of services, believing it to be more cost-effective. The manager for the scheme will provide housing management and care management functions, and have a level of involvement in the assessment of need and development and supervision of care plans.

Hanover Housing promote a model in which they provide and manage the premises and housing services while contracting out care provision, cleaning and catering to separate agencies. They believe this allows for the application of appropriate expertise, flexibility in achieving value for money and protects the role of the scheme manager as advocate for the tenants in relation to providers of other services.

Influencing delivery of care

In all these arrangements the role of the senior member of staff on site is a crucial one. Whether the formal arrangements recognise it or not, they all exercise some degree of influence in the delivery of care to the tenants. Emerging practice allows for the involvement of the manager, with appropriate training, in the initial assessment of suitability for allocation of a tenancy and the development of an initial care plan. The manager would then co-ordinate the various sources of information about emerging patterns of need and adjust the care plan accordingly, subject to audit by the care manager representing the interests of the commissioners. The manager provides a single point of accountability to the funder/commissioner and to the tenant. It may be argued that there is an incentive to exaggerate levels of individual need to maintain income, but emerging experience suggests that when skilfully managed the flexibility of such an arrangement allows for cost-effective outcomes of high quality.

Differences between extra care and Category 2 housing

It is important to establish what distinguishes extra care housing from conventional Category 2 sheltered housing. This is complicated by the changing role of warden and increasing complexity of services required for an ageing tenant population. It may be helpful to introduce a third category of 'enhanced sheltered housing'. This refers to a scheme in which the warden's role has been developed in line with the principles set out in the Metropolitan Housing Trust review[3], a dedicated care team may be attached to the scheme and some additional specialised facilities may have been provided. However it may be distinguished from extra care housing in that the building has not been subject to rigorous appraisal and remodelling to eliminate the limitations of its initial design. Both the culture and facilities of the scheme may fall short of what is required to promote lifelong learning, peer support and the enrichment of old age, all of which are characteristics of extra care housing at its best. Arrangements for care may have been improved but still lack completely flexible 24-hour by 365 day a year cover.

Differences between extra care and residential care

It is equally important to distinguish between extra care housing and a high-quality residential care home. Some would argue that a concentration of very frail older people in a scheme, whatever its physical environment and espoused philosophy, will create the culture and ambience of a residential care home, and that successful extra care housing needs a balanced community that includes people with levels of care need that would not attract services in other circumstances. The original notion of a 'balanced community' in sheltered housing was generally abandoned almost a decade ago. Again there is a danger of confusion of terminology for what is proposed here is a balance struck at a higher mean level of dependency. Even so, the notion that some tenants in extra care housing should not currently need its services and facilities has implications for financial viability and Best Value.

Implications for care home registration

The National Care Standards Agency has taken the view that the provision of personal care is the watershed issue in relation to registration. Where care is provided as part of the services offered by the scheme, it will need to be registered as a care home. Where other arrangements are made, for example by the provision of domiciliary care on the same basis as others living in the surrounding community, this will be registered as domiciliary care.

The issues to be aware of are:

- The nature of the services provided to residents;
- Whether the management of the premises and the services is provided by the same organisation;
- Contractual arrangements between sponsoring organisations (such as social services) and providers;
- Contractual arrangements between the managing organisation and residents;
- The way in which care is paid for.

Size is also an issue here. Some providers argue that to achieve viability in the provision of care staff on a 24-hour 365 days a year basis, aggregate requirement for care within the scheme will need to exceed 300 hours per week, including night-time cover. For a small scheme, or one in which only a small number of units are designated as extra care housing, this may imply an improbable average level of need. In a scheme of 20 units for example, if 70 hours of night-time cover per week are excluded, the implication is that the average tenant will require more than one-and-a-half hours of care each day.

7 The 'village' approach

Some providers have drawn on North American models, blended with influences from Northern Europe, to produce a 'village' model adapted to UK circumstances. The best known are Hartrigg Oaks, developed on the outskirts of York by the Joseph Rowntree Trust, and the Extracare Charitable Trust developments in Stoke-on-Trent, and more recently Warrington.

Hartrigg Oaks

A review of the York development[16] spells out its philosophy:

> "Hartrigg Oaks provides an environment where residents can lead full and active lives, safe in the knowledge that care support is close at hand if it should ever be needed. The communal facilities, including a restaurant and coffee shop, art/crafts room, music room, library and spa pool/jacuzzi, provide numerous opportunities for meeting fellow residents and for pursuing a range of leisure interests."

The approach of the scheme to frailty in old age is progressive:

> "Individuals purchase a bungalow when they are in good health. If care support is needed, it is normally provided to residents in their own bungalows, which are linked through an alarm system to The Oaks Centre. Only where care needs reach a high level – deemed at more than 21 hours of support per week – will consideration be given as to whether individuals should move permanently to one of the rooms (including en-suite bathroom) in The Oaks."

Broadway Gardens

The Extracare Charitable Trust model also places great emphasis upon lifestyle and opportunities for learning and growth in old age, alongside a flexible approach to care provision. The trust's roots are in the re-provision of NHS long-stay units for older people, providing them with substantial experience of higher end dependency. Their first extra care scheme, Broadway Gardens in Wolverhampton, was the initial element in the local authority's total re-provision of its residential care homes with a very sheltered model. With a strong emphasis on flexible care developed from a housing base, and recreational, educational and craft facilities inspired by Scandinavian and Dutch practice, Broadway Gardens has rightly been recognised as a standard-setting scheme.

16 *Living at Hartrigg Oaks: residents' views of the UK's first continuing care retirement community* (Joseph Rowntree Foundation)

Berryhill

Drawing on experience gained at Broadway Gardens, the Extracare Charitable Trust went on to build its first 'village' development at Berryhill in Stoke-on-Trent. Here they moved beyond the conventional size of traditional sheltered schemes, believing that a larger development not only allowed greater investment in high-quality communal facilities, but also enhanced the viability of activities and services that drew upon the expertise of residents. The trust currently regards 250-unit schemes as the norm.

Future schemes

Larger scale developments have also allowed Extracare Charitable Trust to respond to the challenge of rising levels of owner-occupation among older people by providing a proportion of units for sale. At their new scheme in Warrington, units for sale were reserved ahead of work starting on site. According to a report on the trust's approach, it is likely that in future schemes the proportion of units for sale will increase from around 20% to around 50%. Both rented and owner-occupied units are priced to be affordable to a broad cross-section of older people, including those supported by benefits.

Extracare Charitable Trust has also developed substantial experience of marketing such schemes, building up a database of interested renters and purchasers who are kept involved throughout the development phase and consulted about design and future activity.

Large-scale developments

The success of these larger schemes, which offer a wide range of activities and services and depend upon volunteers among residents to sustain them, depends on mixing a relatively high proportion of people with little or no current need for care with smaller proportions of those with medium to high needs. Evidence[17] from the trust itself, and from evaluation by Keele University, indicates that such schemes can reverse dependency for some residents and support a proportion of residents who have high levels of need for services.

But while their advocates are able to indicate significant benefits in such large-scale developments – the range of facilities that can be provided, the balance that can be achieved in a larger community, the capacity for peer support and so on – this should not be regarded as the sole or even normal model.

17 *Now for something different – the Extracare Charitable Trust approach to retirement living* (N Appleton & M Shreeve 2003)

8 Costs

An increasing amount of data is becoming available about costs in development, costs to residents, costs to public authorities and the comparative costs of various styles of provision, although there is no substitute for figures modelled to reflect local circumstances and cost structures.

The capital costs of developing new extra care schemes are enormously varied and will be influenced by land costs, site constraints and particular design features. Housing 21 has well developed design principles so it may be assumed that in many respects their schemes will be comparable, but costs vary significantly from around £50,000 to £70,000 per unit. According to a Housing 21 report[18], the unit cost does not appear to be directly related to the number of units involved.

Remodelling existing sheltered housing can also carry widely varying costs: from £3,000 to £11,000 per unit for communal areas and from £15,000 to £35,000 per unit for the individual flats.

Detailed information on costs in the development and operation of extra care is available in factsheets from the Department of Health's Change Agent Team's website (see useful references page 32).

18 *Citizenship and services in older age: the strategic role of very sheltered housing* (P Fletcher, M Riseborough, J Humphries, C Jenkins & P Whittingham 1999)

9 Identifying a common purpose

Given the variety of models offered by providers, and local circumstances, a single definition for extra care or very sheltered housing is probably neither achievable nor helpful.

A Housing 21 brochure gives an indication of the variety of purposes that an extra care scheme might fulfil:

> "Very sheltered housing provides older people with choice, independence, control and privacy. It also provides local authorities with modern choices in service provision.
>
> The range of options can include:
>
> - A direct alternative to residential care for older people with high levels of physical dependency;
> - A mixed community of both active older people and frailer older people with high care needs;
> - A complete service where the care is provided by our own experienced teams;
> - A partnership initiative where care needs are met by other providers;
> - A setting for a range of services for older people in the surrounding community."

Joint consideration of extra care specification

Providers expect commissioners to have given some thought to what they want, and the purposes that a scheme will be expected to serve. Section Five of this report suggested that those engaged in developing joint commissioning strategies and specifications would have different needs and perspectives. Whoever has the lead responsibility, it is essential that housing, social care, primary care trusts and other health colleagues share in the process. Some features may be regarded as essential and others desirable or open to a variety of responses. The following key areas should be considered jointly:

1. The basis of occupation

This is fundamental and a major distinction between extra care housing and residential care. Anyone occupying an extra care housing scheme does so on the basis of a tenancy, with the rights the status of tenant confers. Occupation on the basis of a tenancy, within the framework of the 1996 Housing Act, should be regarded as an essential element in defining extra care housing.

2. Assessment and allocation

In its report on the role of housing in community care the Audit Commission[7] recognised the difficulties that may arise when assessment and allocation practice is not properly integrated: "The tension between the demands of stock management and the needs of frail older people is perhaps inevitable. Rather than using sheltered housing as a key community care resource, some councils apply straightforward letting criteria – if there are empty places in sheltered units they will be let to waiting older people, irrespective of their degree of frailty. Placing fit, active older people in sheltered housing can be an expensive option." If this is true of conventional sheltered housing, it is all the more apparent in relation to enhanced sheltered housing, extra care or very sheltered housing.

Co-ordinated procedures

The Department of Health[19] has suggested that: "Planning should include partnership between local agencies with responsibility for services, and participation by community care service users and their carers." The department sees developing mechanisms that allow the delivery of a co-ordinated package of housing, health and social care services to address individual's needs as high priority. Guidance from the department to support the development of the single assessment process[20], in line with the National Service Framework for Older People, has carried this agenda forward.

The Audit Commission[21] has highlighted the risk that failure to properly connect assessment and allocation procedures between housing and social service authorities might lead to an inappropriately high level of service: "One danger of poor assessment is that people may receive more services than they need." This phenomenon is often referred to as 'upward substitution'.

Best practice

Best practice indicates that assessment and allocation should be through an integrated process that gives weight to both housing need and care requirements. The two assessment disciplines should be carried out in a parallel and balanced way so that they each contribute to an appropriate outcome. The modification of the housing assessment and allocation process by simply giving greater weight to 'medical factors' does not represent best practice.

The concept of 'medical factors' is outmoded and perpetuates the medicalisation of responses to ageing that has led to dependency models rather than enabling models for service provision. While the opinion of a person's GP may be helpful, assessment by a care manager, occupational therapist or community nurse will have equal or greater significance in allocating accommodation appropriately

Allocation panels

Best practice suggests that an allocation panel, comprising housing and social service representatives, providers (when this is not the housing authority) and the scheme manager, should have both housing and care assessments before them in making allocations. Allocation should not be made on the basis of housing need, even with strong medical support, where the care assessment does not indicate that the applicant's need falls within the range provided within the scheme.

19 *Housing and community care – establishing a strategic framework* (Department of Health 1997)

20 Guidance issued in 2002 can be found at www.doh.gov.uk/scg/sap/index.htm

21 *The coming of age – improving care services for older people* (Audit Commission 1997)

The purpose of the integrated assessment and allocation arrangements is that people who will derive benefit from the particular services and facilities of an extra care housing scheme should have priority in allocation. While those making allocations will wish to avoid an over-concentration of tenants at the upper end of the scheme's dependency range, they will wish to ensure that the aggregate needs of the tenants meet or exceed the minimum viable care capacity provided.

3. Care arrangements

The patterns of work in conventional sheltered housing that laid the foundations for extra care housing were largely a response to wasteful arrangements for providing care to sheltered housing tenants. Different agencies and individual carers attending to the needs of different tenants in an uncoordinated way led to calls for small teams of care staff, dedicated to particular schemes and liaising closely with the scheme warden. Having a dedicated team to provide services within the scheme is a fundamental requirement for extra care housing.

A flexible approach

Best practice indicates that a team should be responsive to the needs and wishes of individual tenants, providing a level of care that neither encourages dependency nor leaves the tenants feeling unsupported. This approach needs constant fine-tuning to the individual's needs and circumstances. Such flexibility requires a high level of training, and management support close to the point of service delivery.
The provision of care within an extra care housing scheme will be on a 24-hour, 365 day a year basis. If tenants do not require such cover, then either the scheme is not extra care housing or people have been inappropriately allocated to it.

4. Management arrangements

Section Six of this report looked at the divergent approach adopted by major providers in defining the role of the scheme manager. Some providers argue strongly that maximum cost benefit and service quality can only be achieved when one person on-site is responsible for all areas of service – housing management, catering, care provision etc. Some would also argue for the integration of management responsibilities above the level of the local scheme.

5. Values and philosophy

The values and philosophy of providers are a crucial element in the creation of genuine extra care housing. The adoption of an integrated approach to meeting the needs of tenants in a holistic way will lead to flexibility in the roles of those who work directly with tenants, and allow them to integrate practical assistance with emotional and social support.

The Housing Corporation has funded work[22] that seeks to develop new models for ageing, including the need to consider aspirations of older people in relation to lifestyle in old age alongside concerns for dependency.

22 *Housing for older people: changing the viewpoint, changing the results. A new model of ageing for housing providers* (HOPE/Housing Corporation 2002)

Providers should be expected to demonstrate a commitment to enabling, to resisting over-provision leading to dependency, and to the personal development of tenants. This will need to be shown in their values and philosophy but also in the practical facilities they offer, the roles defined for staff and the expectations the organisation has of employees and the outcomes they are willing to be measured by.

6. The physical environment

Extra care housing has too often been defined primarily by the additional facilities it provides, ignoring the need for the whole building to support independence. This can only be achieved through high standards of accessibility both in common areas and in individual accommodation. This may be a problem where existing schemes are re-modelled. Accessibility in common areas is only part of the answer and a scheme that is to be regarded as genuine extra care housing needs to comprise individual dwellings that also meet contemporary standards for space and layout. A Housing 21 study offered guidance on remodelling[14].

Specialist facilities

Current opinions about the provision of specialist facilities vary. While some would see the provision of facilities for assisted bathing, treatment rooms, laundry rooms and so on as essential, others would rather meet these needs by enhancing facilities within individual flats wherever possible. Most providers agree on the availability of dining facilities, office and staff accommodation.

Design principles

In overall design there is widespread acceptance of the Housing 21 study's principle of 'progressive privacy'[14]. All new-build schemes and, wherever practicable, remodelled schemes should seek to demonstrate it. This is especially important where facilities for dining and social and recreational activities are to be shared with people from the surrounding community.

The importance attached to facilities for recreational, social and educational activities varies but such facilities, and a clear approach to their use, should be a requirement for all extra care schemes. Craft facilities, and access to computers and the Internet, are examples of what is currently provided and show a commitment to lifelong learning.

The ultimate test of all these design features is whether the provider can demonstrate a clear understanding of why they have provided them and how to ensure their effective use. Providing them because they are on the design guidance checklist should not be enough.

7. Funding

One of the advantages claimed for extra care housing over residential care is that the tenant is left with a higher level of disposable income. Funding arrangements should be equitable to the tenant without any loading of costs to the disadvantage of self-financing tenants. A scheme that is viable only with very high levels of rent, or with a raft of additional charges, will be unfair to those tenants not eligible for benefit.

Value for money

The scheme should also represent value for money when compared to alternative provision for the same person. The key to this equation is appropriate allocation and a flexible response to changing care needs. Some providers argue that a degree of financial imbalance is inevitable in the early years of a scheme, especially where an existing tenant population is retained in a scheme re-designated as extra care housing. They also argue that to achieve all the objectives set out here, costs for a given individual will exceed those that might apply if they were still in their own home or residential care. Their argument is for a view that takes in the whole tenant population over an extended timescale. It is reasonable to recognise this as the reality for perhaps the first three or four years of a re-designated scheme (at average replacement rates a third or more flats would be re-allocated to those with care needs appropriate to the facilities of the scheme within this period) or within the first 18 months to two years of a new scheme.

There is further information on funding for extra care housing for the period 2004-2006 in Annex One of this document.

10 The role of technology in extra care

Assistive technology covers a wide range of devices and applications from those that are well established to those that are still in development. There is a growing literature in this field where potential has sometimes seemed to take a long time to develop into measurable outcomes.

Sheltered housing has long depended upon voice communication between a central point, such as the warden's office, and individual flats. This has generally included the provision of pull cords for emergencies, located in bathrooms, toilets and bedrooms. All extra care housing schemes might be expected to have such systems in place.

Other assistive devices may be provided which fall into two main categories – devices that will monitor safety, such as detecting excess heat, and devices that monitor activity and generate an alert, for example, when someone has left their bed and gone to the bathroom but not returned.

Clearly such devices have potential for unobtrusively supporting independence and managing risk.

23 *Assistive technology and telecare: forging solutions for independent living* (S Brownsell, D Bradley & Porteus 2003)

11 Extra care for people with dementia

The capacity of extra care housing to successfully accommodate and care for people with more than mild confusional states is a matter for debate. There is a widespread acceptance that where confusion develops in residents who are already well-established within the life of a scheme, both they and their neighbours find the situation easier to deal with. Most providers will only look to move residents on to other settings in the most extreme circumstances.

Some local authorities, such as Wolverhampton Metropolitan Borough Council, who have carried through a major programme of re-provision, substituting extra care schemes for their residential care homes, have adopted a two pronged approach:

1. People with very mild confusional states have been allocated to their general extra care schemes. Those already resident who subsequently develop confusional states will be maintained in their existing accommodation for as long as possible.

2. They have also developed a specialist dementia scheme to which some can move on from the general extra care schemes or those with more severe dementias may be allocated directly from the community.

12 Commissioning checklist

In approaching the commissioning of extra care housing it may be helpful to ask:

- Who are the partners in health, housing and social care, in statutory, voluntary and commercial sectors that need to be involved in planning the provision of extra care housing?
- What are the local policy priorities that we need to be considering?
- What information do we have about current and future needs to which extra care housing might respond?
- What is the current supply of sheltered housing in all sectors, what do we know of its condition and of the intentions of those who own and manage it?
- What do we know about extra care schemes already established in the area?
- What is the current supply of residential care places in all sectors, what do we know of its condition and of the intentions of those who own and manage it?
- What capacity is there locally to respond to the accommodation and care needs of people with dementia and their carers?
- What is the relationship between the accommodation and care services we are considering and developments in intermediate care?
- What role might assistive technology and telecare have in supporting the pattern of care we wish to see provided through the scheme?
- Have we considered any specific needs of people from black and minority ethnic communities and how these might be met through extra care housing?
- Are there sheltered schemes that might be refurbished and what level of extra care provision could they provide?
- Have we considered the potential of a village style development?
- What are the elements in our specification for the scheme that we would consider essential and what discretionary?
- What are our arrangements for consulting with older people and securing their input to the specification and design of the scheme?
- Do we wish to develop a plan for comprehensive re-provision or are we adopting a piecemeal approach?

- How shall we select a partner to develop the scheme or schemes?
- Have we considered the potential for the sale of units to owner-occupiers?
- Do we expect management of all aspects of the scheme (housing and estate management, care services, catering, and so on) to be provided by a single organisation or do we wish to see this split between two or more organisations?
- What arrangements have we made for assessment prior to allocation and how have we related this to our single assessment arrangements?
- Have we established a joint structure through which allocations can be made?
- How shall we know if we got it right?

Annex One: Funding from the Department of Health to support the development of extra care housing

Department of Health letter to chief executives of local councils with social services responsibilities, 21 August 2003

At the *New Designs for Older People* conference on 2 July 2003, Stephen Ladyman, Parliamentary Under Secretary of State for Health, announced the availability of additional investment to expand and stimulate the development of extra care housing.

This fund will be run jointly by the Department of Health and the Housing Corporation and has the support of the Office of the Deputy Prime Minister.

The aim of the fund is:

- To develop innovative housing with care options;
- To stimulate effective local partnerships between the NHS, local housing authorities, social services authorities, care providers, housing associations and private sector and other developers of extra care housing in the interests of older people.

In order to meet these aims, the Department of Health will make available £29 million to be spent in the financial year 2004-05 and £58 million in 2005-06. We will be looking to issue allocations and project approvals for up to 1,500 new extra care housing places with an expectation that a substantial proportion of them will be completed and ready for occupation by 31 March 2006.

In 2004-05, £1.16m of the fund will be made available to create a small number of pilot supported-living schemes for learning disabled people who have been living with their parents, but whose parents have died or can no longer look after them. The Department of Health will work with local councils and voluntary groups to develop such schemes, but these will not be part of the current bidding process.

Through this fund we will be testing a number of concepts and are therefore interested in any innovative proposals you may have. They include, among others:

- Provision of extra care housing through remodelling residential care homes or existing sheltered housing schemes;
- Projects that reflect a broad range of partners;
- Projects that include investment from private funding

The projects will be evaluated jointly by the Department of Health and the Housing Corporation and the findings used to stimulate further development and inform future investment.

The extra care housing fund is an element of the access and System Capacity Grant for 2004-05 and 2005-06. Like other parts of the grant, it will be allocated to social services authorities. It will be allocated against successful bids, which meet certain criteria, including the requirement for a range of partnership with public or private sector bodies. These will very often include housing associations, but need not always do so.

It is open to housing associations to bid in respect of the same project to the Housing Corporation for funding in its autumn bidding round, However these must be made separately using the Housing Corporation's IMS. If you want to be considered for both funds you will need to bid to both independently. For further details, please visit: www.doh.gov.uk/changeagentteam/housing-lin.htm

Annex Two: References and further reading

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Other useful information

Change Agent Team housing learning and improvement network
www.doh.gov.uk/changeagentteam/housing-lin.htm

National Service Framework for Older People
www.doh.gov.uk/NSF/olderpeople/index.htm

Guidance on preparation of older people's strategies
www.odpm.gov.uk/stellent/groups/odpm_housing/documents

NHS and Community Care Act 1990

Care Standards Act 2000 (see also Care Homes for Older People, National Minimum Standards, Dept of Health 2001)

Supporting People
www.spkweb.org.uk