Developing and Implementing Local Extra Care Housing Strategies
Acknowledgement

This guide was developed by Andrew Kerslake and Pippa Stilwell of the Institute of Public Care on behalf of the Housing Learning and Improvement Network, Department of Health.

The authors would like to thank all those who contributed to the guide. In particular, to Lynn Collingbourne, South Gloucestershire Council; Mushtaq Khan, Trafford Metropolitan Borough Council; Liz Alvey, Surrey County Council; and Elaine Bond, Nottinghamshire County Council who helped us “roadtest” the guide. In addition, we are grateful for the comments and the feedback received from the DH’s Housing Stakeholder Group.
<table>
<thead>
<tr>
<th>Contents</th>
<th>Page number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>2</td>
</tr>
<tr>
<td>Background</td>
<td>2</td>
</tr>
<tr>
<td>Good Practice in Extra Care</td>
<td>2</td>
</tr>
<tr>
<td>Structure of the Document</td>
<td>3</td>
</tr>
<tr>
<td>Stage 1: Mapping Populations</td>
<td>5</td>
</tr>
<tr>
<td>Briefing Notes</td>
<td>6</td>
</tr>
<tr>
<td>Key Elements and Indicators</td>
<td>8</td>
</tr>
<tr>
<td>Tools and Approaches</td>
<td>10</td>
</tr>
<tr>
<td>Stage 2: Mapping Resources</td>
<td>17</td>
</tr>
<tr>
<td>Briefing Notes</td>
<td>18</td>
</tr>
<tr>
<td>Key Elements and Indicators</td>
<td>19</td>
</tr>
<tr>
<td>Tools and Approaches</td>
<td>20</td>
</tr>
<tr>
<td>Stage 3: Partnerships</td>
<td>25</td>
</tr>
<tr>
<td>Briefing Notes</td>
<td>26</td>
</tr>
<tr>
<td>Key Elements and Indicators</td>
<td>27</td>
</tr>
<tr>
<td>Tools and Approaches</td>
<td>29</td>
</tr>
<tr>
<td>Stage 4: Local Management of Services</td>
<td>33</td>
</tr>
<tr>
<td>Briefing Notes</td>
<td>34</td>
</tr>
<tr>
<td>Key Elements and Indicators</td>
<td>38</td>
</tr>
<tr>
<td>Tools and Approaches</td>
<td>40</td>
</tr>
<tr>
<td>Stage 5: Funding and Finance</td>
<td>43</td>
</tr>
<tr>
<td>Briefing Notes</td>
<td>44</td>
</tr>
<tr>
<td>Key Elements and Indicators</td>
<td>46</td>
</tr>
<tr>
<td>Tools and Approaches</td>
<td>48</td>
</tr>
<tr>
<td>Stage 6: Quality and Outcome Measures</td>
<td>55</td>
</tr>
<tr>
<td>Briefing Notes</td>
<td>56</td>
</tr>
<tr>
<td>Key Elements and Indicators</td>
<td>58</td>
</tr>
<tr>
<td>Tools and Approaches</td>
<td>59</td>
</tr>
<tr>
<td>Pulling the Strategy Together</td>
<td>65</td>
</tr>
<tr>
<td>Bibliography</td>
<td>69</td>
</tr>
</tbody>
</table>
Developing and Implementing Local Extra Care Housing Strategies

1. Introduction

This guide has been commissioned by the Housing Learning and Improvement Network (LIN) as part of the Health and Social Change Agent Team Programme within the Department of Health (DH). It compliments a number of other documents that have been produced as part of the Housing LIN programme of work and development – these are available on the Housing LIN website [www.doh.gov.uk/changeagentteam/housing-lin.htm](http://www.doh.gov.uk/changeagentteam/housing-lin.htm). The guide is designed to help authorities develop a strategy with regard to Extra Care housing and as a contribution to local authority bids for funding under the Extra Care housing programme launched in 2003. This programme made £87m available over two years to enable service providers to expand and stimulate the development of Extra Care Housing. The aim of the fund was to:

- Develop innovative housing with care options.
- Stimulate on-going strategic links between health, social care and housing.
- Develop partnerships between the range of local agencies.

The objective is to develop new Extra Care housing places in areas where need has been demonstrated and which:

a) Contribute to the range of solutions to prevent unnecessary hospital admission and/or assist in reducing delayed transfers of care from hospitals.

b) Provides housing with support and long term care.

2. Good Practice in Extra Care

It will be crucial to retain good practice expertise and an understanding of the ethos of Extra Care in the face of a burgeoning agenda involving new pressures and policies, including problems surrounding hospital admissions and discharge arrangements, the rising costs of residential care, and the need for providers to respond to demographic change. Defining elements of Extra Care include:

- Living at home – not in a home.
- Having one’s own front door.
- The provision of culturally sensitive services delivered within a familiar locality.
- Flexible care delivery based on individual need – which can increase or diminish according to circumstance.
- The opportunity to preserve or rebuild independent living skills.
- The provision of accessible buildings with smart technology that make independent living possible for people with physical or cognitive disabilities, including dementia.
- Building a real community, including mixed tenures and mixed abilities, which is permeable to the wider community and benefits from the variety of provision available to all citizens.
Important differences between housing based models of care and institutional care include:

- An ethos of independence /rehabilitation.
- Tenancy or equity stakes give security of tenure.
- Couples stay together.
- Relatives and friends continue to contribute to care.

3. Structure of the document

This document sets out a framework of six key stages for determining strategic direction across ordinary sheltered housing (OSH) and Extra Care. For each stage, commissioning partners are given a briefing note, guidance on the key elements or indicators they need to cover, the reasons why these indicators are relevant to Extra Care, and where further information, tools or approaches may be found. After the six stages, guidance is given on how the information collected during the key stages can be used to assemble the Extra Care strategy.

The six stages are:-

1. Mapping populations.
2. Mapping Resources
3. Partnerships.
4. Local Management of Services.
5. Funding and Finance
6. Quality and outcome measurement.

Working through the key stages will enable commissioning partners to develop their strategy for older people, and should underpin the development of a partnership business plan for implementing Extra Care locally. The intention is that the information collected will form the basis for the Local Authority bid in year 2 of the Department of Health funding, and Local Authorities will have to demonstrate that they have considered all the key stages. The document has been designed in such a way that different teams or managers can tackle the different stages independently, prior to assembling the strategy.

However, the intention is that this strategic framework will have a continuing value over and above the requirements of the bidding process. Many ordinary social housing schemes have been occupied continuously since the sixties, and the provision of Extra Care is a response to enduring demographic change. Therefore, these strategies may well cover ‘quick wins’ in terms of provision, but will also be projected forward over ten or twenty years. It is worth remembering that the ‘quick wins’ will be flagships for Extra Care locally, and setting up high quality schemes from the outset will help to engage potential users, their families and referrers, in the future success of the programme.

Commissioning partners will be given the knowledge and tools they need for planning for the immediate future and for the longer term. The involvement of all potential users, current users and their families will be a key element in much of this decision making, with relevance to every stage, and this document gives some pointers to good practice in securing the contribution of older people in decision making, both from majority and minority groups.
Stage 1

Mapping Populations
1. MAPPING POPULATIONS

EACH AUTHORITY SHOULD DEMONSTRATE A GOOD UNDERSTANDING OF THEIR CURRENT DEMOGRAPHICS (ACTIVITY 1), AND BE ABLE TO IDENTIFY THOSE PEOPLE FOR WHOM EXTRA CARE MAY BE APPROPRIATE (ACTIVITY 2).

1.1 Briefing Notes

Historically many authorities have used crude population figures to show the need for increased provision of services. Whilst of course it is known that the population of older people and particularly the oldest older group will grow over the next twenty years, this is not automatically synonymous with the numbers that will require services. Obviously health and wealth can considerably impact on demand, but so also can the types of services currently available and public and professional perceptions of what they deliver. For example any, or all, of the following may have an impact on who asks for a service.

- The impact of new drug treatments on conditions such as dementia which may influence both the extent and aetiology of the condition.
- Factors which influence the desire of carers to continue or not continue their caring role.
- Appropriateness, availability and accessibility of services, eg, local policies for Ordinary Sheltered Housing, delivery of home care, falls prevention.
- Impact of economic factors on the capacity of individuals to fund their own care.
- Housing conditions and income levels/deprivation factors.

Recent trends suggest that there has been an increase in the number of older people receiving intensive care at home, but a decrease both in the numbers in residential care and the numbers receiving packages of care. Eligibility thresholds for home care have risen, thus reducing the amount of low level preventative interventions in the community. There is also an increase in the average age on admission to residential homes. ¹

Whilst accurate prediction is not possible it is still both desirable and feasible to estimate or narrow down some of the known populations and identify what volumes of care may be required to maintain different groups of older people within housing that offers varying levels of care. This section is concerned with understanding that potential demand for Extra Care Housing now and in the future. On the one hand it needs to move from the broad population, ie, the current and future demographic profile of the population through to more specific populations who may potentially be tenants of Extra Care and to utilise existing information about current tenants and service users. Currently around 5% of those aged 65+ live in sheltered housing, of which 13% is privately owned or rented. ²

All data should be analysed by religion and ethnic background. This information is a first step in estimating the need for culturally sensitive services. People from different ethnic groups may have different expectations concerning accommodation, the role

---

² Centre for Policy on Ageing *Our Homes, Our Lives: page 5.*
their family might play and what kinds of communities they might wish to live in. Consultation with people from local minority ethnic communities could help to clarify some of these issues. Fig 1 shows how these areas may be brought together to identify a target population.

**Fig.1**

The kinds of information required are reflected in the two activities below.

- Activity 1 should give the authority a reasonable picture of the current demographic profile and how some relevant key factors are prevalent within the whole population.

- Activity 2 then bridges the gap between total potential population and the current relevant population known to social services, health and housing, and identifies key target audiences for the future. At the conclusion of this part of the work it should be possible to estimate where the future population of Extra Care currently live, and how they are cared for. This activity is likely to prove more detailed than the first. Being able to predict who may come through the ‘front door’ of any of the care agencies is difficult to achieve with accuracy given that such predictions can be subject to a wide variety of influences.

Therefore, the target population will be drawn from a range of people including:

- Current occupants of ordinary sheltered housing (OSH) and residential care.
- Other older people with assessed support needs.
### 1.2 Key Elements and Indicators

**Table 1**

<table>
<thead>
<tr>
<th>Activity 1: Indicators (broken down by ward, age bands, and by ethnic group).</th>
<th>Activity 1: Relevance of Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indicator 1.</strong> How many older people live within the Local Authority or PCT area? What are the projected populations for older people?</td>
<td><strong>Indicator 1.</strong> Will give an idea of where most older people live, and suggest where Extra Care schemes could best be sited.</td>
</tr>
<tr>
<td><strong>Indicator 2.</strong> How many live alone?</td>
<td><strong>Indicators 2/3.</strong> Studies of the factors which precipitate people into residential care suggest that fear of crime plays a major role. This, combined with increasing frailty, can lead to people becoming more and more isolated, even if they are in receipt of home care services or live in Ordinary Sheltered Housing (OSH). Older people in this situation are particularly likely to benefit from sheltered or Extra Care as an alternative to residential care.</td>
</tr>
<tr>
<td><strong>Indicator 3.</strong> How safe do older citizens feel?</td>
<td><strong>Indicator 4.</strong> Extra Care is not only for the social renting sector. Currently around two thirds of older people nationally are owner-occupiers. Older people who are owner-occupiers could purchase equity in an Extra Care scheme (see Section 5), thus bringing capital into the project. Tenure mix in Extra Care should reflect the mix in the local community. However, leasehold Extra Care units need to be affordable to local owner-occupiers, and if house prices are lower than the value of a unit then a range of equity stakes will have to be offered to potential purchasers.</td>
</tr>
<tr>
<td><strong>Indicator 4.</strong> What is the local mix of housing tenure among older people, and what proportion of older people are owner-occupiers? How do local house prices compare with the price of an Extra Care unit? Will rents be affordable?</td>
<td><strong>Indicator 5.</strong> Extra Care gives a huge advantage over institutional provision because spouses can stay together and the carer continues to care, with support. Nationally, 2% of people aged over 90 are providing more than 50 hours care a week.</td>
</tr>
<tr>
<td><strong>Indicator 5.</strong> How many elderly carers are there? This may be defined as people aged 65 and over who are providing care.</td>
<td><strong>Indicator 6.</strong> Housing needs surveys have found that the need for repairs is a major factor in unsuitable housing, and there may be no way of using the equity in the property to fund repairs. Older people in this position, or in inaccessible housing of any tenure, are likely to benefit from Extra</td>
</tr>
<tr>
<td><strong>Indicator 6.</strong> What is the quality of the housing stock in which older owner-occupiers are living? How many lack amenities?</td>
<td></td>
</tr>
</tbody>
</table>

---

- 8 -
**Indicator 7.** What is the local prevalence, calculated from national rates, of
- Physical or sensory impairment
- Dementia
- Mental ill health
What other estimates are available of local incidence and prevalence of these conditions? What local data is available from the National Service Framework?

**Activity 2: Indicators**

The data underpinning these indicators may not be routinely collected, and it may be necessary to conduct small local studies involving scheme managers, users, carers and/or case managers to obtain this information. Some short cuts are suggested below, but an understanding of current client pathways will be an important component of planning for Extra Care.

**Indicator 1.** How many older people currently live in OSH and Extra Care housing?
What are their reasons for entry to that form of housing, length of tenure and reasons for departure? How does that relate to void levels and ease of lettings for particular schemes?

**Indicator 2.** To what extent do local OSH and Extra Care schemes currently support people who are physically frail or who suffer from dementia, mental ill health or cognitive impairment? Do wardens and scheme managers expect to offer continued support to frailer tenants, or are they encouraged to move into residential or nursing care?

**Indicator 3.** What are the estimated numbers and proportion of residents currently in care homes, whom the experience of Extra Care would have enabled to renew or prolong their independent living skills?

**Care schemes.**

**Indicator 7.** Under most circumstances, Extra Care schemes offer a home for life, and so need to plan for a population which will include the physically frail as well as those with dementia and cognitive problems. Having an idea of likely numbers will enable providers to design suitable buildings, to estimate staffing levels, and to provide staff with the skills necessary to foster social engagement and to maximise independent living for these groups.

**Activity 2: Relevance of Indicators**

**Indicators 1/2.** An overview of the characteristics of existing sheltered housing tenants will be important in helping to predict which tenants would benefit from moving to Extra Care schemes, and also in suggesting the likely future flow of older people between current OSH schemes and Extra Care. Looking at reasons for entry and departure in relation to void levels and ease of lettings in particular schemes should start to indicate tenant preferences for particular elements of the service and modes of service delivery – for example, are some configurations of staff, buildings and location more conducive to a vibrant community than others? Are people with particular conditions more likely to be moved out of OSH into other forms of provision?

**Indicator 3.** Commissioning partners will need to know who is in residential care, what are the factors precipitating the move into residential care, and what effect the delivery of care at home has had on levels of frailty in residential care, in order to estimate which of these residents might...
Indicator 4. What is the volume of Intermediate Care and delayed discharge where housing is the only or predominant factor in inhibiting a return home?

have benefited from Extra Care, either currently or at the time of their move.

Indicator 4. There are already a number of good practice examples of partnerships between Extra Care providers and local Intermediate and Primary Care Teams which enable people to move out of hospital settings when they no longer need medical care (See Tools and Approaches) Knowing the volume of delayed discharge will help Commissioning Partners to develop plans for providing Intermediate Care facilities within Extra Care.

1.3 Tools and Approaches

Data Sources

Forming Information Partnerships

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

Census Data

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

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

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

Information on Disability Living Allowance and Attendance Allowance claimants by ward (though not by age) is available at [www.neighbourhood.statistics.gov.uk](http://www.neighbourhood.statistics.gov.uk) in the Health and Care section.

**Information from local statutory documents**

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

Housing Needs Surveys will be particularly helpful in looking at the proportion of older people who are in unsuitable housing and could not afford to buy in the open market. The reporting of Housing Needs Surveys does not always produce the analysis that would be needed for planning older people’s services, but the information may well be there in the database, and some Local Authorities are now arranging for additional analysis to be done to answer some of the outstanding questions. For example, they may give information on the kinds of reasons that older respondents give for needing to move. Often, older people cite an inability to fund repairs or to maintain the garden as a reason for moving. The discussion paper *Quality of Life for Older People: From welfare to well-being*, published by the Joseph Rowntree Trust in October 2003, discusses equity release schemes for older people and can be found at [www.jrf.org.uk/knowledge/consultation/pdf/TaskForceDiscussion.pdf](http://www.jrf.org.uk/knowledge/consultation/pdf/TaskForceDiscussion.pdf)

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

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

*Community Safety Strategies /Partnerships*

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

*Hospital Admission and Discharge.*

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

**Information from Local Research and Consultation**

Activity 2 relies on some information which is probably not routinely collected. Before setting up special projects, it will be important to refer to Supporting People and Best Value Reviews to see what is being learnt about local service provision and the people it serves.
Surveying Current Sheltered Housing

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

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

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

Surveying Residential Care

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

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

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

Using Prevalence Rates

Melzer, Ely and Byrne\(^3\) quote the following prevalence of cognitive impairment among older people:

- 2.3% of those aged 65-75.
- 7.2% of those aged 75-84.
- 21.9% of those aged 85 and older.

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

**Fig. 2**

<table>
<thead>
<tr>
<th>Local Population</th>
<th>National Prevalence of Cognitive Impairment</th>
<th>Local Prevalence Applying National Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aged 65-75</td>
<td>28,244</td>
<td>2.3%</td>
</tr>
<tr>
<td>Aged 75-84</td>
<td>17,348</td>
<td>7.2%</td>
</tr>
<tr>
<td>Aged 85+</td>
<td>5,251</td>
<td>21.9%</td>
</tr>
</tbody>
</table>

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

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

- The Local Delivery Plan for Older People.
- The National Service Framework Local Implementation Team.
- Local poverty and economic development studies.

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

- Epidemiological research reported in the Forget Me Not report, 2000, and National Service Framework for Older People, 2001, between 10% and 15% of people aged 65 and over are likely to have depression and between 5% and 6% are likely to have severe depression.

---

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

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

Good Practice Examples

The Housing Change Agent Team web site keeps a record of good practice ideas and innovations, including a description of an Ealing partnership between the sheltered housing service and the intermediate care service. This can be found at [www.doh.gov.uk/changeagentteam/housing-lin.htm](http://www.doh.gov.uk/changeagentteam/housing-lin.htm)

In 2001, Sheffield City Council commissioned a Housing Care and Support Strategy for Older People from the Housing and Support Partnership. The work analysed, by ward, 14 indicators of demand, including admissions to residential and nursing care, existing and new referrals for elderly people and those with physical disability or mental ill health, uptake of home care and other community based services, and also numbers of older people. This was matched with supply data, which enabled the researchers to identify areas (in this case, PCT areas) having high demand and low supply. To analyse who needs Extra Care they reviewed:

- Demographic trends
- Unsatisfied needs and demand
- Needs of the BME communities


DH Capacity Planning Spreadsheet

The Department of Health has produced a spreadsheet model to help local authorities to plan for older people. The model covers a range of local authority services for older people including residential and nursing home care, Extra Care, intermediate care and home care. The model allows the Authority to compare their planned growth in these services between 2002/3 and 2005/6 with their expected share of the planned growth in national capacity announced in the spending review. This Capacity Planning model is to be found at [www.doh.gov.uk/changeagentteam/capacityplanningmodel.pdf](http://www.doh.gov.uk/changeagentteam/capacityplanningmodel.pdf).

1.4 Conclusion

This first part of the strategy should show that the authority has a good grasp of the match between relevant demographic characteristics of their total population, the potential population for Extra Care housing, and those who currently receive services for whom Extra Care may have been or still could be an alternative and appropriate form of provision. This should lead to identifying a target population now and in the future. Such a population may incorporate minimum and maximum numbers for
different potential types of provision with distinctions between different elements of the population. Other key elements to explore may be potential hidden populations within owner-occupiers who may currently move straight to residential care and those currently self-funding within residential care who could potentially transfer to extra care housing when the Local Authority assumes funding responsibility.

In addition the strategy may also:

1. Identify potential estimated numbers by ethnic group and the impact this may have on future housing choice.
2. Numbers of people where Extra Care resources may be relevant to intermediate care and hospital discharge.
3. Identify populations by potential problem, eg, dementia or other mental health conditions.
4. Describe current tenant pathways through sheltered housing.
Stage 2

MAPPING RESOURCES
2. MAPPING RESOURCES

EACH AUTHORITY SHOULD SHOW THAT THEY CAN PROVIDE AN EFFECTIVE MAP OF PROVISION. THIS MEANS NOT JUST LISTING STOCK BUT BEING ABLE TO ANALYSE THE VALUE AND USE OF THAT STOCK/SERVICE, ASSESS ITS CAPACITY AND CAPABILITIES, AND IDENTIFY EXISTING AND FUTURE PLANS FOR DEVELOPMENT

2.1 Briefing Notes

Mapping population should provide a reasonable idea of the target population and their needs. Mapping resources involves identifying the quantity and quality of current provision in terms of relevant housing stock and care, identifying any shortfall and where new services may need to be developed. The activity should embrace not just the public sector but also cover the voluntary and private sectors. Collecting information about supply will enable commissioning partners to:

- Benchmark their volume of supply against that in other authorities.
- Identify unpopular OSH schemes, with the aim of identifying sites for possible remodelling or redesignation.
- Estimate the value of the current stock.
- Have a good perspective on how existing schemes are viewed by residents, relatives and older people within the community.

In some instances current sheltered housing schemes may not attract sufficient tenants either through poor location, poor quality of the premises or the wrong type of accommodation on offer. Careful scrutiny of the value of land/premises, costs of conversion/improvement etc will form part of the decision as to whether to refurbish or realise the assets.

It may be appropriate for some Local Authorities to examine the current stock of residential care homes in their area. If there are plans to close these, they may provide appropriate sites either for sale or for development as Extra Care.

In mapping resources, it will be important to look at the total market. Private sector developers are playing an increasing part in the provision of housing with care schemes, and commissioning partners will need to be aware of their contribution to total provision. The private sector provides a high proportion of total care, both residential and domiciliary. The same need to map supply would also be true of voluntary sector provision.

Identifying and mapping services potentially relevant to Extra Care should help to answer a number of questions:

- Is current service provision sufficient?
- Is it appropriately located?
- Does this type of housing require the development of new types of service and/or the re-modelling of old provision?

It is also important to consider the full range of services that tenants might need, including provision by the Primary Care Teams (PCTs), pharmacies, post office, supermarket, mobility services, etc.
### 2.2 Key Elements and Indicators

**Table 2**

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Relevance of Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indicator 1.</strong> How many sheltered and retirement housing schemes are there? What are the number and type of units within the scheme – are they bedsits, bungalows, flats, and how many bedrooms do they have? How does this compare with national figures for the number of sheltered housing units per older person? (All this data is available from the EAC: see Tools and Approaches) What efforts have been made to ascertain future plans of RSL’s and independent sector providers?</td>
<td><strong>Indicators 1 &amp; 2.</strong> By mapping current stock against national provision, Commissioning Partners will be able to judge whether they have an under or over supply of sheltered housing. Where there is an under supply, Commissioning Partners can expect a larger proportion of Extra Care tenants not to be previously known to any agency. Where there is an oversupply, decisions will have to be made about how existing buildings can be refurbished or re-designated.</td>
</tr>
<tr>
<td><strong>Indicator 2.</strong> What is the quality and accessibility of existing stock, and the volume of, and reason for, voids? How many vacancies are there for each type of unit, by scheme?</td>
<td></td>
</tr>
<tr>
<td><strong>Indicator 3.</strong> What land is available, now and in the future (this includes brownfield sites, or sites released by the reprovisioning or remodelling of existing residential homes or OSH schemes)?</td>
<td><strong>Indicator 3.</strong> Provision for older people may not necessarily be a priority for planners or housing providers. Housing Needs Surveys will have estimated the need for accommodation for older people. It will be important for Commissioning Partners to be aware of planning priorities, and to make planners aware of likely requirements for building Extra Care schemes.</td>
</tr>
<tr>
<td><strong>Indicator 4.</strong> How do OSH populations and waiting lists reflect local BME profiles?</td>
<td><strong>Indicator 4.</strong> People will not apply for services which they expect will not meet their needs, or which they do not expect to be able to access. Probably for both these reasons, mainstream OSH does not usually reflect the local BME profile. Gauging the size of this discrepancy will provide a baseline from which to explore ways of providing a culturally sensitive service.</td>
</tr>
<tr>
<td><strong>Indicator 5.</strong> What is the range of Staying Put services available within the community, eg, housing repair, aids and adaptions, domiciliary care, day care, shopping services, meals and laundry services, 24 hour night</td>
<td><strong>Indicator 5.</strong> What are the services which make the difference between people remaining at home or going into institutional care? Older people say they want ‘help’ – what is the relative contribution of Staying Put, incontinence</td>
</tr>
</tbody>
</table>
sitting services, incontinence services? What use has currently been made of assistive technology (AT)? Which of these services, and in what volume, are currently provided to people in OSH and Extra Care?

Indicator 6. What are the key workforce issues locally that might impact on staffing Extra Care schemes? Considerations here might include identifying current ‘hotspots’ for staff recruitment and retention and the role that any key worker housing might play.

services, or meals on wheels? In some areas, care managers with clients in different PCT areas give anecdotal information of the importance of rapid response teams, 24-hour emergency provision, or other services. What can Commissioning Partners learn from this?

Indicator 6. Having identified the key services that sustain people in the community – what is the capacity to extend those to people in Extra Care? What capacity, service configuration and mix of services will be needed to offer the full range of provision required by local older people? If home care providers cannot recruit or retain staff, or if a lack of affordable housing means that potential recruits are moving away, Commissioning Partners may need to address these issues at an early stage.

2.3 Tools and Approaches

Mapping

It may well be helpful in presenting policy decisions to others, eg, elected members or other key stakeholders, to generate maps showing the location of existing Extra Care and OSH services, and their local populations. Most local authorities will have access to a mapping facility – (software for mapping is expensive and may be located in only one department of the Authority). Strategic Health Authorities will have sophisticated software for mapping incidence and prevalence of health conditions and the social determinants of ill health, and it would be possible to add a table giving, for example, the location of OSH schemes by postcode and number of units. In the case of rural populations, it would be helpful to map existing and planned schemes in relation to public transport networks and other relevant infrastructure.

Mapping services graphically will help to identify gaps in current provision for rural populations, older people from BME groups, and older people with dementia. Supporting People (SP) Teams collect information about local services which are either funded or part funded through Supporting People. This information is held on a database, the Supporting People Interim Local System (SPINTLS) and gives a comprehensive picture of sheltered housing and housing support services for older people, by postcode. In addition, it lists the number of Supporting People services for specialist groups and ethnic minorities.

The Elderly Accommodation Counsel (EAC) provides local maps of housing and care homes for older people in any locality, district, etc. In addition, the EAC regularly provides local SP teams with lists of local housing and care homes for older people, including almshouses, Abbeyfield, leasehold retirement housing;
often such information is not available elsewhere. Data includes types and details of the accommodation. [www.housingcare.org](http://www.housingcare.org)

Local provision can be compared with the national picture by utilising existing benchmarking exercises, for example:

- Supporting People Teams have already done the work of mapping the local supply of sheltered housing against national norms.
- Social Services Best Value Performance Indicators give rates of older people in residential care per 1,000 older people, locally and nationally.
- Local benchmarking groups will provide indicators for OSH, which allow comparison with a group of similar authorities. For example, a useful indicator is the number and proportion of tenants with support plans, the number and proportion of bedsits, and the number and proportion of tenancies terminated by death – i.e. where OSH has effectively provided a home for life for the tenant.

For example, researchers in Sheffield found that the city had less than the expected level of provision of sheltered housing, a considerably smaller number of people aged 75+ in residential care, and a larger number of people in nursing homes. This provided a context for the introduction of Extra Care, by demonstrating that a large number of potential occupants will come directly from the community, in the absence of alternative provision.

**Consulting older people**

Most local authorities will have the capacity and experience to conduct user satisfaction studies, and there may well already be resources such as residents’ panels contributing to the ‘Consult’ element of Best Value reviews. Commissioning partners could use these and other existing consultations to help build a users’ perspective on current and planned provision for older people. In addition, properly planned and managed focus groups, with skilled facilitators, can be a very useful way of getting people talking about service provision. For example, Stonham Housing Association organises focus groups on an annual basis, which are facilitated by an external consultant, and action is prioritised, agreed and fed into the business planning process. Anchor trust have a similar process. Most people hope to stay at home as they grow old – and most in fact do so – but older people can only make choices if they are aware of the full range of services on offer, and if they and their families are able to help shape future provision.

A guide to user involvement for organisations providing housing related support services (Supporting People Summary Number 5, May 2003) can be found on the Supporting People website at [www.spkweb.org.uk](http://www.spkweb.org.uk) under General Documents. Care and Repair England have produced a housing action toolkit for older people “Having our Say”.

Research funded by the Wales Office of Research and Development for Health and Social Care found that older people were most likely to rate privacy, physical space and control of life as important elements for future choices. The study points to a number of research publications which found a preference among older people for remaining at home, and concludes that achieving this means that health and social care will have to be provided at home as people become more frail. Related work by

---

4 Burholt V. Windle G. *Retaining Independence and Autonomy: Older People’s Preferences for Specialised Housing*. Wales Office of Research and Development for Health and Social Care (Undated).
the same authors found that people aged 50-60, and those aged 70+, had different perceptions about their future housing, with the younger group being more likely to contemplate the likelihood of having increasing needs as they grew older — presumably because the prospect was more distant. A larger proportion of older people were unwilling to think about moving. Differences between the two groups suggest that service provision will need to be continually tailored to meet the needs and wishes of future cohorts of older people. Commissioning partners will need to set up mechanisms for an ongoing dialogue with current and future service users.

**European Models**

The Housing Corporation Innovation and Good Practice Research Database (IGP) has funded a range of projects focusing on identifying and disseminating innovation and good practice across Europe. The IGP website can be found at [www.housingcorp.gov.uk/resources.htm](http://www.housingcorp.gov.uk/resources.htm), and European good practice models for older people are described in Section 4.

In the Netherlands, the idea of Service Zones is now current. New areas of building, for example a new estate, might be designated a housing care zone. This area then becomes the focus for a number of interventions – for example, all housing stock within a housing care zone must have the potential to be fully accessible. An increased level of home services is provided, including 24-hour community alarm, burglar and fire alarms with guaranteed call out, emergency aid, home care, shopping and transport services and appropriate leisure services. Nevertheless, these zones would house a mixed population so that older people continue to live amongst people from all age groups.

**2.4 Conclusion**

On the stock side the strategy should address the appropriateness of current sheltered housing provision. That assessment should cover voids, location, value, and adaptability where necessary and the relevant costs of updating as compared to new build? In terms of services then this needs to cover the full range of health, social care and community facilities. Particular activities that follow from this include:

- Give a summary of the number and characteristics of ordinary sheltered housing units and relate this to current demand, local populations and national indicators to describe how future plans for Extra Care will fit with current OSH provision. This should include identifying possible sites for Extra Care, including any existing OSH schemes which are in a suitable location
- Give an accurate appraisal of current community service range and capacity, what is missing and the rationale behind any new requirements. Describe how existing community care services would need to adapt to support people in Extra Care, including any local workforce issues and how they would be addressed.
- Undertaking consultation in order to understand the preference of local older people and their families for different types of housing and support, and location of provision.

---

5 Burholt V. Windle G. Future housing considerations for an ageing population: A qualitative comparison of potential relocation catalysts for two cohorts.
6 Singelenberg J. What is a Service Zone? In Lifetime Housing in Europe, Leuven University Belgium 1999.
The end point of the two mapping activities should be a clear statement that defines the minimum and maximum numbers within the population that might be considered for Extra Care housing now and in the future, their defining characteristics, the type of provision available and to be developed and desired location. Service availability current and planned should then run alongside the potential schemes.
Stage 3

PARTNERSHIPS
3. **Partnerships**

THERE SHOULD BE A CLEAR BUSINESS PLAN FOR CO-ORDINATING PARTNERSHIP ARRANGEMENTS BETWEEN AGENCIES. THIS DOCUMENT SHOULD COVER PLANNING AND DEVELOPMENT, IMPLEMENTATION AND OUTCOME MONITORING. IT SHOULD BE DETAILED ENOUGH TO ENCOMPASS RESOURCE COMMITMENTS FROM PARTICIPATING AGENCIES.

3.1 **Briefing Notes**

The end point of the two mapping activities should be a clear statement that defines:

- The minimum and maximum numbers within the population that might be considered for Extra Care housing now and in the future.
- The characteristics of that population.
- The type of provision available and to be developed.
- Desired location.

Service availability current and planned should then run alongside the potential schemes. The remaining sections of the strategy are therefore concerned with how these plans might be delivered, of which this section concerns partnerships.

Most agencies will already have both formal and informal partnerships in place to support the development of wider strategies towards older people and towards sheltered and Extra Care housing in particular. Experience suggests a number of key issues need to be addressed within these arrangements. Partners who play a less continuous role but on whom the development of schemes depend, must not be ignored, for example planning departments. Secondly, partnerships can be strong in planning and commissioning services but weak when it comes to implementation. Thirdly, there is often too little attention paid to how, on an inter-agency basis, the outcomes of schemes will be measured and monitored against the original objectives. This paper suggests that if partnerships are to have operational meaning then there needs to be common objectives, with an agreed rationale as to why they are being pursued, the ability to measure and monitor outcomes and a realistic action plan which embraces all aspects of implementation.

The full range of agencies is often taken to mean health (both hospital and PCT based) social services and housing authorities. However, discussions need to take place with other Local Authority departments such as Planning and Community Leisure Services, as well as with private sector providers (both buildings and care providers), voluntary agencies, and current and potential users and their carers. Some partners, particularly the smaller agencies from the voluntary sector, may need to be resourced by the Local Authority if they are to play a full part in planning (see Tools and Approaches).

In involving the PCT it is also important that the impact on all community based health services are understood and agreed, eg, physiotherapists, continence services, pharmacies. All health professionals who will offer services to any particular scheme will need to be signed up to the project from the beginning if it is to succeed.

The key objectives of all local strategies should have been reviewed, including objectives set out in:

- Local delivery plans (PCTs).
• Local Strategic Partnerships.
• Housing and planning objectives.
• Supporting People strategies.
• Community Safety plans.
• Regeneration documents.
• Strategic Health Authority documents.
• Housing Strategies (including Regional Strategies).
• Joint plans between Social Services and Housing Departments.

Commissioning partners will also need to be aware of international and national aspirations for older people, including the research quoted in Section 2 which demonstrates that the majority of older people wish to remain at home and in control of their own lives for as long as possible.

The United Nations International Plan of Action on Ageing recommends that:

* A living environment designed to support the functional capacities of older people and the socially disadvantaged should be an integral part of national guidelines for human settlements policies and action. *(UN/Division for Social Policy and Development, 2000)*

Commissioning partners must agree:

• Outcomes to be achieved.
• Routes for measuring and monitoring whether those outcomes have been achieved.
• A shared action plan.
• Timescales.

There is a need to ensure that housing principles and sustainability for the future are embedded in commissioning.

### 3.2 Key Elements and Indicators

**Table 3**

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Relevance of Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator 1. Can the Authority demonstrate that it is working with the full range of agencies that is appropriate?</td>
<td><strong>Indicators 1/2:</strong> These will show that Authorities have considered who they need to work with in developing Extra Care – for instance, larger private developers to help with provision for older people outside the social rented sector, or housing support services and health care teams to facilitate a rapid response scheme for people newly discharged from hospital. Local planners may have a role in identifying and designating possible sites. Older people’s forums or voluntary agencies can help in shaping services.</td>
</tr>
<tr>
<td>Indicator 2. Is there clear evidence that the private and voluntary sectors have been involved?</td>
<td><strong>Indicator 3.</strong> The continuing commitment of partners will be needed in order to plan,</td>
</tr>
<tr>
<td>Indicator 3. Is there clear evidence of the commitment of all system partners or</td>
<td></td>
</tr>
</tbody>
</table>

---

...
stakeholders at the levels of:
Planning
Implementation
Monitoring
For example, what are the timescales for which members will be required to be involved? How senior will the members be? What methods will they have for reporting back to their parent organisations, thus ensuring that they reflect the views of these organisations?

Indicator 4. What are the relevant local strategic objectives, drawn from the main strategy documents, which will influence the development of an Extra Care strategy?

Indicator 5. What common objectives do the partners have that are in line with national and local strategic objectives?

Indicator 6. What mechanisms will be used for consultation with users and carers, and local minority groups?

Indicator 7. Have the necessary steps been taken for managing change? For example, are Local Authority elected members engaged with the process so that they will support the closure of existing provision if necessary?

deliver, and monitor the success of the strategy. This indicator will show that the Authority is aware of the resource implications required to develop and deliver the strategy.

Indicator 4. This indicator will demonstrate that the Extra Care strategy is not at odds with other strategies – for example, although it would be possible to build Extra Care in an area which is committed to increased spending on residential care, this would send out very mixed messages to older people and to local providers. Similarly, siting Extra Care in an area where, according to the Community Safety Survey, older people felt very unsafe, would be counterproductive.

Indicator 5. International, national and local aspirations for older people can be compared across documents in order to set the Extra Care strategy firmly within the overall care economy.

Indicator 6. If Extra Care is to be acceptable and appropriate to older people from all tenures, and also from minority groups, their views will have to be sought early so that they can help to shape the strategy. Commissioning partners will need to demonstrate that they have given thought, both to undertaking new consultation, and to using existing consultation mechanisms or completed research.

Indicator 7. Altering the way services are delivered for older people can become highly political. Members, especially those in whose ward changes are taking place, will need to be engaged with the process from the beginning, as will local communities and the media.
3.3 Tools and Approaches

Which Partners?

Partnering across agencies should promote a whole-systems approach to change. The idea of a whole systems service was outlined in the DH document *Building Capacity and Partnership in Care, an agreement between the statutory and the independent social care, health care and housing sectors* (October 2001). A whole systems approach means the inclusion of all related partners from the public and private sectors who are involved in the purchase of non-acute care services, including private and voluntary organisations, housing providers and others. Extra Care should sit under a whole system, strategic commissioning direction for older people’s services. The Change Agent Team has published a Good Practice Checklist on the topic of Commissioning and the Private Sector, available at [www.doh.gov/changeagentteam/CommindSectorchecklistFinal.doc](http://www.doh.gov/changeagentteam/CommindSectorchecklistFinal.doc)

The authors point out that:

- Two-thirds of the national social care workforce is in the private sector.
- 85% of residential and nursing home care is provided by the private sector.
- 60% of home care is provided by the private sector.

Whilst in some places the closure of residential and nursing homes has compromised current strategies for acute and long-term health and social care of older people, often the domiciliary care providers are frustrated that they have not been given the opportunity to be part of the solution. The Checklist asks a series of questions designed to help organisations to consider the partnership arrangements they have in place and whether they need to be reviewed or changed. The headings are as follows:

- Strategic Commissioning.
- Financial Business Planning and Support: Contracts.
- Liaison and meetings.
- Service Development.

Under each heading there is a series of questions and a commentary.

The Change Agent Team has set out the following likely partners for the various elements of Extra Care, in *Partners in new provision: Change Agent Team November 2003*.

- Providers and Housing Operators - Primarily housing associations, some charities, private sector, possibly local authorities.
- Financing - Housing association sector commercial lenders, Housing Corporation, ODPM, OGC /PFI network, various regeneration and rural funds.
- Care Provision - Housing associations, private sector or voluntary agencies, social services, health.
- Support services - LA housing, housing associations, charities, Private sector.
- Commissioning - Social services, LA housing, health, Supporting People, users.
Managing Partnerships

Suffolk County Council has produced a Partnership Evaluation Toolkit, to enable the evaluation and facilitate the development of all partnerships in Suffolk. The Evaluation Toolkit is the result of a Best Value Review of Partnership Working. The toolkit takes between one and three hours to complete, depending on whether it is completed as a group or separately. The document gives some useful pointers to good practice in partnership working. The toolkit is split into 4 sections, including a Self Assessment Inventory with 28 questions to complete, based on the following principles:

- Action Focus
- Efficiency
- Inclusivity
- Learning and Development
- Performance Management

Actions identified in the Self-Assessment inventory are then transferred to an Action Plan for short term /quick wins and medium /longer term improvements.

This is a useful tool, both for evaluating the success of a partnership, and also for identifying some of the key elements of a successful partnership. Examples include:

- Have available resources been matched against the partnerships plans?
- Does the partnership have effective support and administration arrangements?
- Does the partnership ensure that its membership reflects the purpose of the partnership?
- Does the partnership find out why members leave or fail to engage with the partnership, and learn lessons for the future?

The Suffolk Partnership Evaluation Toolkit can be found at www.suffolk.org.uk/documents/SuffolkPartnershipEvaluationToolkit

In partnership with the consultants Warwick Insight, the Health and Social Care Change Agent Team have produced a workbook which aims to help commissioning partners to commission non-acute services across health and social care systems, including the private sector, and offers checklists and guidance in developing partnerships across agencies. (A Catalyst for Change: Driving Change in the Strategic Commissioning of non-Acute Services for Older People: Jane Crampton, Simon Ricketts): available from the Change Agent web site at www.doh.gov.uk/changeagentteam.

A Master Class on New Strategic Working and Commissioning held by CURS (University of Birmingham) for the Change Agent Team, found that few partnerships were allowing themselves time to develop, or to consider how their direction of travel linked to overarching policy and strategic changes in the wider environment. For example, they were failing to make the links between, on the one hand, Local Strategic Partnerships and the regions, and on the other, older people’s strategies, community strategies, and Local Delivery Plans. It will be important to make these links explicit in preparing the Extra Care Strategy.

The Institute of Local Government Studies, in partnership with the Improvement and Development Agency (IdeA, www.idea.gov.uk) has produced a document called Joint
Reviews: Potential, Pitfalls and Pathways (2003). Six case studies are presented, with the aim of drawing from the stakeholders’ experience to understand key challenges in undertaking joint reviews. Some partnership issues emerge from this: for example

- Individuals have to be alert to potential tension between their loyalties to the partnership and to their own organisation.
- Clarity over shared and individual objectives is an essential basis for trust.
- There is a tension between the need to involve senior managers to give credibility and to get matters agreed, and the reality that senior officers often cannot sustain detailed participation.
- Involving front line staff is especially important when they will be fundamentally affected by the prospective changes.
- Smaller partners may only be able to be involved if they receive additional resources to enable them to release staff. It may be appropriate to resource the capacity of smaller stakeholders to take leading roles, for example where voluntary agencies are well placed to undertake user consultation.
- Models of leadership, co-ordination and administration need to be developed.
- Whatever the level of member involvement, council officers will need to ensure political support for any final proposal.
- Questions of accountability require consideration when the strategy moves towards implementation – whether democratic, legal, and/or performance accountability.

3.4 Conclusion

The strategy should show that key stakeholders have been identified, the extent of their involvement, and their formal commitment to participation. From these arrangements it would be expected that the partnership has developed a joint business plan for Extra Care housing which utilises the information from the strategy to offer:

- A set of common output objectives.
- A shared rationale behind those objectives.
- The ability to measure and monitor whether they are being achieved.
- The resource requirements necessary to fulfil them.
LOCAL MANAGEMENT OF SERVICES
4. **LOCAL MANAGEMENT OF SERVICES**

EACH AUTHORITY SHOULD HAVE DEFINED A MODEL FOR THE DAY TO DAY MANAGEMENT OF SHELTERED AND EXTRA CARE HOUSING.

4.1 **Briefing Notes**

This section, as the title suggests, focuses on how local schemes will be managed to deliver the desired objectives for that particular scheme. This may challenge previous assumptions about the management of the services that are to be used by those schemes, it may have an impact on eligibility criteria and will mean resolving issues around specialist versus generic communities. As explained below it may involve policy decisions about the positioning of this type of service in relation to other older people’s services. Overall, when making decisions about models of delivery, some key points should be borne in mind.

- Extra Care is housing first. It shouldn’t be an institution and should not look or feel like one.
- To achieve flexible care, management of care and support needs to take place close to the user.
- Staff providing support and care need to learn new skills if they are to promote independence and encourage citizenship.
- Assessment and allocation is a joint function which needs to facilitate scheme objectives such as achieving a balanced community with a positive approach to mental health.
- The scheme needs to be positioned as to whether it is on a continuum of care provision or offers a home for life.

**Ageing in place or a home for life.**

In the past, there was an expectation that accommodating older people meant moving from Part 1 to Part 2 to Part 3 accommodation providing that death did not intervene. This model offered a continuum of care in which people moved to increasingly institutionalised accommodation as frailty increased or mental health deteriorated. With each move, the amount of living space diminished. Part of the ethos of Extra Care is that individuals still require private space as they grow older, that space standards should not drop below a certain minimum (about 50 square metres), and that all should be enabled to occupy that space creatively regardless of condition.

Nevertheless, many professionals with responsibility for referring older people to services retain the assumptions of a continuum of care. On the one hand, medical professionals and in particular hospital doctors, and on the other hand housing wardens and scheme managers in OSH schemes, are often those who encourage people to seek admission to residential care – although research has shown that nearly half of all those in residential homes have low dependency.

Given an enabling and accessible environment, there is no reason why older people should keep moving home, or should be forced to accept ever-shrinking
accommodation. With the support of health and social care services Extra Care can offer a home for life, even to the extent that in some authorities, notably Wolverhampton, residential care is being phased out altogether. Therefore, in addition to developing Extra Care it is important that potential referrers to this and residential care are aware of what schemes can provide if appropriate tenants are to be recruited. On the other hand, there may be some older people who would trade space and independence in the expectation that they will be ‘looked after’ in residential care.

Some Extra Care villages provide a separate residential care building where people can move if they no longer wish to live independently. This tackles the problem of moving people away from their customary communities as they grow older, and in most communities people can elect to stay in their own properties if they wish. Obviously, there needs to be clear criteria to govern when occupiers should be cared for, for example, when the tenant needs nursing care beyond that offered by the community nurse. Nevertheless, occupiers will be able to invoke their rights of tenure if they very much wish to stay.

People from local BME communities should be involved in the design of all schemes.

The role of the Scheme Manager

One in depth study of Extra Care\(^7\) concludes that:

There are a number of different models for managing sheltered and Extra Care housing schemes, but in essence the key question is how much management of the care component should take place on site.

*The scheme manager as a housing manager*

- Manages the building.
- Manages cleaning staff and co-ordinates building related services.
- Liases with care and support or other service providers.
- May manage catering staff and handyman service.

*Arguments In favour of the scheme manager as a housing manager only* –

- Separation of accommodation and care is more congruent with community care principles.
- Commissioners are less likely to insist on registration.
- Separating support and care ensures that housing support services in the shape of low level preventative interventions are not lost.

*The scheme manager as housing and care manager*

- Is involved with staff from partner agencies in allocating places.
- Has line management responsibility for both care and support staff.
- Probably involved in deciding eligibility criteria for the scheme.
- Liases directly with social workers to increase or decrease care hours as appropriate.
- Is responsible for community building within the scheme.

*Arguments in favour of the scheme manager as responsible for the delivery of care and support.*

---

\(^7\) Oldman, C. Blurring the Boundaries: A fresh look at Housing and Care Provision for Older People.
• Avoids danger of demarcation disputes between care and support workers.
• Gives control of quality of care – ensures that the philosophy of independent living will be adhered to.
• Provides a seamless service.

Delivery of care and support within the scheme

The roles of care and tenancy support workers may be separate within the scheme, or the two roles may be combined in a single post.

Separate care and support worker roles
• Benefits from high levels of expertise within separate parent organisations.
• Risk of a more institutional feel if care is based on site.
• Easier to extend the partnership, for example to commercial interests and the wider environment.

Care and support roles combined in a single key worker post
• Better continuity of care for users.
• Easier to ensure that care is delivered at times appropriate for the users.
• Easier to manage contract compliance.
• More flexibility in increasing or decreasing care hours – step up step down approach.
• Scheme manager has direct responsibility for training and performance managing staff.

Managing care hours

• Scheme managers with responsibility for both support and care usually have a fixed number of support and care hours which they allocate across the scheme. These hours may be supplemented by the continued support of informal carers, an additional resource which is usually lost when people enter residential care.

• Research by providers suggests that care hours tend to rise on entry to the scheme, but by the end of a year they have usually dropped to a level which is slightly higher than they were receiving at home.

• A flexible approach to assessment, and good partnership working, help to promote a ‘step-up step-down’ approach to care – that is, care can be increased for short periods of time when needed, and reduced when the immediate difficulty is over. A preferred balance is one in which one third of occupants need few or no care hours, one third have medium care needs, and one third have high care needs.

• In many schemes, care and support workers deliver leisure activities either in their own time, or as part of the overall allocation of care and support hours. Neither of these is a good solution: it is important to designate and fund a specific number of hours for leisure activities. Often leisure activities are arranged by a social club run by occupiers. Leisure and social activities are an important part of Extra Care provision, but there is

---

no reason why occupiers should not be able to access the facilities available to other citizens, for example Sport for All funding, and funding available through local authority Leisure and Recreation departments.

Managing tenancy allocations and maintaining a balanced community within the scheme

Eligibility criteria
Criteria for entry to the scheme should be decided well before the opening of any scheme, and needs to be the result of discussion between all the commissioning partners. Most Extra Care schemes offer a home for life, and allocate places to people who will need considerable input from the PCT. It is important that the PCT and local GPs are involved in these discussions.

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

Applicants for Extra Care will usually be required to go on the housing register, and will be in housing need. In addition, applicants will usually have some care and support needs. Suffolk County Council stipulates a minimum of 4 hours care and support, with no maximum, which it finds enables a mixed community to be formed (see Tools and Approaches).

Older people with dementia
Given that they provide a home for life, Extra Care schemes are likely to have a proportion of occupiers with dementia which at the very least reflects the national prevalence. If these people entered the scheme before the onset of dementia, they are more likely to be accepted by the community, and will also find it easier to orientate themselves to their surroundings — already familiar — for longer. Most scheme managers seem able to cater for the needs of people with dementia provided that they are not prone to wandering and do not put other occupiers at risk. Where Extra Care schemes will continue to care for people with challenging behaviour, the strategy needs to consider how this can best be managed whilst retaining the ethos of Extra Care — requirements may include additional staffing, and more specific training for all staff.

Some schemes set aside part of the building for people with dementia, offering smart technology and distinctive design to help occupiers to find their way around. However, if occupiers are to be able to age in their own dwellings without having to move, then all Extra Care buildings should be designed to this standard.

All staff will need some training in the care and support of people with dementia, regardless of whether the scheme offers specialist care for this group.
Older people from black and minority ethnic groups

People from ethnic minorities are generally under-represented in Extra Care. Whilst the reasons for this are likely to be as diverse as the communities affected, some broad similarities apply. Many Asian families are owner-occupiers, so presumably experience the same lack of information about available choices as do white owner-occupiers. Moreover, owner-occupiers from BME groups may own property in run-down areas, making Extra Care leasehold provision unaffordable.

For ethnic minorities there is less likely to be a scheme reflecting their own communities in their immediate neighbourhood. For older people from all groups, both majority and minority, religious observance is often central to their lives, but for minority groups living in a setting designed for the majority such observance may be difficult to achieve.

In Leicester there are a number of sheltered housing schemes run by Black and Asian community groups which are over-subscribed and run waiting lists, although for general OSH there is an over-supply. Giving support to minority groups who wish to set up their own schemes may be a good way of meeting the needs of older people from ethnic minorities.

Workforce issues

There are a number of workforce issues which will effect recruitment, training and retention of staff for Extra Care. Many areas, particularly in the South East, have great difficulty both in recruiting and in housing care and support staff. Some Councils are including housing needs of support workers in their housing needs surveys. Others are using Section 106 agreements or PPG3 to build housing for essential workers. There is an increasing need for commissioning partners to be proactive in addressing these problems.

4.2 Key Elements and Indicators

Table 4

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Relevance of Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator 1. Are there clear local agreements about who commissions,</td>
<td>Indicator 1. Different models of Extra Care draw in local agencies in different</td>
</tr>
<tr>
<td>manages and monitors contracts and management arrangements?</td>
<td>configurations (see Background above). Choosing the model which best fits local</td>
</tr>
<tr>
<td></td>
<td>circumstances will be an early task in developing the strategy, and may involve</td>
</tr>
<tr>
<td></td>
<td>decisions to which both members and prospective users could make a useful</td>
</tr>
<tr>
<td></td>
<td>contribution. However, the principle is that decisions about service delivery should be</td>
</tr>
<tr>
<td></td>
<td>made as close to the user as possible.</td>
</tr>
<tr>
<td>Indicator 2. Can the commissioning partners demonstrate how they will</td>
<td>Indicator 2. One of the ways in which Extra Care is effective is by providing the</td>
</tr>
<tr>
<td>achieve regular reviews and alterations to care plans at short notice if</td>
<td>opportunity for a step-up step-down approach – not a steady increase in care</td>
</tr>
<tr>
<td>necessary?</td>
<td>hours over time, but hours tailored to the</td>
</tr>
<tr>
<td>Indicator 3.</td>
<td>Indicator 3. Is there a programme of staff training and development, which focuses on the unique role of Extra Care housing?</td>
</tr>
<tr>
<td>Indicator 4.</td>
<td>Indicator 4. Have tenants been offered a range of housing options prior to admission?</td>
</tr>
<tr>
<td>Indicator 5.</td>
<td>Indicator 5. Are there clear outcome objectives for each Extra Care scheme, and an admissions policy and eligibility criteria which reflect these?</td>
</tr>
</tbody>
</table>

needs of the user at a particular time, so that the user is always encouraged to be as independent as possible, with support. Therefore care hours need to be diminished or increased at very short notice, and unwieldy management arrangements, with decisions made at a distance from the user, will make this more difficult to achieve.

Indicator 3. It is always easier to do something for someone, than it is to enable them to do it for themselves. Without training, care staff will struggle to balance support and risk in order to promote independence. In addition, Extra Care schemes are communities, and training in community development, promoting citizenship, and relating to residents as individuals with a history, not simply as older people, will all require the exercise of new and different skills. Commissioning Partners will be required to demonstrate an awareness of training gaps, and to describe how they will be addressed.

Indicator 4. Some people want to be looked after in their older age. These are the people for whom residential care will continue to be an appropriate model. Potential users of Extra Care will need to know what the objectives of the model are, in order to understand whether it is a suitable option for them.

Indicator 5. Commissioning partners will need to state the objectives of the schemes, or to indicate how they will be derived, and to demonstrate that their admissions policy will help to achieve this. For example, to achieve a flourishing community, and also to be affordable, the scheme may need to attract and accept a proportion of relatively able older people not currently in need of care. A policy of (apparently) offering an expensive service to people who are not obviously in need will have to be explained and justified, and made absolutely clear in the guidelines for admission.
4.3 Tools and Approaches

Detailed discussion of models of delivery for Extra Care can be found in Blurring the Boundaries: a fresh look at housing and care provision for older people, written by Christine Oldman and published by Pavilion Press in the series Research into Practice (Joseph Rowntree Trust, 2000) This book gives a helpful review of the relevant literature, highlighting some of the current policy debates, and then gives an account of some of the Joseph Rowntree Extra Care schemes, including some user views.

The Royal Commission on Longer Term Care gives a number of examples of good practice in caring for older people. More recent initiatives are summarised on the Change Agent Team web site (see below).

In its Essential Short Facts series, (Fact Sheet 1, page 5, Who Staffs Extra Care) The Change Agent Team describes some of the different options for staffing. See www.doh.gov.uk/changeagentteam/housing-lin.htm.

Consulting service users from ethnic minorities

To achieve the objective of appropriate and acceptable services, which are managed close to the user, it will be important to involve users and potential users in developing the strategy. Some useful guidelines for consulting residents from BME communities are outlined below.

In May 2002 the then DTLR published Reflecting the Needs and Concerns of Black Minority Ethnic Communities in Supporting People, which gives advice on consultation methods, illustrated by good practice examples. The guidance lists a summary of the needs of BME older people, as follows:

- Growing numbers
- Changing family structures
- Poor service provision
- Poverty
- Need for mutual support
- Need for knowledgeable, sympathetic carers.

Salford City Council commissioned the Salford University Housing and Urban Studies Unit to produce a report entitled Moving Beyond One Size Fits All: Information, consultation and participation: involving BME groups in Supporting People (June 2003). This is particularly interesting because Salford was aware that they had a comparatively small BME population, so felt that an in-depth study was all the more important. This document can be found on the Supporting People website (www.spkweb.org.uk/files).

---

Workforce issues

The Changing Workforce Programme offers what is described as an Accelerated Development Programme for support workers in intermediate care. The goal of the programme is to improve service to patients and job satisfaction for staff by implementing new ways of working. Whilst this initiative comes mainly from health/social services rather than from a housing support perspective, there is much that is relevant to Extra Care workforce issues, including the principle that jobs should be designed around older people’s needs, not around agencies.

This is a new initiative, and the website offers the opportunity for dialogue amongst participants. Access is by password, and sites wishing to take part can email lists@taskcare.com.

Eligibility and Allocation Criteria

Suffolk County Council have produced a Guide to Very Sheltered Housing for Team Managers and Named Assessors which sets out clearly their policy for allocations and its role in maintaining a balanced community.

4.4 Conclusion

A key part of the strategy is being clear about local management arrangements for schemes. This needs to describe:

- Who will commission, manage and monitor contracts?
- How flexible care plans, which are responsive to day to day changes in care requirements, will be implemented?
- The current knowledge base of existing care staff and potential new recruits to the service.
- The specific training requirements of Extra Care housing staff.
- How the schemes(s) will be presented to the public and other professionals?
- The proposed admissions policy and eligibility criteria, and how these will help to deliver the stated objectives of the scheme.
Stage 5

FUNDING AND FINANCE
5. **FUNDING AND FINANCE**

AUTHORITIES SHOULD BE ABLE TO SHOW THEY THAT HAVE EXPLORED THE FULL RANGE OF REVENUE AND CAPITAL FUNDING POSSIBILITIES PARTICULARLY IN RELATION TO PARTNERSHIP WITH THE PRIVATE AND VOLUNTARY SECTORS.

5.1 **Briefing Notes**

**Types of scheme**

These may include:

- New, purpose built, stand alone schemes.
- New, purpose built with community resource or hubs.
- Remodelled sheltered housing – can do both above.
- Retirement village – also continuing care community.
- Co – housing.

**Size of schemes**

Schemes can vary in size, from very small numbers of units added on to other types of provision, to large retirement villages which draw on North American models blended with influences from Northern Europe, and for which 250 properties is the norm.

**Economies of scale**

Economies of scale operate in Extra Care, and are particularly significant when considering the provision of 24-hour care to small rural schemes, or schemes designed for specific ethnic groups with small local populations. Larger schemes of 40-60 flats or bungalows are able to take advantage of economies of scale, and also ensure a mix of abilities amongst occupants, which is essential to a balanced community. Smaller schemes can achieve economies by using the development as a place to locate other services for the wider community (see Fact sheet 1: *Essential Short Facts: Extra Care Housing* on the Housing LIN website).

**Developing schemes in rural areas**

It is likely that Extra Care schemes for rural areas will be located in villages and will provide only a small number of units. It would be possible to reduce management costs by having one scheme manager for a number of such schemes, even perhaps adopting a hub and spoke approach by basing peripatetic staff within a single larger scheme which is central to a number of smaller ones.

It may be important to consider how the location of schemes maps to local transport arrangements. Sometimes towns at a greater distance might be more accessible by friends and relatives because public transport is more frequent. On the other hand, it sometimes happens that villages located close to each other may have no public transport access from one community to another.
**Twenty four hour care**

One reason that older people leave their own homes for some other form of provision is because they or their relatives feel that they are at risk at night. Therefore, 24-hour care is an important component of Extra Care provision. However, it is potentially an expensive component, and one provider has estimated that a minimum of 40 units is required to make 24 hour cover financially viable.

Where a very small scheme is necessary to meet the needs of small rural or minority communities, other solutions are possible. One possible solution is to provide sleeping night cover only, but the member of staff on duty has access to an emergency warden scheme, which provides night cover for the local area and can offer immediate support. Another possible solution in the case of a number of small locally based rural schemes is to provide an emergency service, accessed via a community alarm system, which covers a number of schemes. Clearly travel distances would to be such that staff can reach all schemes reasonably quickly.

**Balance of dependency**

It will be harder to maintain a balance of dependency in smaller schemes. However, by opening the scheme facilities to older people from the wider community, a more vibrant atmosphere can be maintained.

**Remodelling versus rebuild**

A key decision for commissioning partners will be whether to redesign existing OSH or to build from new. Understanding which schemes are outdated, not fully accessible, or unpopular, will help to determine the potential for siting Extra Care schemes in existing OSH, or alternatively redesignating unpopular schemes and possibly selling the land to raise capital. Some housing providers will already have done asset management exercises for their sheltered housing stock as part of the preparation for Supporting People or following Best Value reviews or in preparation for transferring stock to housing associations. These reports will be very useful to Commissioning Partners. Remodelling need not involve the whole scheme, but could mean a small number of fully accessible Extra Care units on the site. However, it is important to remember that remodelling does not just involve changes to buildings: it will also require the re-skilling of staff.

A number of sources of information need to be brought together from the supply side in order to make decisions, eg,

- Where OSH schemes are proving hard to let, providers may have opened the scheme to younger people or taken other steps to let unpopular properties.
- If the scheme is badly sited, then expensive building work will not solve the problem.
- OSH which is in the wrong location for an Extra Care scheme may well be suitable for redesignation for some other use – thus generating capital.
- If the indications are that an existing scheme can be remodelled, authorities should undertake detailed costings to establish whether demolishing the existing building might be a cheaper option.
Other costs

It will be important to include all costs that are reflected in decision making, including for example the costs of decanting residents when OSH schemes are refurbished, and the potential cost of running services in parallel whilst developing the programme.

Type of tenure

Whilst some commissioning partnerships may make the assumption that Extra Care is wholly for the social rented sector, this should not be the case. A mixed economy that reflects the balance of tenure within the community, offering equity stakes affordable to local owner-occupiers, brings extra capital into the scheme. When older people sell their main home with a view to buying something more accessible, Extra Care should be a high profile option.

Commissioning partners will need some knowledge of local housing stock condition and tenure mix. Where house values are generally high, owner-occupiers will have no difficulty in purchasing dwellings within the proposed scheme: however they may have less incentive to move house. In areas of poor housing stock and depressed house prices, owner-occupiers may both have more wish to move and more difficulty in affording to buy within Extra Care. In this case shared equity stakes may be appropriate.

5.2 Key Elements and Indicators

Table 5

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Relevance of Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indicator 1.</strong> Authorities should have completed a financial appraisal of current OSH including:</td>
<td><strong>Indicator 1.</strong> This will show the likely costs of refurbishing existing hard to let schemes to Extra Care standards, or alternatively, if the location is wrong, for selling them for redevelopment.</td>
</tr>
<tr>
<td>1. Value of stock, including land value.</td>
<td></td>
</tr>
<tr>
<td>3. Costs of making current premises accessible to the standard the authority requires.</td>
<td></td>
</tr>
<tr>
<td><strong>Indicator 2.</strong> Authorities will be able to show they have undertaken analysis and costings of a balanced range of provision including:</td>
<td><strong>Indicator 2.</strong> This will show that Commissioning Partners have considered economies of scale relating to different sized schemes, and are able to make an informed choice based on an understanding of local characteristics and communities.</td>
</tr>
<tr>
<td>• Very small developments of 6 apartments or bungalows.</td>
<td></td>
</tr>
<tr>
<td>• Medium sized developments of 40-50 units.</td>
<td></td>
</tr>
<tr>
<td>• Larger developments with up to 60 flats or a mix of flats or bungalows.</td>
<td></td>
</tr>
<tr>
<td>• Extra Care Villages or Housing and Care Communities.</td>
<td></td>
</tr>
</tbody>
</table>
Indicator 3. Commissioning Partners should indicate their proposed sources of capital finance, which might include:-

- Housing association sector commercial lenders
- Housing Corporation
- ODPM
- A Private Finance Initiative
- Corporate/Charitable Funding
- A Public Private Partnership
- Regeneration or rural funds
- User equity stakes
- Available land – either suitable sites owned by the local authority or health service,
- Or opportunities for redevelopment of ordinary sheltered housing.

Indicator 4. Authorities must demonstrate that they have explored a range of revenue routes for their proposals. They should explore:

- Ways in which locating other types of provision within Extra Care developments (including Intermediate Care beds, day centre provision for people from the local community, provision for people with dementia, community facilities such as nurseries shops, etc), might broaden the possible sources of funding.
- Different forms of tenure available within single schemes, which may provide for private purchase or lease schemes.
- The role of housing benefit, Supporting People funding, Community Care funding and other sources of funding in helping to make Extra Care affordable to tenants and lessees. Will current levels of housing benefit cover rents? What will be the impact of rent restructuring.

Indicator 5. What will be the revenue commitments for repayment of capital loans?

Indicators 3 and 4. These indicators will demonstrate that Commissioning Partners know where capital and revenue funding will come from for the scheme, and how both housing and care will be made affordable for tenants and lessees. They should also show projected income from rents or equity sale.

Indicator 5. This will show the impact of repayment of loans on future budgeting.
5.3 TOOLS AND APPROACHES

Costing proposals

Costings for remodelled and new build Extra Care schemes were presented to the Housing LIN in June 2003 by Peter Fletcher and Moira Riseborough (Centre for Urban and Regional Studies, University of Birmingham) and are available via the Housing Change Agent web site at www.doh.gov.uk/changeagentteam/commissioning-extra-care.pdf

On potential costs for remodelling existing schemes, the presentation concludes that:

- Costs are dependent on the buildings/site and vary enormously.
- Re-housing costs and void losses during this period have to be accounted for.
- Timescales can be extensive.
- Design and specification compromises are inevitable.
- But – many do work – excellent examples from Housing 21.

Extra Care Housing for Older People: A model for Commissioners, www.doh.gov.uk/changeagentteam/commissioners03.pdf provides examples of costed proposals (p29-30). In particular it explores the schemes of payment initially described by Sturge (2000) for the Hartrigg Oaks scheme, which amongst other forms of payment involves a one–off refundable sum paid on departure or death.

The Chartered Institute of Housing has produced a document called A Stake Worth Having? The potential for equity stakes in social housing (CIH/IPPR 2002). Whilst their case studies are not applicable to Extra Care, they do outline some general principles, as follows:

- Equity stakes must be easy to understand and not too complicated to administer.
- In using equity stakes, care must be taken not to reinforce existing inequalities – either between areas with high capital values and excess demand and areas with low demand/low value, or between those who receive housing benefit and those who do not.

Maintaining the balance of dependency in smaller schemes

One smaller scheme that has addressed the problem of maintaining the balance of dependency is Baron’s Meadow/Esmond House, Orford, Suffolk. Partnership with the local community is key.

Elements include:

- Rural partnership scheme – HA, County, District and local community.
- 6 bungalows for frail older people.
- Day centre for 15 people from local parishes.
- Mini bus provided/funded by local charity.
- Flexible staff for home care and day care.
- Local people closely involved in concept and as a local resource.
Tenure

Some different types of tenure are listed below:

- **Social Rent**: Schemes that provide permanent housing for rent from Housing Associations, funded partly from grant or other public subsidy and partly from private loans.
- **Open Market Sale**: Leasehold, with covenants restricting age of owner/occupiers.
- **Shared Ownership**: A home-ownership scheme designed to help people who wish to buy a home of their own. It allows people to buy a share of a property and pay a rent on the remainder, although for older peoples’ housing, no rent is payable on the last 25%. An element of the Total Scheme Cost is provided by public subsidy and the balance is raised from a private loan.
- **Market Rent**: The market rent is paid by tenants. Similar restrictive covenants regarding age of occupants.
- **Intermediate Care**: A term used to describe a range of short term rehabilitative services for people leaving hospital, and for people who are at risk of hospital admission. It acts as a bridge between a variety of care settings, including hospitals, residential and nursing homes, very sheltered, and people’s own homes. Intermediate care usually involves a short programme of support with input from social services and health professionals. Government defines an intermediate care episode as typically lasting no more than six weeks.
- **Co-housing**: Co-housing communities of older people have developed in the Netherlands, Denmark and to some extent in Germany. An important condition for membership is a commitment to mutual support within the group – defined as everyday neighbourly assistance rather than as a replacement for professional care services. In the Netherlands, Co-housing communities may be helped with planning permission and sometimes with cheaper land or redundant buildings. The Older Women’s Co Housing Project (OWCH) is a pilot project based in London: information can be found at www.cohousing.co.uk/owch.htm

**Private Finance Initiatives (PFIs):**

The Easy Guide to Delivering Decent Homes (Ian Harries, Housemark, 2002) has a useful section on PFIs. This document can be found at www.idea-knowledge.gov.uk.

Typically, a PFI involves the Council entering into a long-term (25-30 years) service contract with a private sector provider. The Council defines the standards and outcomes it wants, and could, for example, retain nomination rights.

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

The author of the Housemark document acknowledges that PFI has proved complicated. Some Authorities have been put off by expensive legal and contractual issues. Moreover, an Extra Care scheme would take up 75% of PFI credits for the
next three years. Will the Commissioning Partnership agree to long term contracts if PFI based funding demands it?

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

Nevertheless, there are examples of successful PFI s for Extra Care. For example Kent County Council and its partners the Primary Care Trusts will provide specialist residential, recuperative and rehabilitative care to people at two new Social and Health Care Centres in Tenterden and Margate. A consortium called Integrated Care Solutions, led by the company Costain has been selected to design, build, finance and operate the centres, which are designed to help older people in the transition between leaving hospital and returning home. Information is available from www.kent.gov.uk.

**Housing Corporation Funding**

The Housing Corporation is a non-departmental Government body, which funds and regulates Housing Associations. In the past 12 months there have been a number of changes to Housing Corporation grants, including the abolition of Local Authority Social Housing Grant and the transfer of the Corporation’s Supported Housing Management Grant to the Local Authority’s Supporting People pot. The updated Housing Corporation Capital Funding Guide (2004) can be found on the Housing Corporation website at www.housingcorp.gov.uk/resources/cfg.htm.

Housing Associations can bid for funds from the Regional Housing Bodies (administered through the Housing Corporation). Bids have to be endorsed by the Local Authority, must demonstrate value for money, and should be demonstrably in line with the Regional Housing Body’s strategic objectives. Additional funds can be secured through private borrowing, and bids are more likely to be successful in cases where the Local Authority has demonstrated its commitment by contributing funds.

**Department of Health Funding**

The Department of Health has committed £87m over two years to the development of Extra Care.

**Local Authorities**

Local Authorities can invest their own capital from borrowing, capital receipts from sale of land and buildings, and commuted sums from planning agreements on affordable housing, including Extra Care. In some cases there may be an opportunity to secure the development of new Extra Care schemes as part of the negotiations for transferring the Council’s housing stock to a Housing Association.
Supporting People Grant and Registration under the Care Standards Act

Many providers of Extra Care expect that the Supporting People grant will help to make schemes affordable to tenants and lease holders on low incomes by contributing to the costs of support. The main aim of the Supporting People grant is the promotion of independence through non-intensive, housing-related support in the community. However, there is concern that some schemes will have to be registered under the Care Standards Act, and residents of registered establishments are not eligible to receive Supporting People grant.

However, the Department of Health has issued Guidance on Regulation of Supported Housing and Care Homes, (August 2002), which states that: “As a matter of policy, the Department does not envisage good practice extra care housing …being registered as care homes. Provision of personal care within these schemes would usually be expected to lead to registration as a domiciliary care agency”.

The guidance is very clear that a person receiving domiciliary care, as opposed to a fully integrated package of accommodation and care will have a high degree of autonomy in relation to their accommodation – ie will enjoy secure tenancies. Whether or not an individual enjoys security of tenure is a matter of fact, but could be tested by asking whether that individual would have the right to deny access to care workers and still remain in the property. In the case of most Extra Care schemes they would have that right, as most tenants and leaseholders of Extra Care schemes, unlike those living in residential care, enjoy security of tenure.

The guidance also discusses the case of people living in supported housing which is shared accommodation, for example group homes occupied by people with learning disability or mental ill health. Whilst it is legally possible to have an assured joint tenancy in shared housing, the guidance suggests that the case for and against regulation will be less clear cut when discussing shared accommodation for service users with highly intensive care needs. Some organisations provide both registered and non-registered units in the same scheme, eg Red Lodge in York

The guidance lists 4 main types of care, which are:

- Assistance with bodily functions such as feeding, bathing and toileting.

- Care which falls just short of assistance with bodily functions, but still involving physical and intimate touching, including activities such as helping a person get out of a bath and helping them to get dressed.

- Non-physical care, such as advice, encouragement and supervision relating to the foregoing, such as prompting a person to take a bath and supervising them during this activity.

- Emotional and psychological support, including the promotion of social functioning, behaviour management, and assistance with cognitive functions. Registration as a care home is only triggered where the most intensive kind of personal care (1st bullet) is available.
The Guidance states that:

*Non-physical care, emotional and psychological support do not of themselves trigger a requirement for registration with the National Care Standards Commission. Such care and support may be provided by various agencies according to the context and the persons’ overall needs. This may be part of housing-related support, funded through Supporting People.*

Some users will be required to pay for Supporting People services, which are set out in the October Administrative Guidance on the Supporting People Knowledge Web (www.spkweb.org.uk). There will be:

- Free support services for all those currently receiving Housing Benefit or income support.
- Free services for all those receiving a service, which is intended to be temporary.
- People with long-term support will be means-tested, but there will be a single means test for Home Care and Supporting People services.

Some schemes provide support and care in a single, dual funded post. One well-established Extra Care Scheme in Worcestershire, which consists of 35 one-bedroom flats and 19 bungalows, is jointly funded by Social Services and Housing to offer 143 hours care and 160 hours support, or nine-tenths care to support hours. This ratio has been found to work well, with high volumes of care being delivered in the mornings between 7am and 10.30 am, and again in the evenings. Examples of the distinction between support and care activities are shown in Fig 3 below.

### Fig 3

<table>
<thead>
<tr>
<th>Type of help</th>
<th>Support</th>
<th>Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morning visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Help with getting up, washing, toileting</td>
<td></td>
<td>*</td>
</tr>
<tr>
<td>Liaising with health professionals</td>
<td></td>
<td>*</td>
</tr>
<tr>
<td>Help tenants to prepare breakfast</td>
<td></td>
<td>*</td>
</tr>
<tr>
<td>Assisted bath</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Remind to take medication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Encourage/leisure activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assist to restaurant on a daily basis</td>
<td></td>
<td>*</td>
</tr>
<tr>
<td>Assist to restaurant from time to time</td>
<td></td>
<td>*</td>
</tr>
<tr>
<td>Emotional and psychological support</td>
<td></td>
<td>*</td>
</tr>
</tbody>
</table>

5.4 **Conclusion**

The strategy needs to show that local partnerships are thinking about the full range of possible funding routes. This means not only Local Authority sources of funding but funding routes that embrace the voluntary and independent sectors and take account
of the equity that older people may wish to use to help fund their accommodation and/or care. Some schemes may also be developed alongside other community facilities, eg, Post Office, GP surgeries, nurseries. Partnerships also need to show that they have

- Demonstrated the best ways to utilise existing stock, either to retain, refurbish or sell.
- Outlined proposals for scheme sizes which take account both of needs of local communities and opportunities for economies of scale.
- Identified proposed sources of revenue and capital funding, with a particular emphasis on prospective partnerships with the private and voluntary sectors.
- Put in place a process for identifying suitable sites.
- Summarised likely costs of buildings per cubic metre, and of different models of care and support.
- Reviewed opportunities for provision of other services on site, such as Intermediate Care, Day Care, and leisure activities.
- In partnership with local people, reviewed opportunities for utilising the scheme as a local resource for older people.
QUALITY AND OUTCOME MEASURES
6. QUALITY AND OUTCOME MEASURES

EACH AUTHORITY WILL HAVE A PLAN FOR MONITORING THAT SCHEMES ARE MEETING THE PARTNERSHIP OBJECTIVES OUTLINED IN SECTION 3, AND AN APPROACH TO MONITORING QUALITY OF LIFE FACTORS THAT ACTIVELY INVOLVES TENANTS AND THEIR CARERS.

6.1 Briefing Notes

What constitutes success in Extra Care?

Section 3 describes the development of a partnership business plan as a logical extension of the overall strategy document. The strategy should outline the outcomes to be delivered, the rationale and research that underpins those outcomes and some of the outputs that will deliver the outcomes. The business plan then defines those outputs in more detail, the role that each partner organisation will play and develops an action plan to ensure the outputs are delivered.

Implicit within the business plan is the ability to measure the success of schemes and that they are delivering the outputs that were initially intended. Measurement will need to include a mix of both qualitative and quantitative measures. Agreeing measures are likely to involve discussions with users and stakeholders and different stakeholders will have different views of what constitutes a good outcome. For example:

- For an older person, it might be about living independently, whilst knowing that help and companionship are readily available.
- For a PCT, it might be about the opportunity to place people no longer in need of medical care straight into a non-institutional environment designed to promote independence.
- For a carer, it might be about continuing to care for a relative without having to worry about building repairs or their relative being alone at night.

What measurable outcomes could be used to develop performance indicators?

User aspirations should be fundamental in shaping the development of Extra Care, and success should be measured at least partly against user satisfaction. Although Extra Care has evolved more as a response to demographic change and national policy requirements than because it has been shaped by older people, questionnaires to tenants have repeatedly found high levels of satisfaction with this form of provision. Users value the concept of their own front door, and of progressive privacy – that is, security in the public spaces and privacy in their own. The availability of low level preventative care, or 'help' as older people put it more simply, contributes towards the sort of enabling environment described by the Supporting People Administrative Guidance (see page 52 below).

It is crucial to involve older people in the design and delivery of the services they use. However, this needs to be done in a way that makes all participants feel that their contribution is valued, and contributors need prompt feedback on the content and result of discussions if they are to remain engaged with the process. Consultation needs to be done in good faith, and it needs to be seen to be so.
A report based on research amongst older people from ethnic minority groups. (Housing Options for Ethnic Elders, SAMEC Trust /Hanover Housing Group) has challenged some of the assumptions that mainstream service providers may have about minority groups. They found that

- The provision of support within extended families is not necessarily what older people want, especially if younger family members are at work all day.
- The stigma that arises from appearing to neglect the duty to afford care to older family members may inhibit those older people from uptake of services.
- There are cultural variations in the openness to alternative housing and care options. The extended family plays an important role, but gradually religious and community groups are stepping in to help.

Standards for Extra Care

A number of standards are available for assessing both building quality and the care agencies involved in Extra Care. Domiciliary Care Agencies will be registered under the Care Standards Act and will conform to those requirements. However, standards need to be developed to measure the success of schemes in:

- Balancing risk with intervention, so that people have the support to do the things they want to without being put in danger.
- Keeping people out of institutional care for longer, enabling people to make choices and express their aspirations, and giving them control over their own space, even to the extent of enabling them to die there if they wish.
- Enabling older people to remain engaged with their own communities and families and with the Extra Care community, rather than becoming dependent on paid carers for their social contacts.
- Enabling people from all ethnic groups to grow old in the context of their own culture, where they can continue to practice their own beliefs and keep their own customs in the company of people who share them.
- Facilitating hospital discharge, the provision of Intermediate Care, and the prevention of unplanned hospital admissions.

Some Suggested Outcome Measures

Some suggested outcome measures are listed below. These are suggestions only and not prescriptive, but they do demonstrate how outcome measures need to be linked with those outcomes that are seen to define a successful scheme. It would be important to involve potential users, partners, and staff (or occupants) who will have to collect the data before finalising the list.

A. Balancing risk with interventions

- Measures describing staff training, NVQ levels, practice or training links between ECH staff and Intermediate Care and Rapid Response Teams.
- Numbers of occupiers accessing the wider community, by dependency level or by age (could be leisure activities, trips, shopping etc).
- Number of people with dementia (note severity) or other cognitive problems supported in the Extra Care community.
B. Keeping people out of institutional care for longer
• Proportion of all those who die at home or after a brief hospital stay, per year.
• Proportion who are enabled to prepare their own breakfast or evening meal, by age (as opposed to having it done for them by home care staff).

C. Enabling older people to engage with their own communities
• Provision and uptake of leisure facilities within the scheme.
• No of trips /places per year.
• No of overnight guests per occupier per year.
• Estimated total support from informal carers.
• Numbers involved in tenants' forum /social club / focus groups / other citizenship activity.

D. Accessible buildings
• Conformity with standards for accessibility in building.
• Use of smart technology.

E. Catering for the needs of people from BME
• Proportion of occupiers from BME.
• Profile of occupiers' religion matched with local profile from census, by age.
• Range of religious observances accessible to occupiers.
• Number of staff with whom occupiers can speak their own language.

F. Meeting local targets for hospital discharge, Intermediate Care, and preventing unplanned hospital admissions.
• Baseline: number and proportion of older patients unable to be discharged from hospital for housing-related reasons, before and after the setting up of Extra Care.
• Unplanned hospital admissions as a proportion of all admissions for older people, before and after the setting up of Extra Care.
• Number of Intermediate Care beds delivered through Extra Care.
• Measures linked to falls prevention or quick response to alarm calls – eg number of pendant alarms issued and used.

6.2 Key Elements and Indicators

Table 6

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Relevance of Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indicator 1.</strong> Is there a process for monitoring each scheme against the outcome objectives defined in the partnership plan?</td>
<td><strong>Indicator 1.</strong> There should be a clearly stated progression from the aspirations outlined in the vision statement for the strategy, to the service objectives, and, for each objective, the expected outcomes. These outcomes must be measurable, either in terms of numbers or through feedback from users and other stakeholders, and methods of measuring should be defined from the outset. Commissioning partners will need to</td>
</tr>
</tbody>
</table>
**Indicator 2.** Is there an agreed process for monitoring the volume and quality of outputs delivered, and does this match the expectations defined in sections 2 and 4?

**Indicator 3.** Have the commissioning partners developed clear quality of life indicators for each scheme?

**Indicator 4.** Are there mechanisms in place for actively involving tenants and their carers in monitoring quality of service offered?

demonstrate the logic of this progression in their strategy.

**Indicator 2.** Systems for data capture need to be set up and agreed between partners, also from the outset.

**Indicator 3.** Quality of life indicators will be derived from a knowledge of existing good practice in Extra Care, and conversations with potential users prior to the setting up of the service. Knowing what these quality of life indicators should be for the local target population will help to shape the decisions outlined in Section 4.

**Indicator 4.** Throughout this document we have stressed the importance of citizenship and user involvement. Relying solely on numerical targets for monitoring the success of the service may result in users becoming marginalized and alienated from decision making, and the gradual loss of the defining elements of Extra Care.

---

### 6.3 Tools and Approaches

#### A model of success in Extra Care

Section 3B(16) of the Supporting People Administrative Guidance relates to service reviews for sheltered housing, and is helpful in setting out a vision for the ‘home for life’ model of sheltered housing (See Background section above). The review tool is designed to support the review of individual sheltered schemes as part of the Supporting People Support Service Review process. The review tool will create a mechanism for working with providers to improve services.

The review tool offers a service delivery model which develops the idea of a continuum from dangerous services to stifling ones, and allows SP review teams to plot the position of existing services on a quadrant (see figure below). In terms of Extra Care, one would want all services to be listed in the ‘Enabling’ square of the quadrant. One might think that representing Residential Care and Nursing Home Care as stifling is unnecessarily pejorative, as both will continue to have an important role in overall service provision. However, for those still able to exercise Private living skills they are probably not the right solution.
The strategic questions that then arise are:

1. What are the estimates of the proportion of local services in each quadrant?
2. How can services be reshaped, re-engineered or decommissioned in order to move towards enabling at a strategic level?
3. To what extent do current and future service plans lead toward promoting the enabling quadrant?
4. How is the enabling service model and philosophy reflected in joint strategies and plans?

**Commissioning for quality**

Riseborough and Fletcher (2003) outline the ideal strategic commissioning model as follows:

- An approach and dynamic process that leads to change.
- NOT a mechanistic and static model of purchasing services and contracting.

---

10 From Supporting People Administrative Guidance
• Intelligent: based upon knowledge and built around outcomes for the population.

They link suggested vision statements with outcome aims as follows:

**Fig 5**

<table>
<thead>
<tr>
<th>Vision examples</th>
<th>Outcome aims examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Tackle health and service inequalities and direct resources to meet need</td>
<td>• Improve health and well-being of population</td>
</tr>
<tr>
<td>• Involve communities in decision making</td>
<td>• Improve access to services</td>
</tr>
<tr>
<td>• Promote the power of partnerships and solving problems together</td>
<td>• Locally provided</td>
</tr>
<tr>
<td></td>
<td>• Improve citizens experience’</td>
</tr>
<tr>
<td></td>
<td>• Quality providers</td>
</tr>
</tbody>
</table>


**Buildings**

The Housing Corporation produce a useful list of references and descriptions of good practice in their *Innovation and Good Practice guide* (Section 6 is on housing for older people) at [www.housingcorp.org.uk](http://www.housingcorp.org.uk).

*The goal of flexible, accessible housing*

One premise of the politics of disablement is that we are disabled by the buildings that deny us entry. Increasingly, there is a recognition that all housing needs to be flexible enough to cater for small children, older people, and people who become temporarily or permanently disabled during their lifetime. In the future, the presence of accessible mainstream housing should reduce the need to move people into specialist provision simply because they are no longer able to access their bedroom or bathroom. Good design principles which are relevant to accessibility in mainstream housing may also be relevant in OSH and Extra Care schemes, and vice versa.


*Housing Corporation Scheme Development Standards*

The Housing Corporation scheme development standards (found at [www.housingcorplibrary.org.uk](http://www.housingcorplibrary.org.uk)) require that Housing Associations should produce appropriate good quality housing to meet identified needs.

The Housing Corporation will assess achievement against the following standards:

• External environment
• Internal environment
• Accessibility
• Safety and security
• Energy efficiency, environmental sustainability and noise abatement
• Maintainability, durability and adaptability
**Lifetime Homes**
The Joseph Rowntree Foundation, already concerned about the inaccessible nature of much of British housing, developed through the Lifetime Homes concept sixteen design features that ensure a new house or flat will meet the needs of most households, from the very young to the very old or those in wheelchairs. Information on Lifetime Homes can be found at [www.jrf.org.uk](http://www.jrf.org.uk).

Considerable financial savings are anticipated in the long term as a result of the Lifetime Homes concept, because of reduced expenditure on adaptations and reduced need to move people to residential care, or other provision. There would be further savings in health care and re-housing costs.

**Secured by Design**
Secured by design ([www.securedbydesign.com](http://www.securedbydesign.com)) is a UK Police initiative to encourage the building industry to design out crime by adopting design principles which make for good visibility, safety on the ground floor, and other more locally relevant features, with a link to advice from local police forces. Research by Huddersfield University shows that residents living on Secured by Design developments are half as likely to be burgled, two and a half times less likely to suffer vehicle crime and suffer 25% less criminal damage, and reference to the principles it supports will be particularly important when designing housing for older people.

**Design principles specific to Extra Care schemes**
Both Hanover Housing and Housing 21 have published design principles specifically for Extra Care schemes:
- Housing 21 1997: Remodelling Sheltered Housing
- Hanover Housing 1997: Homes for the third age

**Designing for Dementia**
Publications relating to good practice in designing for people with dementia are listed in the Housing Corporation Innovation and Good Practice database, which can be found at [www.housingcorp.gov.uk](http://www.housingcorp.gov.uk) under resources.

**Smart Homes**
Older people with cognitive problems can be offered technological solutions to problems, which undermine their independence. These can range from monitoring that cookers are not left on, to monitoring of occupants, such as daily routine reminders and falls monitoring. Homes containing this technology are now called Smart Homes.

The Housing LIN have posted a document called “Smart Home, a Definition”, which gives the results of a research project carried out by Intertek for the Department of Trade and Industry, DTI Smart Homes Project. This offers a clear definition of a Smart Home with all its attributes, and can be found at [www.doh.gov.uk/changeagentteam/smarthome.pdf](http://www.doh.gov.uk/changeagentteam/smarthome.pdf).

**6.4 Conclusion**
With the growth of planning in local authorities it is easy for documents to leap from objectives to action plans. This tends to ignore establishing processes for measuring if schemes are meeting the outcome objectives that were intended when initially developed. In this instance it is important that within the strategy:

- There are clear measures linked to objectives, which will tell partners whether they are delivering the results that were intended.
• An agreed process for monitoring.
• A good balance between quantitative and qualitative measures.
• A structure for consulting about desired outcomes and outputs with tenants, potential tenants the wider community of older people, relatives and carers, both individually and through organisations.
PULLING THE STRATEGY TOGETHER
7. PULLING THE STRATEGY TOGETHER

This section brings together and repeats the conclusions from the six stages that local authorities should follow to help develop a good quality strategy for extra care housing.

7.1 EACH AUTHORITY SHOULD DEMONSTRATE A GOOD UNDERSTANDING OF THEIR CURRENT DEMOGRAPHICS, AND BE ABLE TO IDENTIFY THOSE PEOPLE FOR WHOM EXTRA CARE MAY BE APPROPRIATE.

This first part of the strategy should show that the authority has a good grasp of the match between relevant demographic characteristics of their total population, the potential population for Extra Care housing, and those who currently receive services for whom Extra Care may have been or still could be an alternative and appropriate form of provision. This should lead to identifying a target population now and in the future. Such a population may incorporate minimum and maximum numbers for different potential types of provision with distinctions between different elements of the population. Other key elements to explore may be potential hidden populations within owner-occupiers who may currently move straight to residential care and those currently self-funding within residential care who could potentially transfer to extra care housing when the Local Authority assumes funding responsibility.

In addition the strategy may also:

5. Identify potential estimated numbers by ethnic group and the impact this may have on future housing choice.

6. Numbers of people where Extra Care resources may be relevant to intermediate care and hospital discharge.

7. Identify populations by potential problem, eg, dementia or other mental health conditions.

8. Describe current tenant pathways through sheltered housing.

7.2 EACH AUTHORITY SHOULD SHOW THAT THEY CAN PROVIDE AN EFFECTIVE MAP OF PROVISION. THIS MEANS NOT JUST LISTING STOCK BUT BEING ABLE TO ANALYSE THE VALUE AND USE OF THAT STOCK/SERVICE, ASSESS ITS CAPACITY AND CAPABILITIES, AND IDENTIFY EXISTING AND FUTURE PLANS FOR DEVELOPMENT

On the stock side the strategy should address the appropriateness of current sheltered housing provision. That assessment should cover voids, location, value, and adaptability where necessary and the relevant costs of updating as compared to new build? In terms of services then this needs to cover the full range of health, social care and community facilities. Particular activities that follow from this include:

- Give a summary of the number and characteristics of ordinary sheltered housing units and relate this to current demand, local populations and national indicators to describe how future plans for Extra Care will fit with current OSH provision. This should include identifying possible sites for Extra Care, including any existing OSH schemes which are in a suitable location.
• Give an accurate appraisal of current community service range and capacity, what is missing and the rationale behind any new requirements. Describe how existing community care services would need to adapt to support people in Extra Care, including any local workforce issues and how they would be addressed.

• Undertaking consultation in order to understand the preference of local older people and their families for different types of housing and support, and location of provision.

• The end point of the two mapping activities should be a clear statement that defines the minimum and maximum numbers within the population that might be considered for Extra Care housing now and in the future, their defining characteristics, the type of provision available and to be developed and desired location. Service availability current and planned should then run alongside the potential schemes.

7.3 THERE SHOULD BE A CLEAR BUSINESS PLAN FOR CO-ORDINATING PARTNERSHIP ARRANGEMENTS BETWEEN AGENCIES. THIS DOCUMENT SHOULD COVER PLANNING AND DEVELOPMENT, IMPLEMENTATION AND OUTCOME MONITORING. IT SHOULD BE DETAILED ENOUGH TO ENCOMPASS RESOURCE COMMITMENTS FROM PARTICIPATING AGENCIES.

The strategy should show that key stakeholders have been identified, the extent of their involvement, and their formal commitment to participation. From these arrangements it would be expected that the partnership has developed a joint business plan for Extra Care housing which utilises the information from the strategy to offer:

• A set of common output objectives.
• A shared rationale behind those objectives.
• The ability to measure and monitor whether they are being achieved.
• The resource requirements necessary to fulfil them.

7.4 EACH AUTHORITY SHOULD HAVE DEFINED A MODEL FOR THE DAY TO DAY MANAGEMENT OF SHELTERED AND EXTRA CARE HOUSING.

A key part of the strategy is being clear about local management arrangements for schemes. This needs to describe:

• Who will commission, manage and monitor contracts?
• How flexible care plans, which are responsive to day to day changes in care requirements, will be implemented?
• The current knowledge base of existing care staff and potential new recruits to the service.
• The specific training requirements of Extra Care housing staff.
• How the schemes(s) will be presented to the public and other professionals?
• The proposed admissions policy and eligibility criteria, and how these will help to deliver the stated objectives of the scheme.

7.5 AUTHORITIES SHOULD BE ABLE TO SHOW THEY THAT HAVE EXPLORED THE FULL RANGE OF REVENUE AND CAPITAL FUNDING POSSIBILITIES
PARTICULARLY IN RELATION TO PARTNERSHIP WITH THE PRIVATE AND VOLUNTARY SECTORS.

The strategy needs to show that local partnerships are thinking about the full range of possible funding routes. This means not only Local Authority sources of funding but funding routes that embrace the voluntary and independent sectors and take account of the equity that older people may wish to use to help fund their accommodation and/or care. Some schemes may also be developed alongside other community facilities, eg, Post Office, GP surgeries, nurseries. Partnerships also need to show that they have

- Demonstrated the best ways to utilise existing stock, either to retain, refurbish or sell.
- Outlined proposals for scheme sizes which take account both of needs of local communities and opportunities for economies of scale.
- Identified proposed sources of revenue and capital funding, with a particular emphasis on prospective partnerships with the private and voluntary sectors.
- Put in place a process for identifying suitable sites.
- Summarised likely costs of buildings per cubic metre, and of different models of care and support.
- Reviewed opportunities for provision of other services on site, such as Intermediate Care, Day Care, and leisure activities.
- In partnership with local people, reviewed opportunities for utilising the scheme as a local resource for older people.

7.6 EACH AUTHORITY WILL HAVE A PLAN FOR MONITORING THAT SCHEMES ARE MEETING THE PARTNERSHIP OBJECTIVES OUTLINED IN SECTION 3, AND AN APPROACH TO MONITORING QUALITY OF LIFE FACTORS THAT ACTIVELY INVOLVES TENANTS AND THEIR CARERS.

With the growth of planning in local authorities it is easy for documents to leap from objectives to action plans. This tends to ignore establishing processes for measuring if schemes are meeting the outcome objectives that were intended when initially developed. In this instance it is important that within the strategy

- There are clear measures linked to objectives, which will tell partners whether they are delivering the results that were intended.
- An agreed process for monitoring.
- A good balance between quantitative and qualitative measures.
- A structure for consulting about desired outcomes and outputs with tenants, potential tenants the wider community of older people, relatives and carers, both individually and through organisations.
Bibliography


Baker T. An Evaluation of an extraCare scheme, Hanover Housing Association, October (2002)


Department of Health: Modernising Health and Social Services: National Priorities Guidance 2000/01 – 2002/03. See www.doh.gov.uk/npg/


Department of Health, *Supported Housing and Care Homes: Guidance on Regulation.* (2002)

Fletcher, P. East Sussex Extra Care Housing Strategy 2003-8.


Hanover Housing Association / Winstanley Research *Limited Evaluating Older People’s Housing Needs.* Staines: Hanover Housing Group, (1997)

Health and Social Care Change Agent Team: Housing Learning and Improvement Network: *Essential Short Facts: Extra Care Housing. Fact Sheet 1. What is it? Fact Sheet 2. Commissioning and Funding Extra Care Housing*

Health and Social Care Change Agent Team: Housing Learning and Improvement Network. *Defining a Whole Systems Approach.*

Health and Social Care Change Agent Team: Housing Learning and Improvement Network: Record of Practice Ideas and Innovations.

Hill S., Lupton M., Moody G., Regan S. *A Stake Worth Having? The potential for equity stakes in social housing.* Chartered Institute of Housing /IPPR.

Housing Corporation Innovation and Good Practice Research Database: Older People, *www.housingcorp.gov.uk*


Kent County Council: Sheltered Housing – A New Strategy


King N., Intertek Research and Testing Centre, with the Health and Social Care Change Agent Team: Housing Learning and Improvement Network: *Smart Home – a definition* (2003).


Riseborough M and Fletcher P. *Note on Master Class on New Strategic Working and Commissioning* held on 7 and 8 May 2003 at Hornton Grange, University of Birmingham. School of Public Policy, University of Birmingham.

Singelenberg J. What is a Service Zone? In: Lifetime Housing in Europe. Leuven University, Belgium (1999).

Southampton City Council: Housing Strategy for Older People for Southampton

Suffolk County Council Partnership Evaluation Toolkit


Salford University Housing and Urban Studies Unit to produce a report entitled Moving Beyond One Size Fits All: Information, consultation and participation: involving BME groups in Supporting People June (2003).