

Extra Care in Buckinghamshire

A Strategic Plan

**Buckinghamshire County Council
Adult Social Care**

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Buckinghamshire County Council Adult Social Care

Foreword

In line with government policy and the wishes of the majority of older people, Buckinghamshire has been steadily increasing support to assist older people to continue to live independently in their own homes. The shift in the pattern of services is evidenced by an increase in the need for more domiciliary care support, an increase in prevention services and a decline in the number of new residential care home placements over the last 3 years.

Over the next 20 years those over 65 living in the County will increase by a third. Even more dramatic, the number aged over 85 will double. These demographic changes present a huge challenge for health, social care and housing agencies. The extra care strategy will be an integral element of the overarching strategy for older people's services in the county which includes the plans for residential, nursing home provision, domiciliary care provision, housing support, transport, prevention and health services all of which need to be sustainable and based on ongoing needs analysis and demographic forecast.

The overall objective of extra care linked to national policy is to address the issues of moving away from institutional provision towards supporting older people in houses in their communities. As older people become more frail housing issues become more crucial, such as physical location; characteristics of the person's living situation coupled with the interface with care support, health transport and community access. The provision and service design of extra care seeks to address these challenges in order to allow the individual to maintain feelings of safety, security and quality of life and therefore see extra care as a positive alternative to institutional care.

The older people's commissioning team is very pleased to introduce the first stage of the extra care strategy in Buckinghamshire. The strategy has been developed to engage local stakeholders and agree the way forward for the development of extra care in Bucks. It will be the vehicle for accessing potential funding from the Housing Corporation, Department of Health and other sources.

To date we have received a range of feedback from housing and care partners, which can be summarised as follows:

The strategy was generally considered a sound base from which to develop extra care housing. Comments included 'impressive', 'very comprehensive, and well researched', 'valuable source of information', 'thought provoking'.

A number of constructive points were raised, summarised as follows:-

- Clearer links needed to local strategies, policies and community initiatives to set extra care in context in Bucks
- Care and support to be more clearly defined, and proposals more closely linked to the Supporting People agenda
- Greater emphasis on the preventative role of extra care in relation to health
- Insufficient consultation with older people and the voluntary sector
- Specialised training for extra care staff will be key to success
- Further work required on the impact of extra care on sheltered housing, and its future role in housing for older people
- Further research required on demand, particularly extra care for sale
- Further work required on specific needs, e.g. BME groups
- Better links needed with District priorities, e.g. making best use of existing housing
- Aim to build on successful partnership work, e.g. the development of Bucks Surplus Land Protocol
- An appraisal of available land and sites is needed

This strategy acts as a building block for ongoing consultation in partnership with stakeholders and the wider community that will feed into a detailed project brief for implementation.

The outcome will be a joint development plan for Buckinghamshire with other statutory partners and the involvement of local older people, housing and care providers, voluntary organisations and other interested parties. This will provide a 20-year plan for the development of extra care.

The full final strategy document is available on the Bucks County Council website. The website will be maintained with progress reports on the strategy implementation and up to date references about any other developments.

Executive Summary

1. Introduction

National and County policy is to:

- Support older people at home as far as possible
- Provide a wider range of choices of both housing and support
- Support people to be as independent as long as possible, as they age

Extra care housing is based on self-contained accommodation, extensive facilities, 24-hour support, provision of meals and an ethos, which emphasises independence, health and being active rather than being a passive recipient of care. It is seen as one type of provision that can satisfy all the policy requirements.

Over the next 20 years those over 65 living in the County will increase by a third. Even more dramatic, the number aged over 85 will double. These demographic changes present a huge challenge for health, social care and housing agencies.

This strategy maps out the part extra care can play by:

- Looking at the hurdles and how they can be overcome
- Setting out the facts and figures in relation to needs and how these are met
- Explaining funding and looks at the resources available
- Outlining the views of key agencies and older people consulted
- Using this and the empirical evidence to propose models of extra care for Buckinghamshire including a specification (Appendix 1)
- Establishing initial targets for extra care in each district
- Setting out a process for implementing the strategy which requires an effective partnership between housing and care providers, Adult Social Care and the District Housing Authorities

Strategic purpose of Extra Care

- Positive alternative to residential or nursing care
- To reduce reliance on more institutional forms of provision thus aiding the shift away from these types of care
- To enable older people to carry on living independently while feeling secure and not socially isolated
- To provide older people and their carers with a new option across the county
- To create more settings in which care can be flexible and respond to changing needs
- To prevent admission to hospital through case management and opportunities for health prevention and promotion e.g. falls prevention, dietary and exercise advice
- To develop a modern sheltered housing model and allow some older or less satisfactory schemes to close or be re-modelled to a contemporary standard
- To provide an attractive and accessible option for all older people who want more suitable, purpose-designed housing including older homeowners. This may contribute to the release of some family housing
- To provide a new option for some older people with learning disabilities and mental health problems
- Provide a model that can be tailored to the needs of different minority groups currently not well provided for.

Vision

- Create a culture which puts older people at the centre of services
- Develop a culture in conjunction with care and housing providers that is committed to quality, supporting independence, being customer focussed
- Developing high quality buildings that are suitable for frailer older people
- Offer a range of facilities that are valued by older people, that contribute to an active, healthy and interesting life
- Offer and facilitate a range of leisure activities
- Develop ways of working which support independence and support a healthy and active process of ageing in the individual's own home
- Offer applicants a range of options in terms of how they acquire their property and possibly also a range of options in how they fund care
- Deliver high quality meals
- Be able to operate a flexible care and support service that matches individual needs that is able to change on a day to day basis

2. Needs and Supply – Figures and Facts

Age structure – numbers of people over 60 years old in Buckinghamshire in 2001 census

	People aged							
	All	60-64	65-69	70-74	75-79	80-84	85-90	90+
Aylesbury Vale	165,760	7,279	6,481	5,064	4,392	2,781	1,666	913
Chiltern	89,237	4,894	4,512	3,681	2,933	2,009	1,196	703
South Bucks	61,937	3,575	3,109	2,685	2,156	1,447	949	497
Wycombe	162,106	7,732	6,671	5,532	4,377	2,969	1,927	1,031
Bucks Total	479,024	23,489	20775	16,955	13,857	9,210	5,740	3,138

Source: ONS Census

- Those over 65 make up 14.5% (69,675 people) of the Buckinghamshire population
- In the 2001 census there were 30,612 people in the 70-79-age bracket – by 2028 this will rise to 42,500: An additional 11,900 people (39%).
- The older elderly group, those over 80, is expected to double from 18,088 to 37,500.
- The forecast is that between 2005 and 2025 the population over 65 in Buckinghamshire will grow from 73,800 to 100,200; a 36% increase.

Proportion of population in Buckinghamshire's over 65's (%)

	2005	2010	2020	2025
Buckinghamshire	15	17	19	20
Aylesbury Vale	14	15	18	19
Chilterns	18	19	21	22
South Buckinghamshire	18	19	20	21
Wycombe	15	16	18	19

Source: Buckinghamshire County Council

The impact on demand for services from Adult Social Care is reflected in an increase in the total number of older service users over the last 3 years. Whilst much has been achieved to improve the range of choices available to respond to this demand, the dramatic changes over 25 years, shown in this table, provide a key driver for extra care housing.

Demand

In Buckinghamshire the general health of the population is good and relative deprivation is very low. Nevertheless:

- 8700 older people claim Attendance Allowance (non-means tested benefit for the most severely physically or mentally disabled).

- In the northern, rural part of the county constraints in house building and limitations on community services cause difficulties particularly for older people
- The urban areas of Aylesbury and High Wycombe house 70% of the population and suffer the highest levels of deprivation.

To help older people who want more specialist accommodation with some care or support there are:

- 3700 sheltered housing dwellings
- 2800 residential and nursing care places

Looking at units/1000 of the population over 65 can test the adequacy of the supply.

Owner occupation amongst pensioner households is high in Buckinghamshire at 73% compared to the norm for England and Wales of 67%.

Retirement housing and extra care /1000 people over 65

	Sheltered for rent	Leasehold for sale	Total
England	51	11.8	62.8
Buckinghamshire	53.4	12.2	65.6

The table suggests there are relatively good supplies of traditional sheltered housing for rent. However, even taking account of 180 new extra care leasehold dwellings currently under development the provision for retirement housing and extra care for sale is not much above the normal levels. This provision might be expected to be higher because of the high level of ownership.

The overall ratios disguise some variation in provision between districts. The provision of sheltered housing to rent is uneven across the county.

Units of sheltered and extra care accommodation to rent per 1000 people

Aylesbury Vale	38.3
Chiltern	35.2
South Buckinghamshire	40.0
Wycombe	86.4

In addition:

- A survey of sheltered housing providers indicates a proportion of the stock – particularly in Aylesbury and Wycombe - is no longer fit for purpose as accommodation for an older (and frailer) group of applicants
- Waiting lists for the four largest sheltered providers are low at around 230 - 290 dwellings each in relation to the stock which becomes vacant each year
- Part of the stock, particularly bedsits or where now poorly located, is becoming unlettable. Wycombe Council for example still has 17 schemes with bedsits
- About 1 in 6 of sheltered housing residents already receive a homecare service from Adult Social Care on average 4.75 hours per week.

One housing association explained 237 households were on the waiting list for sheltered housing and in the last 12 months 124 dwellings had become available. “As you will note that is high compared to a low demand waiting list” also of those actually seeking sheltered housing “I do know a high proportion of those households will have refused at least one offer of a property.”

- The average age of existing residents in retirement housing is around mid or late 70’s
- The average age of new residents is typically 5 years younger

The significance of the age profile is that originally sheltered housing was intended for fitter, older people who might be simply lonely or feel insecure. The average age of entry 40 years ago was mid 60’s. An older and sometimes frailer group some of whom also have mental health problems is now using it in addition.

The evidence is demand for traditional sheltered housing is at best steady and more often declining – despite the demographic changes which should push up demand. Some older people would value a different product, better able to meet the needs of an older and physically or mentally limited group. In our consultation exercise older people and their representatives were overwhelmingly positive about extra care being provided if it was flexible and non-institutional. Feedback from extra care tenants within the local Heritage schemes is overwhelmingly positive. (source: Heritage Care)

Residential and Nursing Care:

Care Home Provision - Buckinghamshire and England

	Nursing Care	Residential Care	All
Places in Buckinghamshire	1,276	1,561	2,837
Places / 1000 people 65+ Buckinghamshire	18.3	22.4	40.7
Places / 1000 people 65+ England & Wales (2004)	19.4	32.7	52.1

Source: GLP Appendix

The chart shows that the provision of both nursing and residential care per 1,000 of the population is less in Buckinghamshire than in England as a whole. This is most noticeable in the case of residential care with 10 places per 1,000 less in Buckinghamshire than in England.

Over the last year capacity across all regions has remained relatively constant, with no more than a 2.1% gain or loss in each region. London, and the surrounding vicinity, continues to have the lowest level of supply relative to the rest of the UK (73% of the national average), largely explained by high property prices which have crowded out care home development in favour of other residential development, and lack of workforce availability. (*Laing & Buisson*)

Future possibility of more closures of smaller sole owners due to the impact of the new regulations, among other factors, is indicated in the market study carried out locally in 2005. (*GLP report*)

Total nursing home places in Bucks graded by build and layout quality

Nursing	Homes	Total Beds	Single	Shared	RoomsWC
Grade 1	7	445	417	14	423
Grade 2	19	744	508	118	198
Grade 3	0	0	0	0	0
Grade 4	4	87	59	14	8
Total	30	1276	984	146	629

Source: GLP

Grade 4 indicates the lowest quality in terms of meeting new standards. A number of homes will not meet new quality standards and there remain a significant number of shared rooms.

Buckinghamshire's policy is to reduce reliance on more institutional forms of provision and instead support people in their own homes as far as possible and if this is their preference.

Help to live at home

Buckinghamshire at present receives relatively low ratings by the Commission for Social Care Inspection in terms of "*helping people to live at home*" and "*households receiving intensive homecare*".

Buckinghamshire performance indicators (2004/05)

	Buckinghamshire	England
Weekly cost residential care £	458	405
Admissions to res. Care/10,000 65+	67	91
Intensive homecare/1000 65+	7	11.5
Older people helped to live at home/1000 65+	38	80

Source: CSCI

Extra care provision could assist in providing accommodation for more vulnerable older people and those with additional needs, e.g. people with learning disabilities, people with mental health problems and those from BME communities.

The lifespan of people with learning disabilities is increasing. This group also age more rapidly and may benefit from extra care provision earlier than those in the community as a whole.

3. Impact of extra care

Chapter 5 reviews the empirical evidence for the effects of extra care.

- High levels of satisfaction are consistently reported by residents of housing with care schemes
- It is the combination of independence and security that is most valued by residents
- Housing with care offers opportunities for social interaction and companionship
- In some circumstances housing with care can provide an alternative to residential care
- “Aging in place” will not always be a reality for everyone
- People with challenging or high risk behaviours associated with severe dementia are not easily accommodated
- Housing with care can have a positive impact on the health and well-being of residents

Other perspectives on gains from extra care from different agencies and interest groups:

Older Residents

- Positive lifestyle choice whereas moving to residential or nursing care is more often seen as the only option or a forced move
- More space and facilities than residential care and most older sheltered housing
- Secure – environment, financial, in an emergency, as health changes – support/care 24 hours in day, with people of similar age but not cut off
- Independence, control, choice
- Not isolated – a community
- A route to more manageable, suitable, well designed housing
- For owners a possible route to releasing equity and boosting income. For less well off owners a way of protecting limited assets that does not compromise entitlement to benefits.

Adult Social Care

- Reduce reliance on residential/nursing care
- Probably less costly alternative than residential care
- Helps with policy of supporting independence, at home and contributes to higher scores on key PAF indicators
- Can be used flexibly not exclusively for high or low needs
- Can cater for minority groups and particular or emerging needs such as older people with learning disabilities

Health

- Easier/quicker to provide some preventative intervention e.g. falls prevention, dietary and exercise advice
- Earlier identification of health problems/prevention by on site staff
- Better care and more suitable facilities for discharge of frailer or vulnerable people
- Offering a local respite or intermediate care facility

Housing Provider

- Alternative to traditional sheltered housing
- Offers opportunity to re-model some schemes
- Possible additional capital funding from Department of Health
- Meet needs of some of own tenants or leaseholders better as they age
- Emerging market opportunity

District Council

- A new form of housing provision for older people for which there is support and some funding
- Meet needs of local residents as population changes continue
- For some an opportunity to re-model stock or re-provide in a positive way
- A route to releasing larger general family housing

In comparison with either residential care or traditional sheltered housing from almost every perspective, whether a potential resident, commissioner or provider, extra care has clear attractions. It delivers on national policy objectives and reflects older peoples' own preferences. It consequently meets the objectives of most of the agencies concerned; better health, more satisfied residents, and an additional option, less reliance on residential care placement.

Three concerns consistently raised are:

- Cost
- Impact on other provision
- Workforce

The capital cost of providing an extra care dwelling will usually be higher than equivalent sheltered or residential care places if there are extensive communal facilities. Operating costs for similar needs, ignoring any quality or external benefits, may be higher overall than residential care and cheaper than intensive homecare. From an Adult Social Care, perspective commissioning a service for someone in extra care is likely to be cheaper than the equivalent residential care or care at home in revenue terms.

The impact of extra care on present residential care provision will be small because of the overall growth in the market and decisions already taken to reduce reliance on residential care. There may be some impact on sheltered housing in hastening decisions to close, re-model unsuitable sheltered housing or improve services, changing the role, encouraging a levelling up of the quality of provision.

Recruiting suitable staff is a local and national problem. Overall extra care may make it easier to meet the increasing demand by providing care more efficiently i.e. on one site and offering more attractive employment opportunities. Comparison of homecare packages from this year to last demonstrates a significant increase in intensive packages, which require double the number of carers for more visits. Logistically this can be very difficult to achieve particularly in some of the more rural sparsely populated areas. (Laing & Buisson were commissioned last year to complete a workforce report in Bucks. which forecast a growing gap in the workforce in terms of meeting both steady state demand as well as any increase).

4. Models of extra care

Central to our strategy are decisions about the type of provision we want to see. A simple typology is used to clarify the main options.

There are four key variables:

- Housing-care provider relationship
- Buildings
- Allocation and eligibility criteria
- Tenure

Typology of Extra Care

Variable	Option			
Housing and Support Providers	Housing and care provider identical	One housing provider with One separate care provider	Housing provider with Social Services as care provider	Housing provider with several care providers
Building i) facilities ii) scale iii) dwellings	One or two additions to Cat 2. including meals Small 40-50 Flats	Three or four additions to Cat 2 including meals Medium 51 - 149 Bungalows	Extensive facilities. Five or more additions including meals Large/community 150+ Mixture	
Allocations and eligibility criteria	Those in need of residential care	Managed lettings only some needing residential care	Letting to those seeking sheltered housing	
Tenure	Rented	Mixed Tenure	Owned	Special financial arrangements

There are some key decisions to be made about models of extra care. While accepting there will be a variety of scale and type of provision, we expect the following to be common throughout Buckinghamshire's extra care.

- i. The provision of housing will generally be separated from the provision of care. Where an organisation has real expertise as both a specialist housing and care provider, we would expect there to be some separation internally between housing and care and support functions so that contracts for care and support can be varied without jeopardising housing. Buckinghamshire County Council is not ruled out as a care provider, but more commonly care will be provided by an independent specialist agency.
- ii. In principle the lettings and sales policy will be designed to maintain a mix of abilities and not let/sell **exclusively** to those who are already quite frail. This is to ensure a mixed, more vibrant community is maintained and older people continue to have a range of choices and options. Neither position on a waiting list or assessment of high physical or mental needs will guarantee access – lettings will be a managed process.

Provisionally, we propose needs are banded high, medium and low and in larger schemes about one third of residents at any one time would be in each band. The mix will be agreed on a scheme by scheme basis.

- iii. Drawing on experience elsewhere and locally our preference is to have new-build extra care averaging around 60 dwellings with a good range of amenities in each project. The practicalities of land and cost may mean some schemes have to be considered down to 30 dwellings and a few more specialised learning disability or mental health projects much smaller than this, around 6 dwellings. Smaller schemes may be possible where there is scope for the building and care service to be used to support the wider community based on a “hub and spoke” approach.
- iv. Developments will offer dwellings for rent or sale including sale on shared ownership terms. This is in order to match the high level of owner occupation in the county, growth in elderly owner occupation and the needs of less well off older home owners – including those in poor condition or low value properties unable to buy outright.

It is possible some extra care developments will be exclusively for sale also that different innovative financial plans to enable less well off owners to move into extra care can be successfully developed.

In addition, in letting extra care it is proposed to offer a small number of properties to older people with learning disabilities further extending their opportunities available to disabled people.

- v. Schemes will incorporate design features to support people with dementia. For people with advanced dementia there is an ongoing debate as to the particular advantages of the extra care model and this will be kept under review.

- vi. We want to develop an “Enabling Model” of service delivery that sets out to assist tenants to carry out day-to-day tasks of independent living for themselves rather than simply “doing” the tasks. (Appendix 3 explains the culture of extra care)

Models for Buckinghamshire - Summary

Variable	Option
Housing and Support provision	One housing provider Separate care provider Care provider could be Adult Social Care If an expert housing and care provider it must be possible to terminate any contract with Adult Social Care without jeopardising housing
Buildings	Around 60 dwellings with a good range of amenities preferred Smaller development around 30 dwellings consider a hub and spoke approach serving a wide community to support good range of amenities. A few very small developments for people with additional requirements considered
Allocation and Eligibility	Managed lettings Balance agreed scheme by scheme but roughly equal proportions of high, medium and low needs
Tenure	Mixed tenure preferred Including shared equity or other special financial arrangements to assure less well of owners or facilitate equity release

5. Resources

The strategy explores capital and revenue funding options. Sources of capital include:

- Land Five sources are identified and surprisingly this may be less of a hurdle than anticipated although planning, particularly on large developments, is widely seen as a hurdle to quality provision and where District Housing Authorities have a pivotal role
- Core Capital Department of Health extra care grant and Social Housing Grant via the Housing Corporation
- Sales It is envisaged because of high property values and high levels of ownership most schemes will be partly funded by sales
- Private finance Long term, loans repaid from rents

The capital cost of construction will be met by varying combinations of:

- SHG via Housing Corporation who have said funding for re-modelling sheltered housing is in principle available.
- Department of Health - £40 million available. Buckinghamshire has not so far had any of the DH pot
- Free land – various sources identified but sites to be assessed for suitability
- Sales receipts – both to reduce overall borrowing and if land is provided, to effectively subsidise rental units and/or fund communal facilities
- Mortgage

The Anchor Trust Denham Village demonstrates a combination of available land and sales can deliver a high quality scheme without additional public subsidy in Buckinghamshire.

Additional sources of funding may be available. Some form of public-private partnership is also conceivable.

Revenue includes: rent, service charge, Supporting People Grant, Attendance Allowance and Adult Social Care funding care packages for those eligible. A proportion of residents, as in residential care homes, will be self-funding

The principles are explained in the next chart followed by an example for an older person with a high level of dependency.

Meeting costs of extra care

COSTS	TENANTS	OWNER OCCUPIERS
Property and property maintenance/management costs	Rent and some non SP eligible service charges – paid by the individual but may be covered wholly or partly by (means tested) Housing Benefit	Individual responsibility to be met from pension/other personal resources. A shared owner eligible for Housing Benefit or part rented can get management and maintenance costs met by their Housing Benefit
Individual heat, lighting, power, water charges	To be met from pension/other personal resources	
Council tax	To be met from pension/other personal resources – means tested council tax benefit may apply. Single person rebate and disability reduction will apply as appropriate	
Housing related support	Means tested Supporting People grant. Otherwise from pension/own resources	In theory Supporting People Grant available to owners who are eligible
Personal care and support	Care contract funded by Adult Social Care but subject to prevailing charging policy and the further development of direct payments	To be met from pension/other personal resources plus any attendance allowance/disability premiums etc, and the further development of direct payments
Help with housework	May be included within care package for more disabled people. Otherwise, to be purchased from pension/other personal resources which could include Attendance Allowance and the further development of direct payments/individualised budget.	
Additional services	Self purchase arrangements and/or subsidized through wider community use e.g. leisure and sports facilities, shops, pub and so on	

Indicative example of high care model of extra care (£/week)

TYPE OF EXPENDITURE		HOW EXPENDITURE IS MET		
	£		£	
Rent (including some housing services)	115.00	Housing benefit	115.00	
Council tax	8.00	Council tax benefit	8.00	
Heat, light, power	15.00	Pension	84.25	
Food, clothes, household bills, personal items, entertainment etc	69.25			
Housing Related Support	20.00	Supporting People grant	20.00	
Personal care and support	159.65	Pension	76.65	
		Credit/severe disability addition		
		Attendance Allowance (higher rate part)		20.60
		Social Services contribution		62.40
Help with housework	41.65	Attendance Allowance (higher rate part)	41.65	
TOTAL	428.55		428.55	

In 2005-06 Buckinghamshire Adult Social Care spending on older people was:

Nursing homes	£ 5,725,128
Residential care	£ 7,909,822
Domiciliary care (external)	£ 5,835,422
Internal home care	£ 8,715,717
Direct Payments	£ 731,824
Day care	<u>£ 1,968,116</u>

The total older person spend was £32,732,974

- Our strategy assumes about a third of places in extra care will be for people who would otherwise enter residential care. Thus some of the £7.9m currently used for care home places will instead fund extra care
- Costs to Adult Social Care of placements fall in extra care so there will be an additional gain in funding available of perhaps £3000 or more per place, per annum available for extra care
- The study of residents in ordinary sheltered housing found about 1 in 6 already received some level of domiciliary care. To the extent extra care simply replaces outmoded sheltered housing this part of the £14.5 million domiciliary care budget will shift instead into extra care

- As with the switch from residential care there should also be an additional efficiency gain. If 20% of the domiciliary carer’s time is lost in travel alone this, at least in simple terms, should translate into a 20% productivity gain in an extra care setting. Put another way £14.5 million would in effect buy another £2.9 million of care
- The Supporting People budget in Buckinghamshire is a little over £5million. Typically residents in sheltered schemes get 1-2 hours of support per week from this source. It is not clear at this stage what level of SP funding will be available for people living in extra care schemes.
- Attracting a proportion of self-funders, as commonly found in residential care homes, is one element of this strategy. It helps to spread risk, give an economic scale, ensure amenities like a restaurant are supported.

6. Implementation

The function of all older people’s strategies is to ensure that there is an effective range of housing and support options and choices available for older people throughout the county. There needs to be an examination of the link up across markets for housing and support solutions along the continuum, from independent living to nursing care.

Continuum

Delivering Independent Living			Specialist housing			
			Sheltered housing		Care Homes	
Equipment & Adaptations	Stay put schemes	Floating support	Sheltered schemes	Extra care	Residential care	Nursing homes
Smart technology	Handy persons schemes	Intensive Home care	Supported housing	24 hour	24 hour	24 hour

Effective partnership working is required to make the extra care programme happen. Drawing on the experience of “Project Care” through which a similar size of programme (600 units) is being delivered by a partnership between Buckinghamshire County Council, Housing Solutions (a registered housing association) and Fremantle Trust (the care provider).

- We propose an extra care project group is created to oversee and coordinate the programme:
 - County Council Adult Social Care/Supporting People
 - Each District Council and could include planners
 - PCT(s)
 - A voluntary sector representative

This group would be led and serviced by the County Council with a project manager funded by all main partners, initially to lead on the development of a detailed project and planning brief. One of the group’s first tasks will be to agree an initial 5 year implementation plan in detail

- As each large scheme (or series of developments) takes shape a District led project group is formed to deal with the difficulties and decision at a District level of:
 - The District Council
 - The housing provider/developer if different
 - Adult Social Care
 - The care provider if/when identified
 - Community/local representation

- A dedicated post at county level to project manage the extra care programme on a daily basis.

This would be the equivalent of the consultant employed on “Project Care”. Project management is a condition of Department of Health grant funding for extra care.

Other lessons from Project Care are drawn on in the strategy.

One of the early actions of the “Project Manager” and “Project Group” should be to generate a list of potential extra care sites, carry out a short listing exercise and then appraise the sites for extra care. The list would be obtained by asking the PCT and Adult Social Care to propose sites, a review with planners and leads on older peoples housing in each District Council and an invitation to all RSL’s with sheltered housing in the county to put forward sites for re-modelling or re-development.

This action has already been supported by the Supporting People Commissioning Body.

The over arching Project Group should also consider what activities might engender enthusiasm and sustain interest in extra care, also how best to involve local communities when initial sites to progress are agreed.

We calculate that it is reasonable to plan for around an additional 560 extra care dwellings over the next 20 years, split roughly half for sale, half for rent. This will mean an approximate breakdown between the Districts as follows:

Aylesbury Vale	171
Chiltern	121
South Buckinghamshire	87
Wycombe	181

Some flexibility may be needed on geographical spread given land availability and planning constraints.

Chapter 1 Introduction

1. Why do we need an Extra Care Housing Strategy?

The development of Extra Care housing is a key element in promoting independence, extending choice and improving quality of life for older adult service users. The Buckinghamshire Commissioning Strategy for Older People 2004 highlights a number of local factors which drive extra care housing development:-

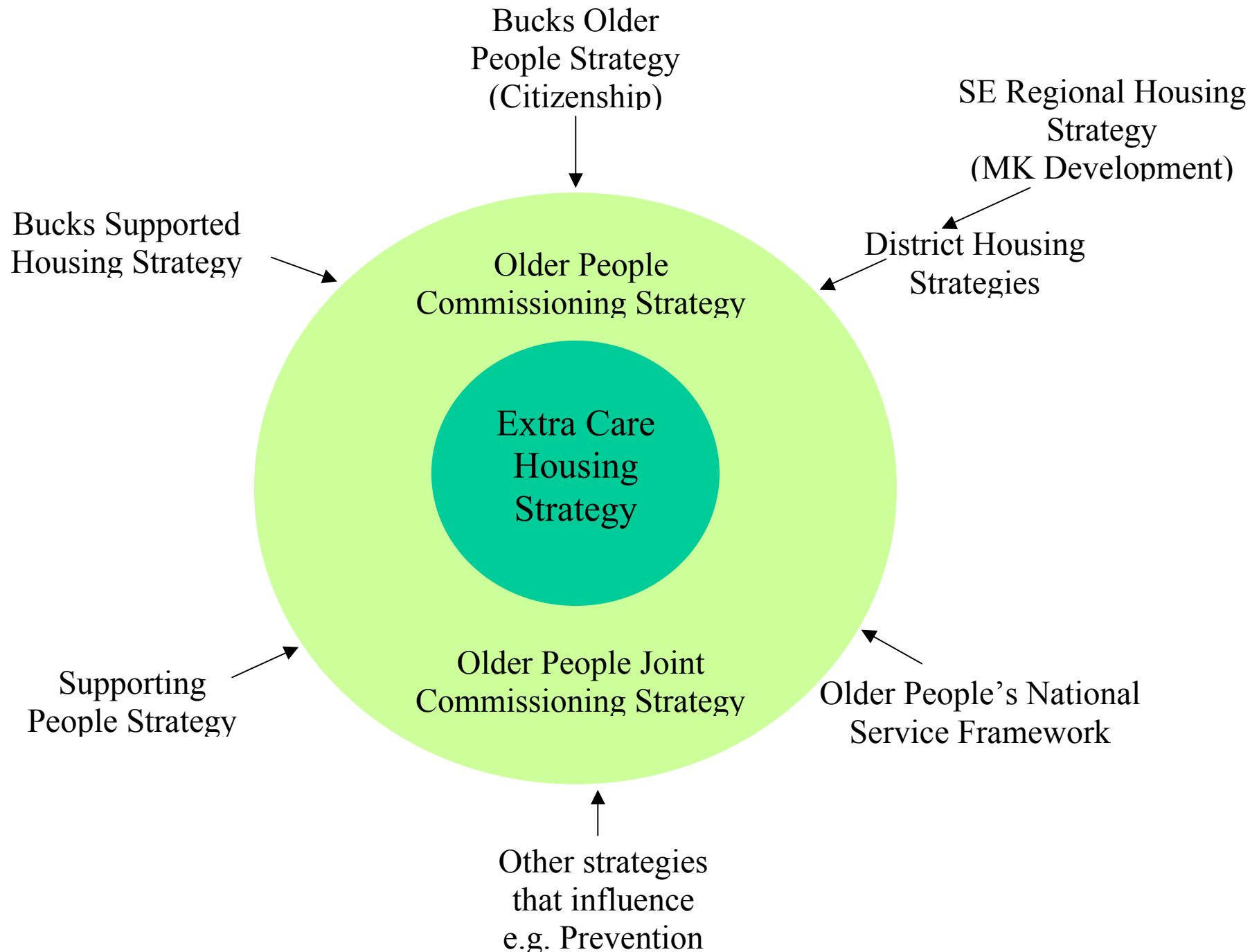
- Need to provide more flexible person centred services for older people
- Lack of appropriate capacity in the long term care market
- Under utilisation of sheltered accommodation
- Need to improve links with local housing partners to consider better utilisation of local housing stock and the provision of community care
- Demographic change – e.g. increasing numbers of older people increasing the demand for social care putting pressure on available resources and funding

In addition, the document Towards a Joint Health and Social Care Commissioning Strategy for Older People 2005 includes the development of extra care housing as one of its objectives.

All the latest policy and legislation surrounding care for older generations continues the drive to increase the proportions of older people living at home, whilst supported by a range of domiciliary and health care services. The aims are to maintain and hopefully reduce the current numbers of admissions into residential care and to reduce delayed discharge from hospital, resulting in improved quality of life for older people and savings for the NHS. The Department of Health continues to support extra care housing development around the country with the provision of some capital funding, comprehensive guidance, and facilitating information exchange between local authorities.

Extra Care in Buckinghamshire – a Strategic Plan explains this model of housing and care and how it could operate in Buckinghamshire, and provides the basis for working in partnership to deliver improved services.

The Strategy has a central role in delivering key targets in a range of other strategies, as indicated in the following diagram.



2. Context

This is a strategy to introduce a new option for older people called extra care housing.

We are an ageing society. In the last century life expectancy increased by 50%. In the next 50 years in the UK:

- Those over 85 will increase by 2.9m
- Those over 65 will increase by 7.5m

The forecasting model of the Personal Social Services Research Unit projects that the number of disabled older people is likely to increase by nearly 70% between 2002 and 2031.

As a result, demand for long-term care services is projected to increase markedly, even if informal care rises in line with demand. To keep pace with demographic pressures over the next 30 years, residential and nursing home places and home care hours would need to expand by around 75%. The model also projects that long-term care expenditure would need roughly to treble in real terms over the next 30 years. (PSSRU Bulletin 15, 2005).

In Buckinghamshire over the next 20 years a 36% increase in those over 65 is forecast mirroring the national picture, while the number of those over 80 will double.

Housing authorities, along with other providers of services to older people, have to make sure they are in a position to meet the needs arising from this dramatic population change.

“Just like the rest of us, older people want to enjoy good health and remain independent for as long as possible. As people get older remaining independent often depends on health and social care services being effective enough to support them”.
Source: National Service Framework for Older People, ODPM/DH 2001

There is a plethora of public policy and national guidance on how services – Social Care, Health and Housing – should respond to these considerable demographic shifts.

The consistent themes running through the relevant strategies whether social care, health or housing over the last 10 years have been:

- To support older people at home as far as possible
- To provide a wider range of choices of both housing and support
- To support people to be as independent as long as possible, as they age.

Extra care is seen as one form of provision that can meet some of these policy aims because it:

- Provides self contained accommodation – your own home
- Is an additional, different choice

- Offers independence but also a safe environment (a key issue and concern for many older people), a sociable environment (combating isolation another key issue) and consequently contributing positively to mental and physical health, and thus continuing independence
- A place in which care and support can change, is flexible and can meet evolving needs.
- An alternative to either traditional sheltered housing at one end of the scale or residential care at the other and all points in between.

What is extra care housing?

“Extra care” is seen as an alternative to both traditional sheltered housing which simply has warden support and an alarm system at one end of the scale and much more intensive residential care at the other end.

Extra care housing is based on self contained accommodation but with 24 hour support and care on hand. Larger developments will also have an extensive range of facilities to help support independence and maintain a healthy and active lifestyle.

Buckinghamshire has a reasonable amount of warden supported sheltered housing, residential and nursing care. There is also a large retirement village under construction. Access to extra care housing is patchy, with only a relatively small number of properties available. This strategy sets out to analyse the role of extra care and how it might be provided across the county and be accessible to all.

3. How the strategy has been created

The extra care strategy is to set out an approach which will be developed and refined over time. It draws on:

- An analysis of national and local statistics
- Existing district housing strategies and other county wide plans
- Interviews and discussions with a wide range of agencies with an interest in extra care; District Councils, housing associations, Primary Care Trusts, voluntary sector agencies along with the county wide Adult Social Care and Supporting People Team.
- A workshop attended by 30 people involved with older peoples services and issues in the county
- Experience of extra care housing elsewhere in the UK, studies of extra care, national policy and guidance
- Consultation workshop with older people
- A survey of sheltered housing providers

4. Organisation of plan

Following this introduction, the views and preferences of a wide range of organisations and older people, the future customers of extra care, are set out in Chapter 2. This leads into an analysis of present housing and care provision examined against the changing needs of older people in Chapters 3 and 4.

Chapter 5 then brings together the case for extra care housing in Buckinghamshire considering different interest groups.

Chapter 6 follows this with a review of different models of extra care as we begin to shape the strategy for the county. At present extra care is not tightly defined or regulated in the way that residential care or sheltered housing and other forms of provision are. It is still a dynamic, flexible and evolving concept. The strategy sets out potential models for Buckinghamshire in the light of the analysis in the previous sections.

One of the hurdles to achieving extra care is funding and other resources. This is explained in Chapter 7.

Chapter 8 sets out how the vision and models described in Chapter 6 can be achieved in practice and the targets for development.

An outline specification and extra care standards are set out in Appendix 1. One of the issues raised in the strategy is the extent to which traditional sheltered housing will offer a good choice for the next generation of older residents. Appendix 2 considers what “fit for purpose” means.

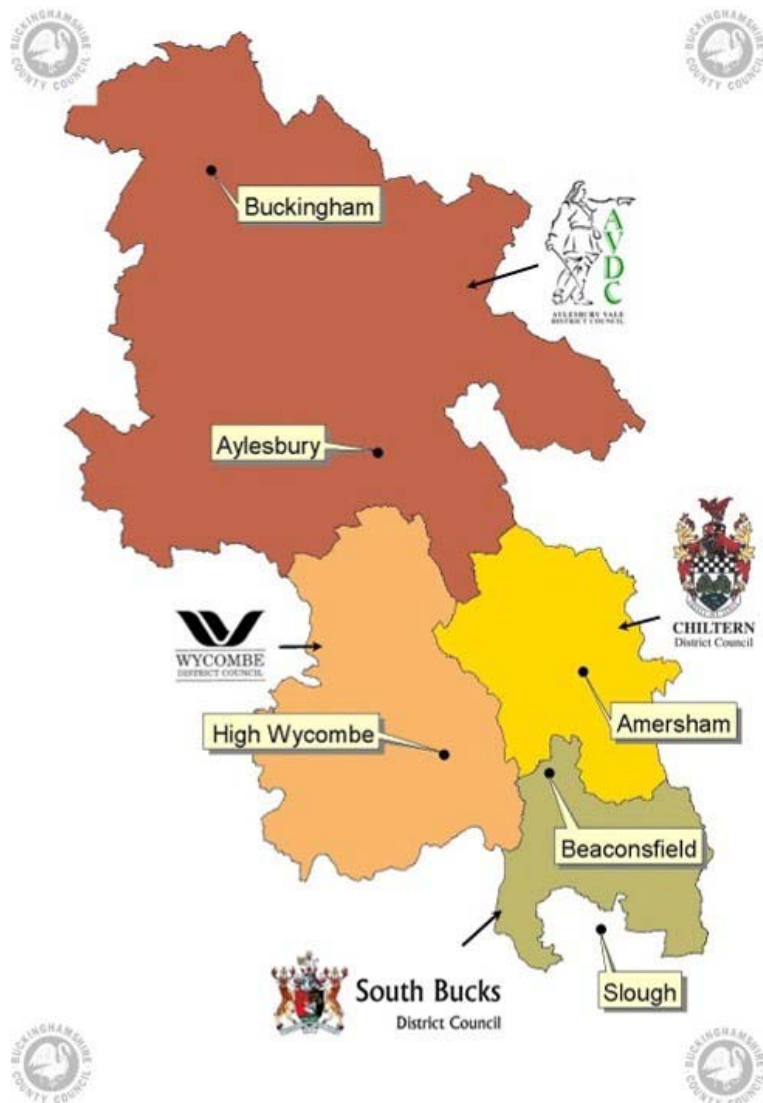
5. The agencies involved in extra care

Extra care housing is by definition a form of housing provision. All four District Councils have strategic responsibility for housing and in principle could therefore be leading on extra care. In practice, as social care is a function of the Buckinghamshire County Council and extra care is in part seen as a means of providing care and support in someone’s home rather than in a residential or nursing care establishment, often Adult Social Care takes the lead in two tier authorities such as Buckinghamshire. Despite extra care being housing, to promote this form of provision, the Department of Health has been providing some capital grant funding direct to Adult Social Care for extra care housing. This is in addition to normal Housing Corporation grants to housing associations.

Two of the District Councils have transferred their housing stock to housing associations a while ago; Beacon London and Quadrant (South Buckinghamshire) and Chiltern Hundreds (Chiltern). Aylesbury Vale District Council transferred its housing stock to the Vale of Aylesbury Housing Trust in July 2006. Wycombe Council however retains direct responsibility for housing provision.

Nearly all new social housing is provided by housing associations and a number operate in Buckinghamshire providing both general needs and sheltered housing.

Primary Care Trusts (PCT's) are responsible for a range of health services including General Practitioners. It is possible for health and social care budgets to be pooled and for some services to be jointly commissioned. PCT's are currently undergoing a re-organisation in Buckinghamshire, and will form one PCT by October 2006.



It is these four agencies District Council, County Council, Housing Association and PCT that have to collaborate to achieve new extra care provision. Finally, there may also be a care provider involved as well.

6. Direction of travel

To guide the reader, where we want to get to is summarised in the box.

Strategic purpose of extra care

This Extra Care Housing Strategy is intended to deliver these results:

- Positive alternative to residential or nursing care
- To reduce reliance on more institutional forms of provision thus aiding the shift away from these types of care
- To enable older people to carry on living independently while feeling secure and not socially isolated
- To provide older people and their carers with a new option across the county
- To create more settings in which care can be flexible and respond to changing needs
- To provide PCT's with an opportunity to discharge people into a non-institutional setting, reduce admissions via Accident and Emergency, assist with the prevention of avoidable causes of admissions, contribute to better health of older people
- To develop a modern sheltered housing model and allow some older or less satisfactory schemes to close or be re-modelled to a contemporary standard
- To provide an attractive and accessible option for all older people who want more suitable, purpose designed housing including older home owners. This may contribute to the release of some family housing
- To provide a new option for some older people with learning disabilities and mental health problems
- Provide a model that can be tailored to the needs of different minority groups currently not well provided for.
- Assessed needs are met and care and support are flexible to meet the changing needs and requirements of service users on a short or long term basis

Chapter 2 Consulting – Partners, Providers and Customers

Those involved in services for older people in a wide range of roles; service commissioners, housing providers, care providers, planners, health services... along with older people, informed this strategy in three ways:

- An initial workshop with 30 professionals and politicians active in housing, care services or health in Buckinghamshire
- Interviews with 18 ‘experts’, some of whom also attended the workshop
- A group discussion with older people, some of whom might be or represent potential customers of extra care

The input from each, but particularly the one-to-one interviews, has shaped nearly all the detail of these plans. It also provided a guide to the matters the strategy needed to include. In this chapter we summarise key findings from each element.

1. Initial workshop

The first event started the process of formulating this strategic plan. It was an opportunity for key professionals along with a small number of Councillors to hear about extra care generally and some of the options, see the two types of extra care currently provided in Buckinghamshire by Anchor Trust and Heritage Care and begin to discuss how Buckinghamshire should approach this form of housing.

The workshop identified the key hurdles to extra care in the county which the strategy would need to consider:

- Shortage of **land** particularly in the south of the county
- Informing people including younger relatives as one element in forming a coherent plan for **marketing** extra care as still a relatively unknown choice
- Working in **partnership** across the county positively with all the key players but particularly District and County Council and key housing associations. Each party it was said would have to ‘let go’ some control
- **Funding** of both capital to build new schemes or re-develop sheltered housing and revenue for care and support services was uncertain. Participants in the workshop had varying degrees of knowledge of the financial alternatives
- Along with finding the money, focus was on the comparative ‘**cost effectiveness**’ of extra care
- Recruiting sufficient care staff has been a national and local challenge. Getting adequate **staffing** was identified as an issue
- Extra care developments are often fairly large scale while parts of Buckinghamshire are characterised by small, rural settlements. There is a question as to whether or how the benefits of extra care can be spread into **rural areas**
- Policy is to make **Direct Payments** available to older people with an assessed care need to buy their own package of care. This is commonly based on employing one or more ‘personal assistants’. In the future this approach is

expected to expand with the introduction of ‘individualised budgets’. It was argued extra care should encompass these arrangements.

The same themes appeared in many of the interviews. Those around money, particularly affordability, along with Direct Payments and location of extra care in the discussions with older people. The strategy therefore deliberately addresses all these points.

2. Interviews

Eighteen people were interviewed. They were all “experts” in various aspects of services for older people. They were employed in the voluntary sector, in housing associations that provide sheltered or extra care housing for older people or similar services, District Councils (the Housing Authorities), County Council, Primary Care Trust, care providers or in a specialist capacity such as Supporting People Manager or Race Equality Council.

Discussions were tailored to the particular organisation and role of respondent. The views and analysis have been used in the relevant part of this strategy. Many discussions covered similar ground and the picture that emerges from this part is summarised here.

i. Has the case for extra care housing been made?

People fell broadly into two groups. The first felt that although extra care had been discussed for a long time a “*hard and fast case had not been made*” or “*I have not seen any hard facts or real analysis*” and “*If the case has been made it has not been well made*”.

The second felt that discussion on the merits of extra care was past “*four years ago we all signed up to develop extra care as an alternative to residential care in Buckinghamshire Supported Housing Strategy*”. Some were already developing extra care in Buckinghamshire or other areas and consequently making a case was not an issue.

ii. Do you have any evidence of need/demand for extra care?

Very few people could point to empirical evidence of need or demand for extra care. The exception was those already involved in extra care in some form. Anchor in developing Denham Village had carried out extensive market research and now had real evidence of demand. Heritage Care with four smaller developments are fully let.

Several of those spoken to, while unable to quote from actual studies, described situations where extra care could play a role. This included moving on from sheltered housing as a better choice than residential care and in a variety of health situations both in a preventative capacity and alternate place to discharge people to.

iii. Is demand for sheltered housing increasing/decreasing?

Most people providing sheltered housing said demand was “*steady*” or “*diminishing*”. Some described reasonable waiting lists but mentioned the familiar scenario of the waiting list being used as “*insurance policy*” and frequent refusals of accommodation. District Councils were frequently said not to be taking up their nomination rights to sheltered housing.

One fear of some of the organisations who have sheltered housing is that additional extra care might further reduce the demand for their sheltered housing.

iv. What model of extra care do you favour?

The majority of those interviewed had an open mind about the model of extra care. “*I have no strong views on models of extra care*” or “*I am starting from a low base and do not have enough information on extra care housing*”. Most were seeking guidance “*a lead*” and hoped the strategy would provide this. “*Tell us what is wanted and we will respond*”. The lack of a clear standard or model was hindering progress.

One or two of the housing providers interviewed described examples of extra care based on designating a few dwellings in a sheltered scheme for people with higher needs, possibly short term lettings. The latter comes closer to what is normally known as “*intermediate care*” (i.e. short term provision normally up to 6 weeks, where relatively intensive support is given tailored to the individual needs such as physiotherapy, speech therapy, following a period of illness or an accident or after discharge from hospital) than extra care envisaged here. Extra care can incorporate intermediate care and consequently there was some interest in this aspect.

Most of those who commented felt that mixed tenure developments would be most relevant in Buckinghamshire, but a few were also concerned not to overlook the traditional social housing function.

Those with most direct experience of developing and operating extra care felt bigger schemes - around 60 dwellings - were preferable for economic reasons and to offer a wide range of facilities. One of these interviewed had recently completed a scheme of 29 dwellings in a neighbouring housing authority and had been able to incorporate a range of facilities like a gym and Jacuzzi but not a restaurant. Those seeking to rejuvenate existing sheltered housing thought smaller schemes should not be ruled out – in one case down to 5 dwellings

v. Where should extra care be developed? What scale of extra care?

In terms of geography and scale of provision, most who commented felt this should come from analysis and there were few strong views. In terms of sites within a locality there were clearer and stronger views. “*Located near to shopping centre and/or village centre and have strong links to the community*”

“Situating an extra care scheme in a isolated location would not be appropriate, residents may want to use buggies to visit local shops and facilities” or “It is essential schemes are sited where there is good public transport”.

Several respondents’ stressed a high quality product was important: *“Design and space standards should be of high quality to attract under occupiers of general needs housing and ensure demand is high so making schemes financially viable”.* One person in particular stressed *“In considering models and scale the strategy will fail if the bigger issue of the need for sheltered housing is not addressed”*

vi. Working in partnership

Many respondents volunteered that partnership working was not a strength in the county. *“I don’t see why we shouldn’t be able to work in partnerships but Buckinghamshire County Council and the District has had its up and downs”* and

“Stronger links with Buckinghamshire County Council are necessary – there is a lack of engagement, staff are aloof and distant, communication is poor, BCC staff do not come to meetings...” The Chief Housing Officers Group in the county was cited as an example of one of the more effective forums. *“We need a clear steer and explanation of why, with evidence to back this up”.*

An example of conflict between a District and the County Council failing to agree on the use of a potential extra care site was used by several respondents to illustrate the lack of understanding or willingness to work collaboratively for the benefit of local people.

vii. Planning.

Planning was seen by many as a potential barrier to achieving the best provision. Green belt, design and density were repeatedly cited as hurdles. Some felt irrespective of the desirability in operational and quality terms of large developments planning constraints would inevitably lead to most extra care housing being based on remodelling or re-developing existing buildings – most obviously redundant sheltered housing. One person thought new developments in excess of 40 dwellings would be difficult to achieve although there are a few bigger existing sheltered schemes.

viii. Provision for minority groups.

The steer was that for the future extra care could potentially be of equal value to all sections of the community. The self contained basis and ability to tailor services even employ a specialist group of staff and possibility of specific design element within dwellings, made extra care an attractive model for a wide range of minority interests.

Some emphasised that although catering for BME needs was not a big issue in most of Buckinghamshire, the *“needs of minority groups are not fully understood and there is a need for some in-depth consultation”* others however felt it was a *“big issue”* and that sheltered housing was not easily accessed by BME groups.

One of the experts interviewed felt that an “*integrated*” model was the ideal but that for the present generation of older people from BME backgrounds this might not work well and that letting, say a wing in an extra care scheme to a particular group would be a short term solution. For the Pakistani community in particular location near a mosque could be important.

Little thought had been given by those interviewed, with a few exceptions, to the needs of older people with learning disabilities. Catering for people with mental health problems was however recognised as a potential role of extra care.

ix. What are the strengths and weaknesses of current services for older people in Buckinghamshire?

One or two felt the counties older people services did not get very high priority. “*Older Peoples’ Strategy has no teeth*” or “*The Older Peoples’ Partnership Board is dominated by health and I feel excluded*”.

Another observed that, “*Secondary care services appear not to be focussed and there is not a specific elderly care model, the geography of the county is a ‘significant issue’ and often the infrastructure is inadequate*”.

And another, “*Weaknesses centre on lack of joined up working with the county and other agencies*”. “*Coordination*” was a theme of several respondents and lack of “*step up/step down services*”.

Others identified strengths in services as HIA’s, Handy Person Services, Safer Homes, and Service Safety Days, all of which help people remain in their own homes.

A PCT representative commenting on how health professionals could best be engaged in using extra care commented “*It’s about aligning systems – people at the coal face are not always aware of the care services available and often don’t have the time and motivation to find out. We need a generic pathway involving all agencies*”.

3. Summary

One interviewee from a District Council provided a concise summary of widely shared key messages:

- “*We are at the delivery end and need a **clear steer** and in particular the provision of a menu of options detailing the **type of schemes** that can be developed*”
- “*There is a need to **identify the client group** that will be eligible for extra care housing and ensure that all Agencies agree with this*”
- “*The Strategy should be **realistic** about what is achievable because of limited land availability and funding*”

These points have led to a detailed consideration of type in Chapter 6, the volume of extra care needed in Chapter 8 and a specification in Appendix 1.

4. Views of older people

Participants in discussion

A group of older people, potential customers of extra care, met together to give their views on the type of extra care they would like developed.

The group of 14 was made up of people currently living in sheltered housing and people living at home. There were three men and two people who used a wheelchair. Drawn from across the county, unusually, there were several participants who used Direct Payments to employ their own personal assistants. All tenures were represented, including renting in both the public and private sector as well as home owners.

The arrangement for the discussion group was:

- Introduction to extra care and some of the issues to be resolved
- Question and answers
- A short film showing different extra care developments in operation
- Discussion
- Completion of individual questionnaires

The questionnaire was used to help crystallise and verify the views of the group, also to pilot a form which could be used for a wider survey. The numbers involved in the group discussion are too small to use the questionnaire results as a representative sample.

Views of group

Extra care in principle

The group was overwhelmingly positive about the concept of extra care; “*Fantastic*”, “*Concept sounds great*” and “*Too good to be true*”. The questionnaires confirmed that the participants were unanimous Buckinghamshire should try to develop more extra care. Only one person said they would personally probably not be interested in extra care.

From the questionnaire replies the group was evenly divided as to whether or not there should be any further provision of residential care.

Model of extra care

The group were also unanimous in saying:

- Extra care should offer a choice of tenure. This included shared ownership and about a quarter of the group were interested in this option for themselves
- Extra care should be based on a range of abilities and ages and not for example simply be a substitute for residential care

Location was of critical importance with access to mainstream public transport and local shops, post offices and other amenities stressed by the group. *“You should not have to rely on Dial-a-Ride”*.

One or two participants were concerned that extra care might be too much like residential care with restrictions imposed by care providers; *“No uniforms, no signs saying ‘extra care’”*.

The discussion emphasised that extra care should be flexible in service delivery, be able to adapt to needs changing over time. The group thought it was not acceptable to set an arbitrary point at which someone might be considered too disabled or frail to continue to live in extra care.

A particular challenge and wish articulated by members of the group with personal assistants was that (in line with Department of Health policy) they should be able to live in extra care employing their own support staff.

At present very few people in extra care are known to be on Direct Payments and interest has been low. There is also a tension between many individuals with their own, personal staff teams and the economics of running a 24 hour service for all residents, along with operating the different activities for all.

Concern about extra care

The group had two main concerns about extra care housing:

- That it would not be **affordable** initially or if Council policy changed in some way and price escalated in the future. There were questions about maintenance costs, what happens if an owner runs out of money to pay for care, conditions in a lease that may depress property value.

It is clear comprehensive information, easy to understand on how the finances work and relate to different benefits for both potential owners, shared owners and tenants is required

- **Health** both in relation to any criteria that might be applied to exclude applicants at the outset and fear of being excluded if health deteriorates.

Here an explanation of individual rights, reinforced in tenancies and leases and any Adult Social Care contracts is required

The discussion also identified the potential attraction of shared equity and there was some interest in the idea of being able to staircase down by selling tranches of equity back to the landlord releasing capital if individuals' circumstances changed.

Some different personal circumstances were articulated by individuals:

- Policy on pets and ‘assistance’ dogs
- How standards would be maintained, monitored and kept up
- Being with a lot of very elderly people

Facilities and buildings

The cliché joke is “*Whatever the question, the answer is a bungalow*”

The group were evenly divided when they completed the questionnaire over whether they would prefer a flat or a bungalow. Bungalows are the most expensive built form but the majority of those who wanted a bungalow would only be willing to pay 10% more, a couple of participants were willing to pay 20 or 30% more. A clear majority of the group expected a 2 bedroom property, a few would settle for a one bedroom property and one wanted a three bedroom property. There was an overwhelming preference for showers rather than baths, in line with most contemporary extra care development.

Participants were asked “*what are the most important facilities extra care housing should have?*” From a list of 17 facilities commonly found in extra care those most often identified as ‘essential’ were:

- Restaurant/café
- Assisted bathing
- Laundry
- Library
- Room for doctor/nurse to visit
- Shop
- Hairdresser
- Guest suite
- Garage/charging facilities for buggies

Surprisingly, since it is a provision normally taken for granted, neither a large lounge or smaller meeting room appeared on the priority list, indeed nearly a quarter of the group identified a lounge as ‘not important’.

Participants were asked about the provision of meals. Replies reflected the diversity of individual preferences with the group equally divided between those who would like one or two meals provided, those who would like some assistance with cooking and those who wanted and expected to continue to cook for themselves. Most people expected to pay £5 – 6 for a midday meal.

What are the key attractions of extra care?

The most frequently used phrase in the questionnaires was ‘peace of mind’. The group reflected evidence from many other studies that what is valued is the combination of ‘independence’ and ‘security’, the latter meaning a variety of things. Flexibility of care from a team you get to know and a wide range of facilities close at hand were all mentioned.

Communication

The group were appreciative of being consulted at an early stage. In attempting to explain extra care to a wider audience they suggested someone already living in extra care able to talk at first hand about the lifestyle would be most valuable.

The key action points for this strategy are:

- Direct Payments – further consideration to be given on how this important choice can be managed in extra care
- Affordability – comprehensive information on finances
- Health – assessment criteria, information on tenancies, leases
- Communication – ongoing consultation with older people including the opportunity to hear about the lifestyle from people in extra care

5. Summary

Bringing the three strands together:

- Most of those involved are positive about extra care; older people overwhelmingly so. Those with some reservations tend to be in District Councils or housing associations. Sometimes this is because of past experiences in trying to develop extra care or ongoing difficulties with letting sheltered housing. Others feel they do not yet know enough about extra care
- The factual case for extra care needs to be set out. There is little local empirical evidence that has been collected either by Districts in, for example, housing needs surveys or other agencies. The exceptions are the three local housing associations and care providers actively involved in extra care who now have direct evidence of demand and the role extra care can play
- How extra care is financed needs to be explained – there is quite a wide variation in knowledge. How extra care can be afforded by both owners and tenants also needs to be set down including the linkage with benefits for those eligible. The cost benefit equation also needs explaining
- Land is identified as a potential barrier but the suggestion from several agencies is that this will be less of a difficulty than expected. A number volunteered they had sites or buildings to offer for extra care. Sites do however need appraising for suitability for extra care. It is also likely that sheltered housing that does not have a long term future will often only provide sites for smaller extra care developments
- Planning consent, particularly for bigger developments, is widely seen as a hurdle
- Getting the necessary partnership working is similarly seen as a challenge. However there is also a widely shared desire to move on with extra care and some sense that the county is beginning to lag behind in provision for older people. Many are looking for leadership and greater clarity on what extra care should mean in the county; what the model is
- There is consensus around key aspects of the core model for Buckinghamshire. Developments should:

- Be available to a spectrum of home owners and tenants
- Cater for a range of ages, needs and circumstances and not be simply an alternative form of residential care
- Be located in sites that would be good for sheltered housing i.e. access to public transport, a range of local amenities, part of a community
- Cater for people who want to employ their own care staff if possible

There is rather less consensus on scale or how to embrace more isolated rural communities. Some of the uncertainties relate to (admitted) lack of knowledge or experience of different models of care. Those with more direct experience of extra care favour larger developments around 60 dwellings (or more) with a wide range of amenities

- Many worries about extra care similarly stem from uncertainty of what extra care means and how it works in detail. A need for good information, direct advice, was articulated by many from different perspectives. Overall it was summed up as requiring ‘marketing’ in its widest sense.

Chapter 3 Needs and Demand

The previous chapter explained the case for extra care housing needed setting out. One aspect is evidence of changing needs of older people and how these can be met by the present provision of specialist accommodation and care services¹.

1. Demographic data

Older people in Buckinghamshire

Figure 1 shows the numbers by age profile for people aged 60 or over in the four districts of Buckinghamshire and Figure 2 depicts these figures in percentage terms.

Figure 1: Age Structure – numbers

	People aged							
	All	60 to 64	65 to 69	70 to 74	75 to 79	80 to 84	85 to 89	90 plus
Aylesbury Vale	165,760	7,279	6,481	5,064	4,392	2,782	1,666	913
Chiltern	89,237	4,894	4,512	3,681	2,933	2,009	1,196	703
South Bucks	61,937	3,575	3,109	2,685	2,156	1,447	949	497
Wycombe	162,106	7,732	6,671	5,532	4,377	2,969	1,927	1,031
Bucks Total	479,024	23,489	20,775	16,955	13,857	9,210	5,740	3,138

Source: ONS Census 2001

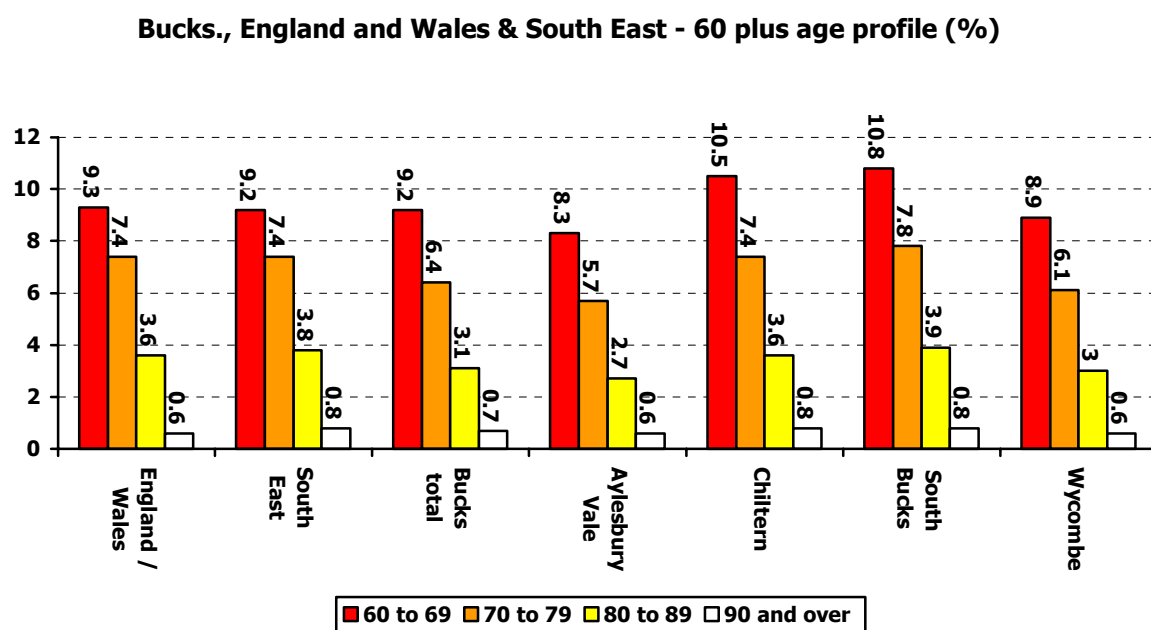
Those over 65 make up 14.5% (69,675 people) of the Buckinghamshire population.

¹ Statistical Profile

The following national sources were used to develop this section:

- ONS Census 2001
- ONS Focus on Older People
- ONS Population Projections
- Department of Work and Pensions Benefits and Pensions Data
- Age Concern England, Policy Positioning Paper on Older Peoples Income
- Quality and Choice for Older People's Housing: A Strategic Framework (ODPM)
- Deprivation Index (ODPM) – 2004 revised
- Commission for Social Care Inspection

Figure 2: Age Structure – percentages



Source: ONS Census 2001

From Figure 2 it will be noted that, compared with England & Wales and the South East, Buckinghamshire overall has 2% fewer people aged over 60 but has a similar number of people in the 60-69 age band. However, the figures for Buckinghamshire as a whole are influenced by marked variations across the four Districts. Again, from the chart, it is clear that the most populous districts, Aylesbury Vale and Wycombe, have lower proportions of older people within all age bands than the more sparsely populated Chiltern and South Bucks districts.

Population projections

Population projections tell us how the composition of older people will change. Figure 3 below provides projections to 2028 for Buckinghamshire taken as a whole.

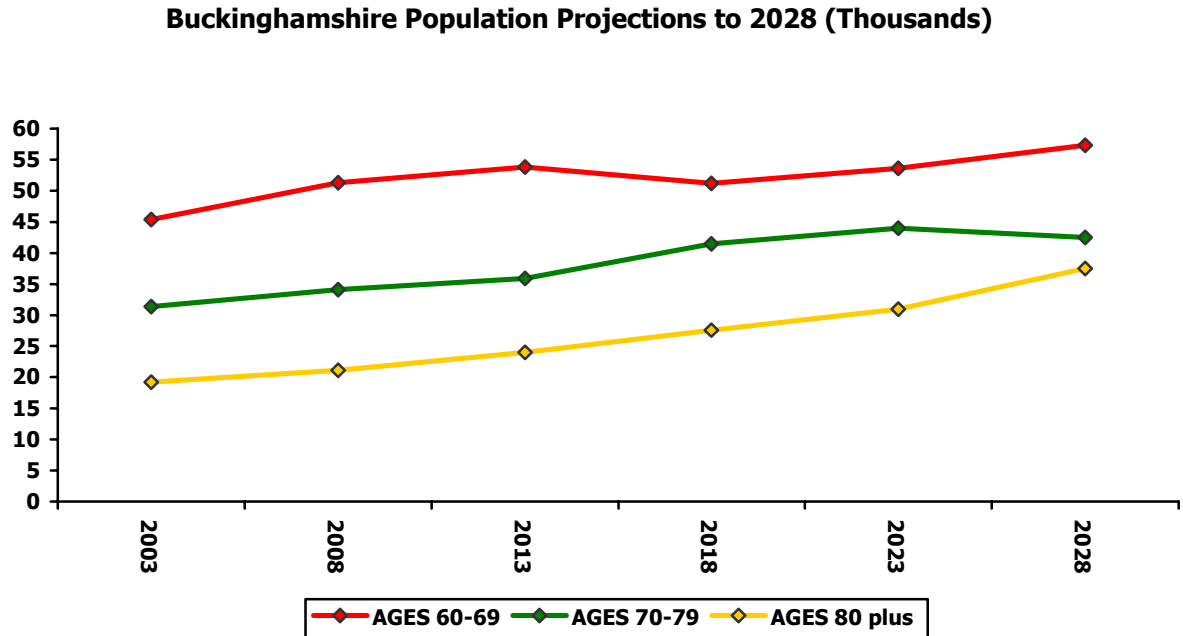
Figure 3: Buckinghamshire population projections to 2028 ('000's with % increases)

	No. Aged 60-69	% increase from 2003 figures	No. Aged 70-79	% increase from 2003 figures	No. Aged 80 plus	% increase from 2003 figures
2008	51.3	13.0	34.1	8.6	21.1	9.9
2013	53.8	18.5	35.9	14.3	24.0	25.0
2018	51.2	12.8	41.5	32.2	27.6	43.8
2023	53.6	18.1	44.0	40.1	31.0	61.5
2028	57.3	26.2	42.5	35.4	37.5	95.3

Source: ONS forecasts

As shown in figure 4 below there are marked increases overall in all three of the categories of older people, with the largest occurring in the 80+ age group.

Figure 4: Population projections from 2003 to 2028



Source : ONS subnational population projections 2003

Figure 5: Population projections from 2003 to 2028 (%)

		England	Bucks
AGED 60-69	2008	11	13
	2013	18	19
	2018	17	13
	2023	24	18
	2028	35	26
AGED 70-79	2008	3	9
	2013	8	14
	2018	28	32
	2023	39	40
	2028	39	36
AGED 80 plus	2008	7	10
	2013	17	25
	2018	29	44
	2023	45	62
	2028	77	95

Figure 5 above shows the increases in the population aged 60+ from 2003 in percentages for both England and Buckinghamshire. This is a key part of the basis of the need for a programme of extra care.

In the 2001 census there were 30,612 people in the 70-79 age bracket – by 2028 this will rise to 42,500: An additional 11,900 people (39%). The older elderly group, those over 80, is expected to double from 18,088 to 37,500.

These are dramatic changes in just over 25 years. They provide a key driver for extra care housing.

The Research Group in Policy Support of Buckinghamshire County Council has produced District level forecasts of population change based on the South East Plan which gives further detail of the potential impact of housing growth including expansion of surrounding areas like Milton Keynes.

Proportion of population in Buckinghamshire’s over 65’s (%)

	2005	2010	2020	2025
Buckinghamshire	15	17	19	20
Aylesbury Vale	14	15	18	19
Chilterns	18	19	21	22
South Buckinghamshire	18	19	20	21
Wycombe	15	16	18	19

Source: Buckinghamshire County Council

This forecast says that between 2005 and 2025 the population over 65 in Buckinghamshire will grow from 73,800 to 100,200; a 36% increase.

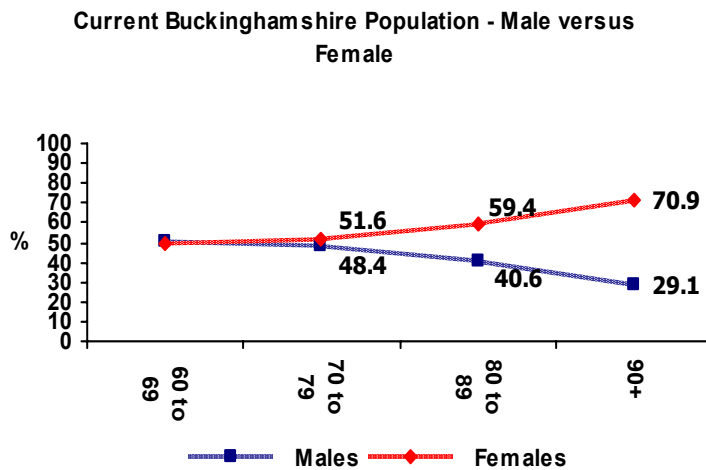
Milton Keynes and South Midlands Expansion (MKSM)

Regional Policy identifies Aylesbury as a major growth town, requiring it to expand by 16,800 new dwellings from 2006-2026. 40% of these dwellings have to be affordable. (Aylesbury Vale Local Development Framework June 2006) Aylesbury Vale are currently consulting on the vision and objectives surrounding this growth in terms of the environment, local economy and community.

Planning for new services will need to be linked to this consultation and to the outcomes of local policy decisions.

The chart below (fig. 6) shows that, in common with the UK as a whole, the proportion of women in Buckinghamshire is higher in the older age groups, most notably in the 80 plus age band.

Figure 6: Population – Male versus Female

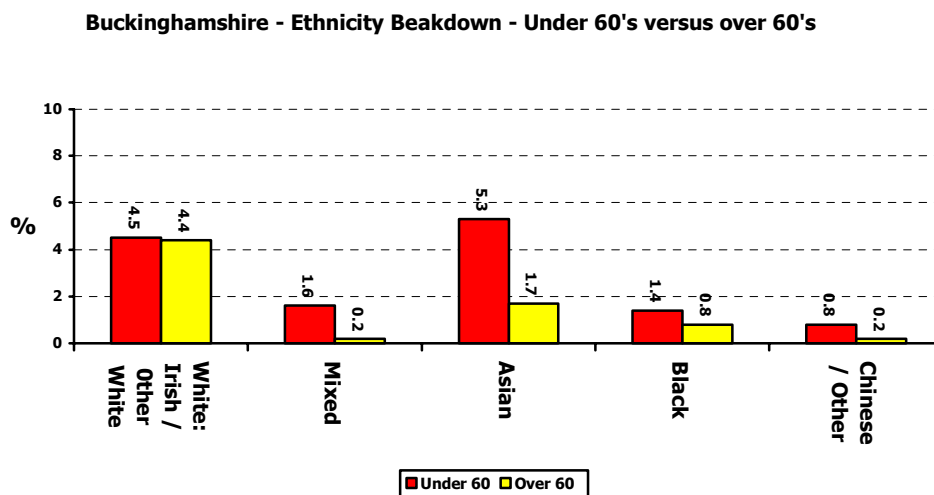


Source: ONS Census 2001

Ethnicity

The ethnic population in Buckinghamshire is in line with that in England and Wales where 12.5% do not fall into the White British census classification. Figure 7 below shows the ethnic mix for the population of Buckinghamshire under 60 years of age and for the 60 plus age group. The most noticeable difference in the profiles is the larger proportion of Asians (predominately of Pakistani origin) in the under 60 category. With regard to the individual LA's Aylesbury Vale and particularly Wycombe have higher non-white ethnic concentrations. In the 2001 census the non-white ethnic proportion was 12.1% for Wycombe.

Figure 7: Population – Ethnicity



Source: ONS Census 2001

Migration

As indicated in Figure 8 below the number of people aged 65 and over in Buckinghamshire as a whole was static in the stated period with the small net inflow within Aylesbury Vale being offset by trends in South Bucks and Wycombe. There is no obvious move out from Buckinghamshire in search of more appropriate accommodation or support in later life nor greater attraction to the county.

Figure 8: Migration rates for persons aged 65 and over mid-2002 to mid-2003

		Persons (thousands)		
AREA	Age	Inflow	Outflow	Balance
Aylesbury Vale	65+	0.6	0.4	0.2
Chiltern	65+	0.4	0.4	0.0
South Bucks	65+	0.3	0.4	-0.1
Wycombe	65+	0.4	0.5	-0.1
Bucks Total	65+	1.7	1.7	0.0

Source: ONS Internal migration within the United Kingdom – gross and net flows mid-2002 to 2003 (thousands).

There is some expectation of increased inward migration particularly from Eastern European Countries who are members of the EEC. It is possible that this will have an impact on improving the availability of workers in the care sector.

2. Household composition

Figure 9 below shows the figures for the number of people in households who are lone pensioners, pensioner couples, and other pensioners.

Figure 9: Household composition – pensioners

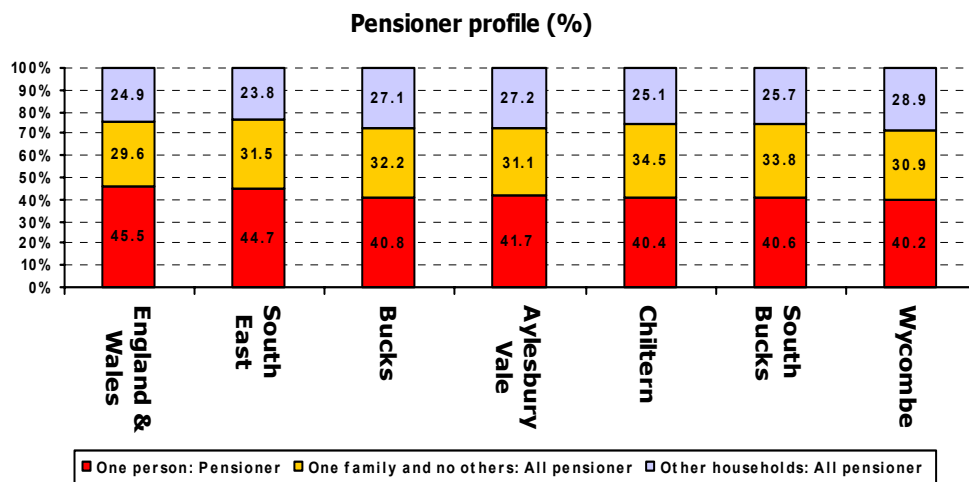
	One person: pensioner i.e. Lone pensioner household	One family and no others: All pensioner	Other households: All pensioner (i.e. households with people of pensionable age who have no family relationship)	Total (i.e. All households with at least one person of pensionable age)
Aylesbury Vale	17,466	7291	5,430	4,745
Chiltern	12,093	4886	4,170	3,037
South Bucks	8,742	3545	2,953	2,244
Wycombe	18,863	7,583	5,836	5,444
Bucks	57,169	23,310	18,389	15,470

Source: ONS Census 2001

Figure 10 below illustrates pensioner household composition statistics in percentage terms and gives the corresponding numbers for England & Wales and the South East.

One noticeable difference, compared with both England & Wales and the South East, is the lower proportion of pensioners living alone in Buckinghamshire, with the figures being fairly uniform across the four districts. For pensioner couples the figure for Buckinghamshire as a whole is only slightly higher than for England & Wales and the South East but within this there are more noticeably higher proportions recorded for the least populous districts of Chiltern and South Bucks. For the third category the figure for Buckinghamshire is noticeably higher than those for England & Wales and the South East and of particular influence here are the higher percentages for the County's two most populous districts.

Figure 10: Household composition – pensioners (%)



Source: ONS Census 2001

3. Health

The health of older people affects the need for specialist accommodation and services. Equally, good quality, suitable accommodation can promote health and play a preventative role.

General Health

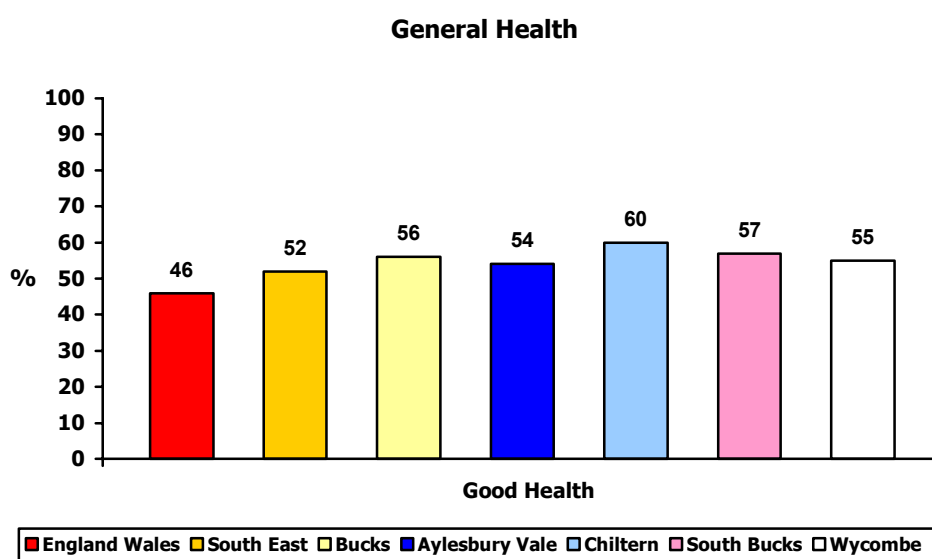
Figures 11 and 12 below show the figures for people in good health, fairly good health and not good health for the 50 plus age group in the Buckinghamshire area. The proportion of those who rate their health as 'good' is significantly higher than the England and Wales average and marginally higher than the South East average. With regard to the proportions within the County a greater proportion of South Bucks and (particularly) Chiltern residents believe they have 'good health' compared with Aylesbury Vale and Wycombe.

Figure 11: General Health (numbers)

	Bucks	Aylesbury Vale	Chiltern	South Bucks	Wycombe
Good	89,108	27,422	19,850	13,435	28,401
Fairly Good	49,919	16,446	9,898	7,229	16,346
Not Good	19,435	6,476	3,593	2,732	6,634

Source: ONS Census 2001

Figure 12: General Health (%)



Source: ONS Census 2001

Limiting long-term illness (LLTI)

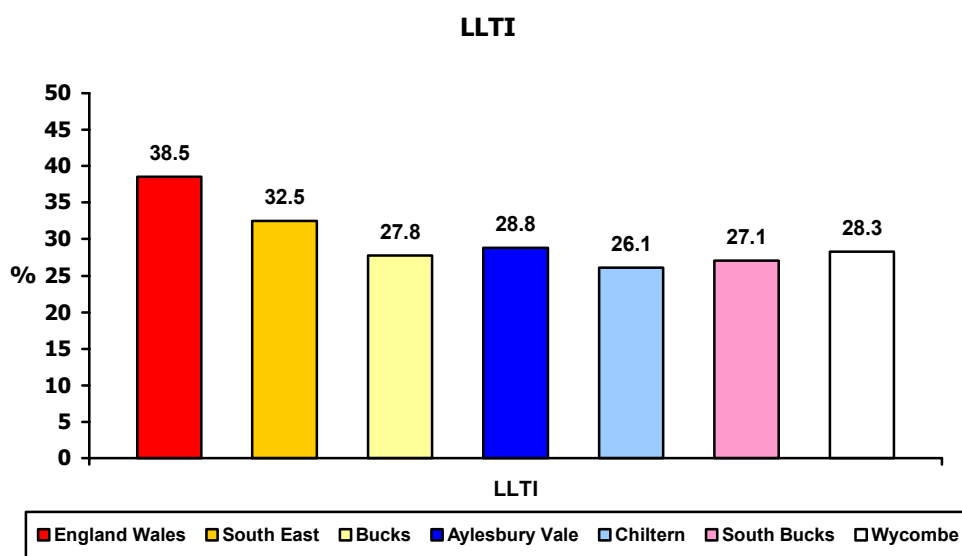
Figures 13 and 14 below show the number and percentages of people aged over 50 with and without LLTI. The proportions of those with LLTI are significantly lower than the corresponding England and Wales and South East averages. Proportions within the individual LAs are marginally lower in the Chiltern and South Bucks areas.

Figure 13: LLTI (numbers)

	Bucks	Aylesbury Vale	Chiltern	South Bucks	Wycombe
With LLTI	44,065	14,475	8,705	6,330	14,555
Without LLTI	114,397	35,869	24,636	17,066	36,826

Source: ONS Census 2001

Figure 14: LLTI (%)



Source: ONS Census 2001

Hospital episodes

Figure 15: Hospital Episode Statistics 02 - 03 Finished Consultant Episodes

	Aylesbury Vale	Chiltern	South Bucks	Wycombe	Bucks total
Males Aged 60 plus	4,669	3,065	2,832	5,370	3,984
Females Aged 60 plus	5,209	3,147	2,927	5,267	4,138
TOTALS	9,878	6,212	5,759	10,637	8,122
%	34.6	31.2	39.9	35.2	34.9

Source: ONS Neighbourhood statistics

The table above shows that the highest percentage of hospital episodes is found in South Bucks with the lowest in Chiltern. The County-wide incidence is broadly in line with the England and Wales which could be expected due to the relatively low levels of deprivation in the County.

4. Health and Benefits

Incapacity Benefit

Incapacity Benefit replaced Sickness Benefit and Invalidity Benefit from 13 April 1995. It is paid to people who are assessed as being incapable of work and who meet certain contribution conditions.

Figure 16 - Incapacity Benefit claimants aged 60 and over (numbers)

	2005	% of 60 plus pop.
England & Wales	305,600	2.8
South East	24,000	1.4
Buckinghamshire	1000	1.1
Aylesbury Vale	400	1.4
Chiltern	200	1.0
South Bucks	100	0.7
Wycombe	300	1.0

Source: DWP

Of note, the percentage of those claiming incapacity benefit in Buckinghamshire as a whole is less than half of the England and Wales figure. South Buckinghamshire has the lowest number of claimants at 0.7% of the over 60 population which is just one quarter of the national average while Aylesbury Vale has the highest proportion of claimants in the County although this still represents only one half of the national average.

Attendance Allowance

Attendance allowance was introduced in 1971 and is a non-contributory, not income related and non-taxable benefit. It is a benefit for older people who are so severely disabled, physically or mentally, that they need someone with them to help with personal care. They could need either frequent help coping with their bodily functions or constant care to stop them hurting themselves or others. This could be either during the day or at night.

There are two rates of Attendance Allowance. A claimant who needs help both during the day and at night can get the higher rate of Attendance Allowance. A claimant who needs help either during the day or at night gets the lower rate.

It is an important benefit for older people as it is available to all and not means tested. We would expect to find a significant proportion of residents in extra care are eligible for this allowance and some care providers use it as a part of the financial package and in the modelling of operating costs.

Figure 17 - Attendance Allowance claimants (totals)

	2003	2004	2005
South East	143900	152200	160000
Bucks	8200	8600	8700
Aylesbury Vale	2800	2800	2800
Chiltern	1600	1800	1900
South Bucks	900	1000	1200
Wycombe	2900	3000	2800

Source: DWP

Figure 18 - Attendance Allowance claimants higher and lower rates (2003)

	All Claimants	Higher rate claimants (no.)	Higher rate claimants (%)	Lower rate claimants (no.)	Lower rate claimants (%)
England and Wales	1,216,823	605,150	33.2	611,673	33.6
Buckinghamshire	7,760	3,830	33.0	3,920	33.8
Aylesbury Vale	2,650	1,400	34.6	1,250	30.9
Chiltern	1,550	780	33.5	765	32.8
South Bucks	1,120	530	32.1	590	35.8
Wycombe	2,440	1,120	31.5	1,315	36.9

Source: DWP

Figure 19 - Claim rates compared to England and Wales

	Claim Rate (2001)	Claim Rate (2002)	Claim Rate (2003)	Difference from 2001 to 2002	Difference from 2002 to 2003
England and Wales	14.01%	13.98%	14.64%	-0.03%	0.66%
Aylesbury Vale	11.45%	11.40%	12.43%	-0.05%	1.03%
Chiltern	9.32%	9.42%	10.32%	0.10%	0.90%
South Bucks	9.49%	9.08%	10.32%	-0.41%	1.24%
Wycombe	10.48%	10.33%	10.84%	-0.15%	0.51%

Source: DWP

The chart above shows Attendance Allowance claim rates amongst those over 65 in Buckinghamshire compared to England and Wales. Overall the claim rates in the County are lower than in England & Wales with Aylesbury Vale having the highest percentage (12.43% in 2003), although claim rates overall are showing an increase in line with the population changes set out earlier.

5. Deprivation

Measuring Deprivation

The common method of pinpointing deprivation in England is via the Indices of Deprivation 2004, produced as a result of work commissioned by ODPM to strengthen and update the set of deprivation indices developed from 1998 by the then DETR.

The 2004 indices are produced for Super Output Areas (SOAs) which no longer correspond to ward boundaries, since they are based on Census 2001 output areas.

At the highest level is the Index of Multiple Deprivation (IMD 2004) which is made up of seven SOA-level 'Domain Indices', i.e. those relating to: Income; Employment; Health Deprivation & Disability; Education Skills & Training; Barriers to Housing & Services, Crime and, Living Environment. There is also a sub-set of indices devoted to 'Income Deprivation Affecting Older People'.

Deprivation in Buckinghamshire

Viewed at both a County and district level relative deprivation in Buckinghamshire is very low:

- The County's rank among the 149 Upper-Tier authorities is 144 (on a scale where 1 is the lowest rank)
- Among England's 354 District authorities the Buckinghamshire's four district councils are ranked as follows (again 1 is the lowest):
 - Aylesbury Vale: 324
 - Chiltern: 349
 - South Bucks: 327
 - Wycombe: 299

However, these high level results cannot reflect the fact that there are pockets of deprivation in Buckinghamshire; in this regard, for example, 15 of the County's SOAs are ranked within the top 31-40% of deprived areas of England. There are two main dimensions to this and these stem from the sheer diversity in the County's make up. The northern area in particular is mainly rural and here, as in other rural areas of the County, constraints on house building and the relative lack of community services cause challenges, particularly for older people.

In contrast there are the two significant urban centres of Aylesbury and High Wycombe which together are home to nearly 70% of Buckinghamshire's population. It is these two centres that suffer the highest levels of multiple deprivation, reflecting issues such as higher unemployment and crime together with challenges concerning housing and health.

Chapter 4 Supply – Meeting the Needs

Having considered an overview of the population and potential accommodation, health, care and support need, we set out in this chapter how needs are met in this area and some of the resources available. The vast majority (90%) of older people live in their own homes and never need any special accommodation so we start by looking at ordinary housing before moving on to consider sheltered housing, residential care and extra care.

1. Housing

Property Type

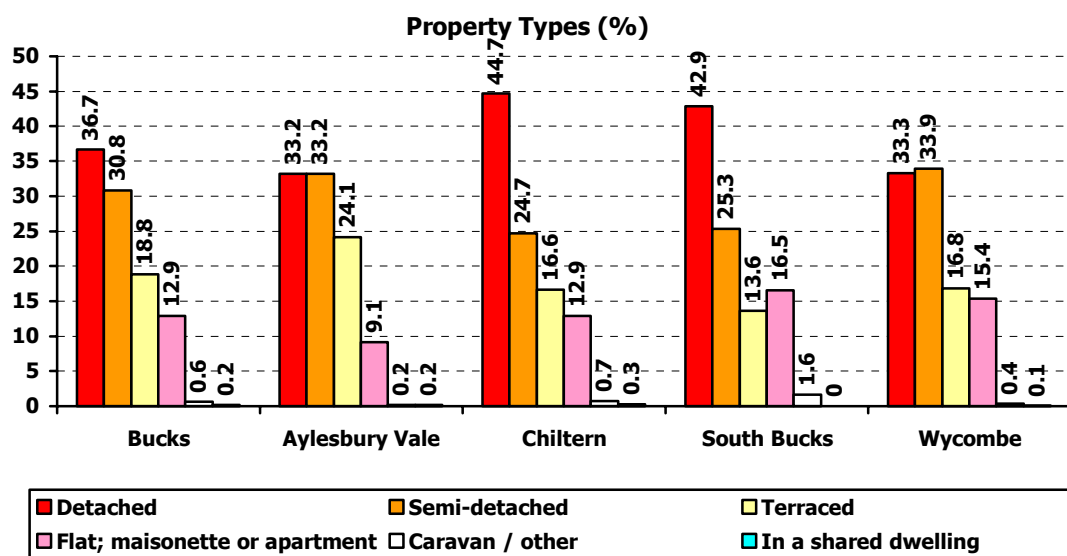
The numbers of each property type in the County and its districts are set out in Figure 21 while Figure 22 illustrates these in percentage terms.

Figure 21: Property types (numeric)

	(Detached) House or Bungalow	(Semi-detached) House or Bungalow	(Terraced) House or Bungalow	Flat, maisonette /apartment	Other	In a shared dwelling
Bucks	71,094	59,561	36,460	24,982	1,087	341
Aylesbury Vale	21,989	21,961	15,950	5,990	119	135
Chiltern	16,283	8,977	6,053	4,711	272	105
South Bucks	11,121	6,559	3,519	4,271	425	12
Wycombe	21,701	22,064	10,938	10,011	272	90

Source: ONS Census

Figure 22: Property types (percentage)



Source: ONS Census 2001

If they were viewed in isolation the figures for the County as a whole would mask some marked variations among the four districts. From Fig 22 it can be seen that there is one distinct similarity in housing type composition in Aylesbury Vale and Wycombe and that the same can be said about the more rural districts of Chiltern and South Bucks. As shown, in the former two districts there is parity between the numbers of detached and semi-detached properties whereas in the latter case there are not far short of double the number of detached properties compared with semi-detached ones.

The picture concerning terraced properties and flats is, however, more diverse. Aylesbury Vale has a far higher proportion of terraced houses than any of the other three districts and significantly fewer flats. Figures for the other three districts show closer matches between the proportions of terraced houses and flats and it is only in South Bucks where there are more flats than terraced properties.

Tenure

Figures 23 and 24 illustrate the high levels of home ownership among pensioners with the proportions being considerably higher in Chiltern and South Bucks. At 73.1% the average for Buckinghamshire is broadly in line with the average for the South East and significantly higher than the average for England & Wales. This factor suggests that there could be a significant future demand for leasehold retirement properties across the County if these were to be made available. Currently, however, there are no new schemes in evidence other than the large phased development underway at Denham Garden Village in South Bucks which currently offers some 2 and 3 bedroom leasehold properties (see Section 4.2 for details of leasehold retirement stock).

The combined (Council and RSL) social rented sector is however significant and represents an average of circa 20% of the County's pensioner tenure (the highest proportion can be seen in Wycombe area). As illustrated in Fig 24 below the dominant provider was Aylesbury Vale (which transferred to Vale of Aylesbury Housing Trust in July 2006) and Wycombe Councils whereas RSLs own the majority of stock in Chiltern and South Bucks following the transfer of the council stock to housing associations.

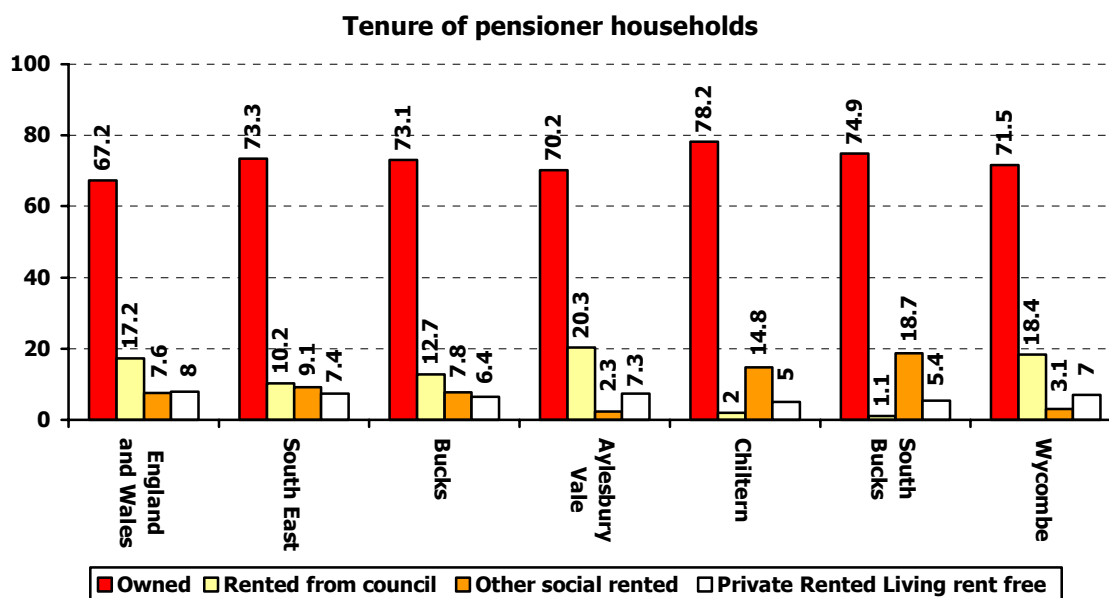
Lastly, the private rented sector / living rent free averages 5% across the County with the proportions being marginally higher in Aylesbury Vale and Wycombe.

Figure 23: Tenure of pensioner households (numbers)

	Owned	Rented from council	Other social rented	Private Rented Living rent free
England and Wales	3,453,109	881,864	390,503	412,143
South East	590,127	81,738	73,026	59,849
Bucks	30,388	5,296	3,248	2,662
Aylesbury Vale	8,906	2,578	287	922
Chiltern	7,071	183	1,337	454
South Bucks	4,844	71	1,208	348
Wycombe	9,567	2,465	416	938

Source: ONS Census 2001

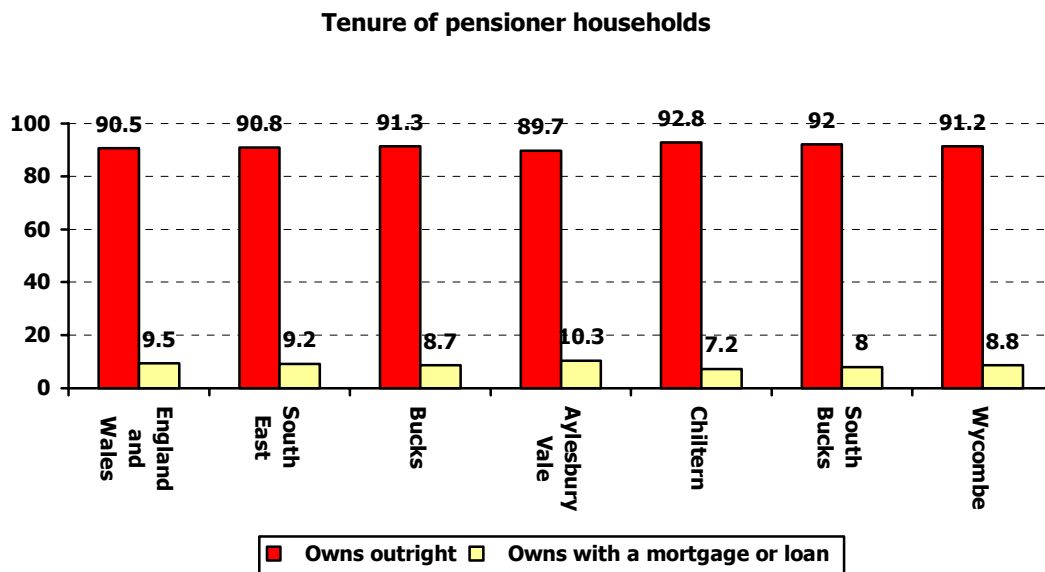
Figure 24: Tenure of pensioner households (%)



Source: ONS Census 2001

Figure 25 shows the proportion of pensioners who own outright and those who own with a mortgage or a loan. With the exception of Aylesbury Vale the proportions of those who own outright are higher than the corresponding averages for England and Wales and the South East.

Figure 25: Tenure of pensioner households (%)



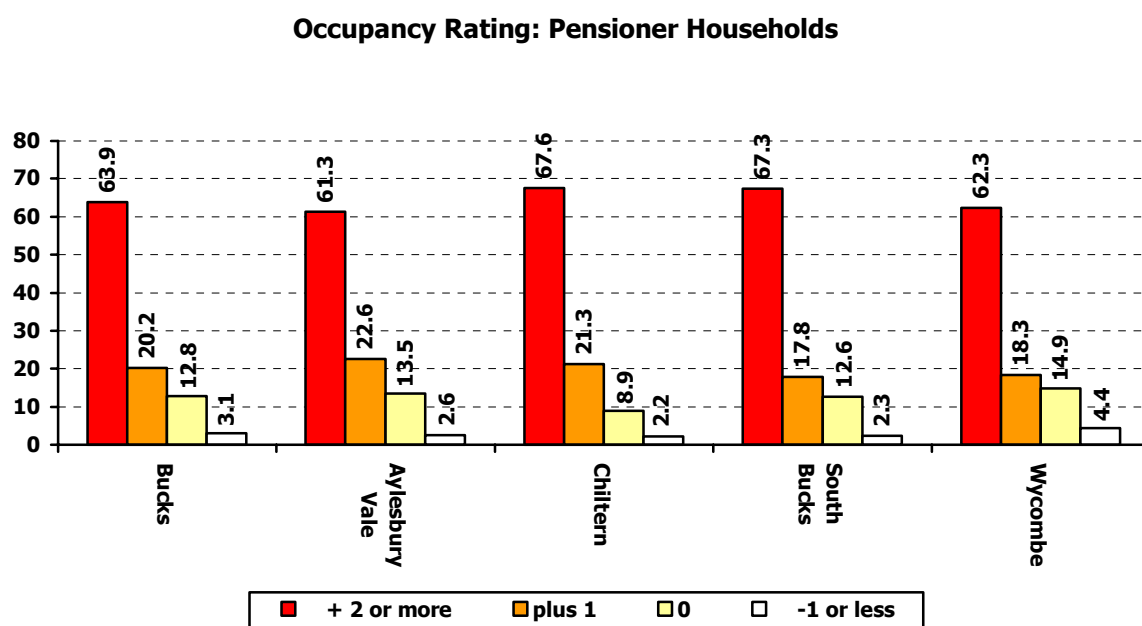
Source: ONS Census 2001

Under and over occupation

Properties with occupancy ratings of ‘+2 or more’ are deemed to have 2 or more rooms than are necessary for the occupants and, towards the other end of the scale, properties with a rating of ‘-1 or less’ are deemed to have 1 or more rooms less than are required for the occupants.

From Figure 26 it is apparent that there are considerable levels of under-occupation in the County with the highest levels of ‘+2 or more’ being evident in Chiltern and South Bucks. The extent of this under-occupation suggests that there are a significant number of 3 and 4 bedroom homes occupied by lone pensioners and pensioner couples.

Figure 26: Occupancy rates for pensioner households (%)



Source: ONS Census 2001

Provision of bathrooms and central heating and stock condition

Figure 27 suggests that the condition of the majority of properties in the County is good with very small proportions of properties without either or both central heating and sole use of bathroom.

Individual Districts will have complete stock condition surveys but in the public sector the target to meet the Government defined “Decent Homes Standard” by 2010 should ensure the vast majority of the ordinary housing stock is of a reasonable standard albeit not necessarily specifically tailored to meet the requirements of frailer older residents.

Figure 27: Properties with/without central heating and sole use of bathroom

	Bucks	Aylesbury Vale	South Bucks	South Bucks	Wycombe
With Central Heating with sole use of bath / shower and toilet	182,526	62,460	34,319	24,138	61,609
With Central Heating without sole use of bath / shower and toilet	428	167	88	22	153
Without Central Heating with sole use of bath / shower and toilet	5,059	1,858	853	618	1,721
Without Central Heating without sole use of bath / shower and toilet	78	34	6	3	22

Source: ONS Census 2001

House Price data

The value of property in the area is relevant to strategic plans because:

- It indicates what equity is available to purchase more specialist accommodation
- It informs policy on the use of equity release mechanisms to adapt or improve existing accommodation
- Gives an idea to the extent to which choices and solutions to accommodation problems are in individuals own hands

‘Quality and Choice for older people’s housing: a strategic framework’ (ODPM) provides valuable information on tenure and income. In England and Wales there was a substantial number, and proportion, of older social renters living on relatively low household incomes. Circa 90% had weekly household incomes of less than £200. It is also of interest to note that 44% of older owner-occupiers nationally had household incomes of below £200 per week.

The table below shows average house price data for Buckinghamshire and constituent Local Authorities (October to December 2005).

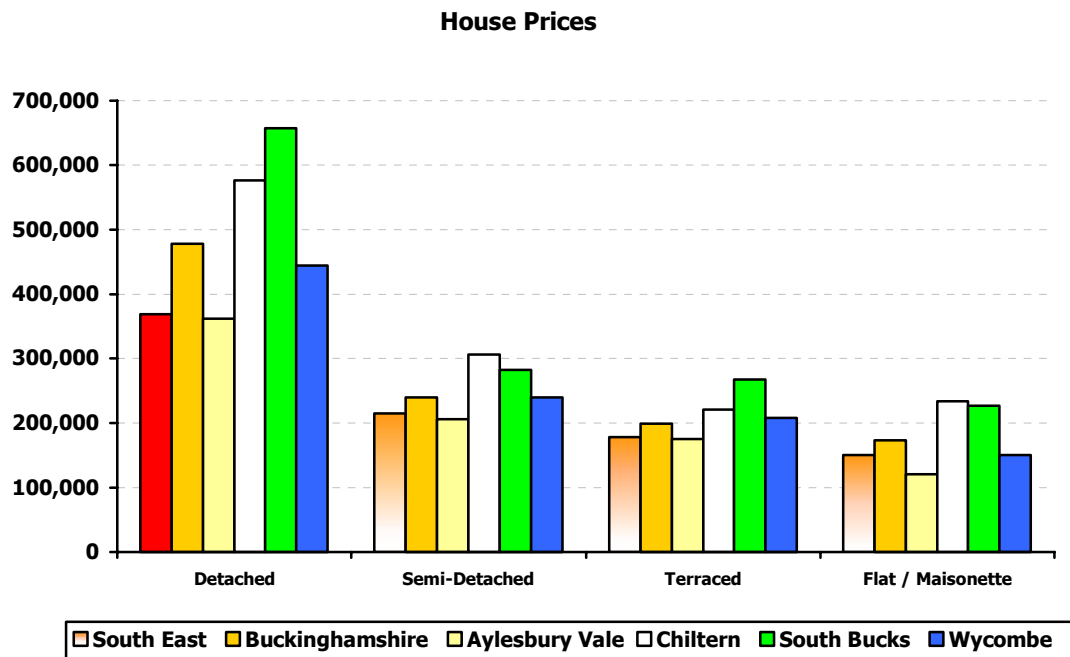
Figure 28: House Prices (£’s)

	Detached	Semi-Detached	Terraced	Flat / Maisonette	Overall
South East	368,609	215,336	178,187	150,713	229,083
Buckinghamshire	477,754	240,342	199,081	173,294	299,245
Aylesbury Vale	362,255	206,215	175,063	121,089	238,106
Chiltern	576,106	306,732	221,195	234,436	387,630
South Bucks	657,253	282,452	267,946	227,098	416,558
Wycombe	444,321	239,804	208,285	150,406	272,185

Source: Land Registry

For all property types, average Buckinghamshire prices exceed the corresponding price averages for the South East region significantly as shown in the chart below. At a County level, properties in the Chiltern and South Bucks Local Authority areas command significantly higher prices than in the Aylesbury Vale and Wycombe areas.

Figure 29: House Prices



Source: HM Land Registry

Taken together the characteristics set out in this section support the prospect of strong potential demand for purpose-designed retirement properties and, for the frailer, extra care/'assisted living' provision, that can be purchased. For local authorities and younger households with children there is potential value in making some larger/family houses available.

The large numbers who own outright without a mortgage is also a clue to the potential of people who need it, funding care and support themselves from equity released.

Having considered general needs accommodation, we turn to more specialised housing. This primary source of data for this section is a report produced for the purpose by the Buckinghamshire County Council supplemented by a survey of housing providers.

Rented Stock – Local Authority and other Social Landlords

The following tables give details of the stock by District and the stock type is defined within the County as follows:

Type	Definition
Alarm only	Individual properties or clusters of properties receiving a community alarm service only
Floating Support	Individual properties and sheltered housing schemes receiving a mobile warden and community alarm service
Sheltered	Where a Scheme Manager / Warden either residential or non-residential manages a sheltered housing scheme which is normally a block of flats with communal facilities
Extra Care Housing	An extra care housing scheme for people who require housing with care and support. Normally a block of flats or bungalows with communal facilities plus other features, e.g. a restaurant. This provision is normally has a scheme manager with an on-site care team with care available around the clock

Current stock of designated older people's housing by District

Aylesbury Vale District				
Category	Provider	No of Schemes	No of Units	Service Provision
Sheltered	AVDC	15	556	Resident Mgr & Alarm
Sheltered	AVDC	1	19	Non-resident Mgr & Alarm
Floating support	AVDC		962	Mobile warden
Extra care	English Churches	2	24	On site care staff / resident manager
Sheltered	Abbeyfield Society	1	16	Resident Manager
Sheltered	Housing 21	1	34	Resident Mgr & Alarm
Sheltered	Shaftsbury HG	1	48	Resident Mgr & Alarm
Sheltered	Masonic HA	1	32	Resident Mgr & Alarm
Sheltered	Thomas Hickman Trust	1	7	Resident Mgr & Alarm
Sheltered	Hanover HA	1	28	Non-resident Mgr & Alarm
Sheltered	Thame & District HA	1	23	Non-resident Mgr & Alarm

Chiltern District				
Category	Provider	No of Schemes	No of Units	Service Provision
Sheltered	Abbeyfield Societies	2	27	Resident Manager
Sheltered	Abbeyfield UK	3	33	Resident Manager
Sheltered	English Churches	1	15	Resident Manager
Sheltered	Chiltern Hundreds HA	5	156	Resident Mgr & Alarm
Sheltered	Chiltern Hundreds HA	10	313	Non-resident Mgr & Alarm
Alarm only	Chiltern Hundreds HA	N/A	351	Alarm only
Sheltered	Amersham Utd Charities	1	13	None

South Bucks				
Category	Provider	No of Schemes	No of Units	Service Provision
Sheltered	Abbeyfield Society	1	12	Resident Manager
Sheltered	Anchor Trust	1	20	Resident Mgr & Alarm
Sheltered	L & Q / Beacon HA	14	348	Resident Mgr & Alarm
Sheltered	Chiltern Hundreds HA	1	29	Resident Mgr & Alarm
Sheltered	Guinness the Hawthorns	1	25	Part time manager / alarm
Floating support	Beacon HA	N/A	340	Mobile warden
Alarm only	Beacon HA	N/A	486	Alarm Only

Note: Anchor Trust is re-developing Denham Village as an extra care community available with Licensed Victuallers having 100% nominations. The village will have 326 units – 143 rented and 183 leasehold retirement.

Wycombe District				
Category	Provider	No of Schemes	No of Units	Service Provision
Sheltered	WDC	34	1681	Resident Mgr & Alarm
Alarm only	WDC	26	222	Community Alarm only
Alarm only	Warden HA	1	10	Community Alarm only
Sheltered	Abbeyfield Societies	2	19	Resident Manager
Sheltered	Anchor Trust	1	38	Resident Mgr & Alarm
Sheltered	English Churches	1	10	Resident Mgr & Alarm
Sheltered	Hanover HA	1	36	Resident Mgr & Alarm
Sheltered	Housing 21	1	32	Resident Mgr & Alarm
Sheltered	James Butcher HA	1	16	Resident Mgr & Alarm
Sheltered	Guinness Trust	1	25	Resident Mgr (p/t) & Alarm
Sheltered	Buckinghamshire HA	1	33	Non-resident Mgr & Alarm
Sheltered	Chiltern Hundreds HA	1	30	Non-resident Mgr & Alarm
Extra care	English Churches/Heritage	2	24	On site care staff/resident manager

Figure 30: Sheltered Stock / Older People's Support Services

	Aylesbury	Chiltern	South Bucks	Wycombe
Alarm Only	0	351	486	231
Floating Support	962	0	340	0
Sheltered - non-resident scheme manager	70	313	0	67
Sheltered - resident. scheme manager	691	231	422	1857
Extra Care Housing	24	0	0	24

The chart above shows that:

- The majority of the stock in the County is warden controlled with 87% of the wardens living on site and 13% having non-resident status
- Only Aylesbury Vale and South Bucks are providing floating support services with Aylesbury Vale providing the majority of such services
- In relation to alarm only services Aylesbury Vale is the only authority that does not provide this service and this is because all their customers receive the enhanced floating support services

- The only 48 units of extra care housing available across the whole county (plus Anchors Denham Village under construction) are four schemes with 12 units in each scheme

The charts below show the proportion of Local Authority and RSL sheltered rented stock by District. Of note is that over one half of the stock (approximately 52%) is situated in Wycombe while the least amount of stock is in South Bucks (approximately 11%).

Figure 31: Sheltered & Extra Care Stock in Buckinghamshire

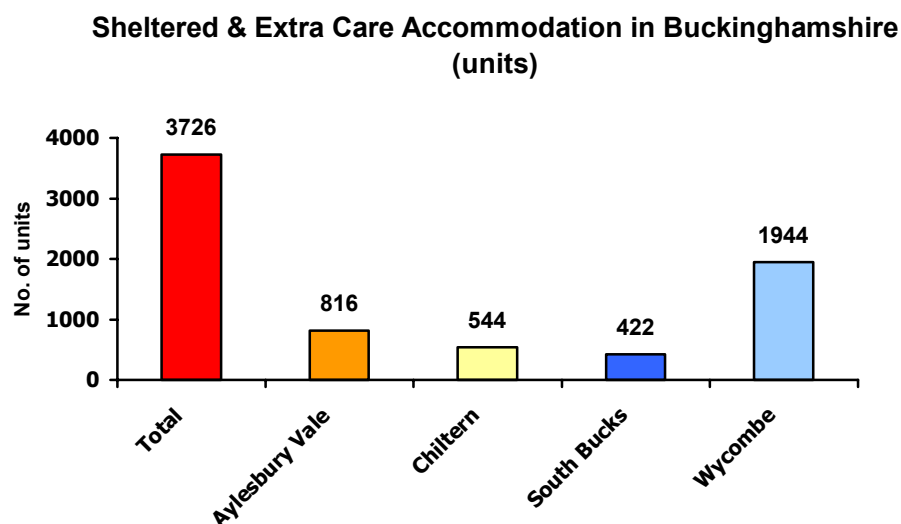


Figure 32: Units of Sheltered & Extra Care Accommodation per 1000 people over 65

	Units per 1000 people over 65 to rent
England	51.0
Aylesbury Vale	38.3
Chiltern	35.2
South Bucks	40.0
Wycombe	86.4
Bucks Total	53.4

Figure 32 above shows that proportionately, the numbers of sheltered and extra care units to rent in Buckinghamshire as a whole is close to the norm for England. However, in Wycombe the numbers of units, per 1000 of the population are considerably above the figure for England and in other Districts slightly less. Thus there is a rather uneven distribution of sheltered housing at district level.

Having set out the crude numbers of sheltered housing units, we need to consider the quality of the stock and core service provided.

2. Homecare currently provided in sheltered housing

In considering the potential role of extra care it is helpful to consider how much support is already being provided in traditional sheltered housing.

In a sample of 10 schemes (395 dwellings) across the county, run by seven different organisations, 64 people received a homecare service following a care assessment. This is 16% of residents. Care provided ranged from 1 to 11 hours per week with an average of 4.75 hours. In addition residents were getting a variety of other help, most commonly meals (17 people) or a laundry service (14 people) or attending a day service.

This provides only a partial picture of the level of domiciliary care already going into sheltered housing. Other residents will be supported by relatives while some will be making their own arrangements paying for home care from their own resources or using the Attendance Allowance. Finally each scheme has a resident or visiting warden service and an alarm link, part of which is usually now funded by Supporting People

Homecare in sheltered housing

Schemes	Dwellings	Residents receiving homecare	Hours purchased	Average care hours p. w.
10	395	64	304	4.75

3. Survey of sheltered housing providers – current and future plans

A survey of local housing associations and local authorities showed the following:

- The average age of **existing residents** in different organisations sheltered developments is between 69 and 85 with a norm around mid or late 70's
- The average age of **new residents** is typically 5 years younger
- Waiting lists are small in relation to supply

The significance of the age profile is that originally sheltered housing was intended for fitter, older people who might be for example simply be lonely or feel insecure. The average age of entry 40 years ago was mid 60's whereas now it is 70's.

One housing association explained 237 households were on the waiting list for sheltered housing and in the last 12 months 124 dwellings had become available. *“As you will note that is high compared to a low demand waiting list”* also of those actually seeking sheltered housing *“I do know a high proportion of those households will have refused at least one offer of a property”*. This picture of supply being adequate, or even more than adequate, to meet present demand was repeated by other providers.

The four largest providers of sheltered housing; Aylesbury Vale District Council, Wycombe District Council, Beacon and Chiltern Hundreds, provided details of lettings and waiting lists. Together they have 3100 sheltered properties.

Waiting list and lettings of sheltered housing

	Waiting list	Lettings in year	Stock
Beacon Housing Association	270	50	348
Chiltern Hundreds Housing Association	237	124	469
Aylesbury Vale District Council	232	58	579
Wycombe District Council	291	166	1713

Knowing that waiting lists for sheltered housing tend to overstate and are not an entirely reliable guide to real demand, it is apparent that the available sheltered housing stock is probably more than adequate to meet the present demand. This does not of course necessarily mean that it is the right “product” for all applicants or that the modest demand figures mean actual **need** is being met. There is limited demand despite the rising population, increase in claims for Attendance Allowance and similar features outlined in Chapter 3.

Abbeyfield Societies commonly provide modest sized accommodation, with some support and meals provision, in small developments. Three Abbeyfields took part in the survey and showed a slightly different picture:

- The average age was notably higher; 85, 87 and 90 in each society
- Waiting lists, despite some being small units, were much bigger, (28 waiting for one scheme of 16 flatlets for example) in two of the Societies

This provides some support for the proposition that:

- Demand for traditional sheltered housing is declining, particularly when it has some sub-standard characteristics
- While demand for specialised accommodation for frailer, older people is rising (and/or not being met) this is despite accommodation being of limited size.

Several of the respondents expressed interest in developing extra care housing. Only one was considering any new, ordinary sheltered housing but a number of organisations had plans for some re-modelling or improvements. One Abbeyfield intended to add some additional flats to a scheme. Any other plans for services for older people were tied to Supporting People policy decisions.

Aylesbury Vale District Council provided detailed reviews of 12 sheltered schemes. Common across most schemes were:

- Fire safety improvements
- Provision for mobility scooters

- Work to make schemes generally better/more usable by physically disabled or people with some sensory impairment – for example automatic door openers/closers

The reviews show that:

- In no case was “do nothing” considered an option
- The average age of residents is now late 70’s or early 80’s in most schemes
- Re-modelling to move towards an extra care type or improve size and layout of flats of provision was considered an option in over half the schemes
- The demand/preference for showers is almost universal, in part reflecting the increased frailty of those now entering traditional sheltered housing and inability to manage a bath in safety, with confidence

Since the transfer of the housing stock from Aylesbury Vale District Council to the Vale of Aylesbury Housing Trust on 17th July 2006 some of these identified works have been completed. The Trust will be using the reviews in preparation for stock improvement programmes for sheltered housing. It will also be looking at remodelling and reprovision projects to better meet the needs of current and future residents.

The kinds of issues found in this example were echoed in discussions and material supplied by other providers and is indicative of a more general position across the County.

A different perspective on quality comes from the assessments made by Supporting People which we consider next.

4. Supporting People Service Review of Sheltered Housing

Supporting People Grant is available to providers of some older people services that give support as opposed to personal care.

The Buckinghamshire Supporting People Team (SP) reviewed a sample of sheltered housing schemes in 2005 and early 2006. These reviews are to test the quality of provision and ensure the services funded by SP are being delivered in the way required under the contract.

The SP inspections covered 17 providers including three Abbeyfield societies and two District Councils with the balance of the organisations being registered housing associations or care based charities.

The SP Team visits each development, surveys or talks to residents and to staff. The review included extra care at Anchor Trust's Denham Village and some of the smaller extra care schemes run by Heritage Care.

District Councils sheltered housing

Aylesbury Vale District Council and Wycombe District Council continue to provide sheltered housing. (As noted above, Aylesbury Vale District Council transferred their housing stock to Vale of Aylesbury Housing Trust in July this year).

Aylesbury Vale has 575 sheltered dwellings with support provided by 13 on site managers and 6 mobile managers covering the 15 schemes.

The support service is judged by the SP Team to be of a good quality, whilst the physical accommodation is described as "fair to good". At the time of the review, residents were concerned about the implication of a possible stock transfer and a poor maintenance service, the latter the SP Team consider with justification.

There are small waiting lists, overall there is felt to be a continuing demand and need. Schemes which are of a reasonable quality continue to be in demand although sometimes lettings are to people outside the borough.

Wycombe District Council has a much larger stock of 1713 dwellings in 34 sheltered schemes. The support service is based on 29 wardens and 4 assistant wardens' posts.

At the time of review there were said to be 200 people awaiting sheltered housing. Nearly all (98%) of residents said they felt safe in their homes. Again the service is judged good quality with resident's main concern focusing on security and maintenance.

Housing Association and other providers

The housing association and other sheltered providers range from major national organisations like Anchor, large but more local associations that have taken over stock previously owned by District Councils, to a small local charity.

Subsidy costs and ‘value for money’ varies. Nearly all services are judged to be good. Physical buildings again are variously judged fair to good.

There is no consistent quantification in the SP reviews of waiting lists. It was also noted District Councils despite having 50-75% nomination rights, refer very few people although some stakeholders still said “*Demand for the service is strong*”.

Concerns identified at various schemes include:

- Poor consultation
- Lack of community facilities
- Frequent staff changes
- Absence of lifts creating mobility problems
- Withdrawal or reduction in on site staff presence

In a few cases it was noted schemes were no longer in demand and had an excessive number of voids. Chiltern Hundreds, (part of the Paradigm Housing Group) for example with 563 dwellings in 17 schemes is to close two services.

Overall conclusion from review

It is notable in SP reviews how often services are described in various ways as limited, but positively fostering independence. For example: “*This is a low level service where independence is encouraged and where many tenants don’t recognise the assistance they receive as support...*”

There is frequent reference to schemes still containing bedsits and problems in letting.

Services are seldom judged other than good but the quality of the accommodation is more variable. The picture on demand is mixed. There are waiting lists as set out above, but there are also some unpopular schemes. Despite positive feedback from some key stakeholders on the continuing value of sheltered housing there also appears to be limited use of nomination rights. In part this is explained by two District Councils having their own sheltered schemes to fill and these receive priority.

5. Retirement leasehold stock

Given the general rise in home ownership among older people and their preference to remain in this tenure there is steady growth nationally in this form of provision. Normally purpose-built schemes constructed on level, brownfield sites, near amenities comprising flats and bungalows the majority of which are usually one-bedroom properties. In terms of service delivery and communal facilities these schemes follow the traditional RSL/LA model for rented sheltered provision with the delivery of services often being an integral part of the leasehold agreement.

The primary source of information used to map the leasehold stock in Buckinghamshire has been the database maintained by the Elderly Accommodation Counsel (EAC), supplemented by a search of other information posted on the Internet, for example from Retirement Homesearch, part of the Peverel Group.

As shown in the tables below there is a roughly similar quantity of retirement leasehold stock in the Aylesbury Vale, Chiltern and Wycombe districts, managed variously by the private sector, RSLs and, in Wycombe, also by the District Council. There is, however, no evidence of new developments being built or planned within these three districts.

South Bucks, by contrast, appears to have only one established leasehold retirement scheme, built in 1989 by Aldwyck HA. However, this situation is set to change significantly over time as a result of the phased £62m Denham Garden Village development by Anchor Trust at the former Licensed Victuallers Housing Trust site in Denham. By 2009 this development is set to comprise 326 flats and houses plus shops, communal facilities and entertainment. Phase I represents 118 properties, just over half of which are available for leasehold purchase with price levels between £279,000 and £450,000.

Current leasehold retirement schemes in Buckinghamshire

Aylesbury Vale						
Scheme	Location	Manager	Units	Built	Services	Price & other info
Churchill Ct	Aylesbury HP21 7RG	Warden Housing	62 flats, 1- bed, 2-bed	1985	Resident Mgr & Alarm	No current vacs
Florence Ct	Aylesbury HP19 9QN	Peverel	40 flats, 1- bed, 2-bed	2001	Resident Mgr & Alarm	Resale 1-bed flats priced between £99,000 and £127,000
McKenzie Cl	Buckingham MK18 1SS	NBH	32 flats & bungs – 2-bed	1989	Non-resident Mgr (p/t) & Alarm	No current vacs
Paynes Ct	Buckingham MK18 1NQ	Peverel	40 flats, 1- bed, 2-bed	NK	Resident Mgr & Alarm	No current vacs
Sycamore Ct	Aylesbury HP19 9SL	Peverel	48 flats, 1- bed, 2-bed	1996	Resident Mgr & Alarm	Resale 2-bed 1 st floor £130,000
Total units			222			

Chiltern						
Scheme	Location	Manager	Units	Built	Services	Price & other info
Blenheim Lodge	Amersham HP6 5HX	Churchill Retirement Living	30 flats, 1-bed, 2-bed	2005	Non-resident Mgr	Units still for sale, no prices stated
Archer Ct	Amersham HP6 5UL	Peveler	30 flats, 1-bed, 2-bed	1998	Non-resident Mgr & Alarm	No current vacs
Giles Gate	Gt Missenden HP16 0PH	Peveler	40, 2-bed	1989	Resident Mgr & Alarm	No current vacs
Kingslodge	Amersham HP6 5TT	Raglan HA	43 flats, BSR, 1-bed, 2-bed	1989	Resident Mgr & Alarm	No current vacs. Scheme has mobility std & wheelchair units
Old Town Farm	Gt Missenden HP16 9PA	Beechcroft Trust	16 flats, houses, 2-bed	1996	Resident Mgr (p/t) & Alarm	No current vacs
Townbridge Ct	Chesham HP5 1LN	Shaftsbury Housing Group	38 flats, 1-bed, 2-bed	1989	Resident Mgr & Alarm	No current vacs. Scheme has mobility std & wheelchair units
Total units			197			

South Bucks						
Scheme	Location	Manager	Units	Built	Services	Price & other info
The Hollies	Beaconsfield HP9 1RH	Aldwyck HA	26 flats, 1-bed, 2-bed	1989	Resident Mgr & Alarm	No current vacs. Scheme has mobility std & wheelchair units
Total units			26			

Wycombe						
Scheme	Location	Manager	Units	Built	Services	Price & other info
Eliot Ct	Marlow SL7 3AA	Peveler	22 flats, 1-bed, 2-bed	2001	Non-resident Mgr (p/t) & Alarm	No current vacs
Jasmine Cr	Princes Risborough HP27 0AF	HPML	30 flats & bungs, 1-bed, 2-bed	1989	Resident Mgr & Alarm	No current vacs. Scheme has mobility std & wheelchair units
Russell Ct	Naphill, High Wycombe HP14 4RP	Buckinghamshire HA	29 flats, bungs & houses, 1-bed, 2-bed	1987	Resident Mgr & Alarm	No current vacs. Scheme has mobility std & wheelchair units
The Acorns	Cressex, High Wycombe HP11 1UB	Guardian Mgt Services (Anchor Group)	30 flats, 2-bed	NK	Resident Mgr & Alarm	No current vacs
Trinity Ct	Marlow SL7 3TZ	Peveler	39 flats, 1-bed, 2-bed	1987	Resident Mgr & Alarm	Resale 1-bed 2 nd floor £180,000
Woollerton Ct	Princes Risborough HP27 9HJ	Wycombe Dist Council	90 BSR, flats & bungs, 1-bed, 2-bed	NK	Resident Mgr & Alarm	No current vacs. Scheme has mobility std & wheelchair units
Total units			220			

From the above charts, the total number of leasehold retirement properties in the County is 665 which represent 9.5 units per 1,000 of the population over the age of 65. This total is set to increase by 183 to 848 when the Denham Village development is completed in 2009. Assuming that there are no other new developments undertaken within this timeframe the number of leasehold retirement properties will then represent 12.2 units per 1,000 of the population in the County. This is very close to the national norm of 11.8/1000.

Extra care retirement leasehold properties

Currently there are no extra care retirement leasehold properties in Buckinghamshire. However, data from the Elderly Accommodation Counsel lists the following schemes in adjacent Counties.

Scheme	Location	Manager	Units	Built	Services	Price & other info
Saxon Court	Bicester OX26 6AZ	Hanover Property Management Ltd	54 flats, 1-bed, 2-bed	2001	On-site care/non-resident mgr	Currently no units for sale
Thamesfield	Henley on Thames RG9 2LX	Thamesfield RG9 2LX	39 flats, 1-bed, 2-bed	2002	Resident Mgr associated Care Home	Currently no units for sale
Bushmead Court	Luton LU2 7GY	Retirement Security Ltd	41 flats, 1-bed, 2-bed	2002	On-site care/non-resident mgr	Re-sales from £170,000
Oaktree Court	Milton Keynes MK15 9LP	Retirement Security Ltd	43 flats, bungalows	1989	On-site care/alarm	Re-sales: 2 bed apartment £133,000

Conclusion on supply of sheltered housing

Summing up, overall the level of retirement for sale and sheltered housing for rent taken together is close to the normal, expected level. Wycombe appears to have an excess of traditional sheltered housing for rent while the other Districts have rather less than normal. This lower level does however appear adequate for the needs of the local population probably because of generally better health and greater wealth.

	Units/1000 65+	
	England	Buckinghamshire CC
Sheltered housing to rent	51	53.4
Retirement housing for sale	11.8	12.2
Total	62.8	65.6

There is little extra care for rent or sale but in South Buckinghamshire additional provision is under construction.

The crude statistics mask the fact that some of the stock is no longer “fit for purpose” certainly for a frailer and older cohort of residents; demand for the traditional product is modest while the average age of residents has risen.

Moving now to consider the supply of more specialised care homes.

6. Residential and nursing care provision

Figure 33: Care Home Provision - Buckinghamshire and England

	Nursing Care	Residential Care	All
Places in Buckinghamshire	1,276	1,561	2,837
Places / 1000 people 65+ Buckinghamshire	18.3	22.4	40.7
Places / 1000 people 65+ England & Wales (2004)	19.4	32.7	52.1

Source: GLP Appendix

The chart above shows that the provision of both nursing and residential care per 1,000 of the population is less in Buckinghamshire than in England as a whole. This is most noticeable in the case of residential care with 10 places per 1,000 less in Buckinghamshire than in England. There are no Local Authority nursing or residential care homes in Buckinghamshire and in relation to residential care one provider, Fremantle Trust, owns 45% of provision (571 bed spaces), making it the predominant provider.

In 2004, Buckinghamshire commissioned a market study to analyse the care home fitness for the future, in line with future care standards.

A grading tool was used which graded the residential and nursing care establishments – the tool used four grades with ‘one’ being the highest and ‘four’ the lowest. Grades 1 and 2 generally met National Minimum Standards while grades 3 and 4 did not. The grading breakdown for the County is shown below.

Figure 34: Nursing and Residential Care Grading in Buckinghamshire

	Nursing Care	Residential Care
Grade 1	445	302
Grade 2	744	446
Grade 3	0	571
Grade 4	87	242

Source: GLP Appendix

Of note, only 7% of nursing home places do not meet National Minimum Standards while 52% of residential care places are in this category.

Project Care is a property and funding strategy agreed between Fremantle Trust, the main supplier of residential care to Buckinghamshire County Council, Housing Solutions and Buckinghamshire County Council to redevelop and modernise all the current sites in line with a new specification, referred to later on.

Figure 35 below illustrates that there was a reduction in both nursing and residential care in Buckinghamshire during the financial year 2005/2006 despite the growth in the population of older people.

Figure 35: Decline in Nursing and Residential Care in 2005/06

	2005/06	
	Residential Care	Nursing Care
New admissions	225	216
End of placement	261	225
Net reduction	36	9

Source: Buckinghamshire County Council

Profile of people placed in care homes

Based on placements by Adult Social Care of people over 65 during 2005/06 we can build up a picture of those with higher needs, some of whom may prefer extra care in the future.

The table below shows the majority (60%) had been supported at home prior to entering a care home.

Figure 36: Types of services clients were in receipt of prior to admission to a placement in 2005/06 for Clients 65 and over

Care Item Description	Nursing		Residential		Grand Total	
Professional support	2	1%	2	1%	4	1%
Health funded nursing care	5	2%		0%	5	1%
Direct Payments	3	1%	2	1%	5	1%
Self funded nursing care	11	5%		0%	11	3%
Intake	7	3%	7	3%	14	3%
Self funded residential care		0%	17	8%	17	4%
Laundry	12	6%	18	8%	30	7%
Day care	29	14%	57	26%	86	20%
Meals	30	15%	57	26%	87	21%
Respite	40	20%	70	32%	110	26%
Residential to nursing transfer	42	21%		0%	42	10%
Support at home	98	48%	155	71%	253	60%

* Percentages shown above are a percentage of the total number of clients in receipt of a service before admission

Often a move is preceded by some critical event like the death of a partner, illness or a fall.

The vast majority (85%) were already known to Adult Social Care as they were already in receipt of some services from the authority. This still however leaves 15% (73 people in 2005/06) who were not in receipt of a service.

The mean average period of occupation in a residential care home is 137 weeks but this is skewed by a few very long term residents. The median is much less at 79 weeks i.e. 18 months and is a more useful guide as to how long people will typically be in a residential care home once admitted. The figure for nursing care is about half.

Having set out the provision of specialist accommodation and trends, we can put the County's work in supporting older people in residential care and at home in a national context. The reduction in care home placements can be seen as successful implementation of a social care policy.

7. Personal Adult Social Care Performance Assessment Framework

The Performance Assessment Framework (PAF) data is produced by the Commission for Social Care Inspection (CSCI) and covers the following areas relevant to our plan:

- Unit cost of residential and nursing care
- Admissions to residential and nursing care
- Households receiving intensive home care
- Older people helped to live at home

The performance of Councils is divided into five bands which are intended to flag up the need for investigation of the service. The bands are:

- Band 1: Investigate urgently
- Band 2: Ask questions about performance
- Band 3: Acceptable, but possible room for improvement
- Band 4: Good
- Band 5: Very good

The average gross weekly expenditure per person on supporting older people in residential and nursing care (including full cost paying residents) in Buckinghamshire is £458 per week. The average cost for England is £405 per week.

Supported admissions of older people to residential care, per 1,000 of the population (aged 65 and over) in Buckinghamshire were 67 which equates to 485 admissions in 2005/06.

Older people helped to live at home in Buckinghamshire per 1,000 of the population (aged 65 and over) was 38 which equates to 2,741 people helped to live at home. This places Buckinghamshire in band 1 (the lowest rating). The target is to increase them to 50/1000 by 2006/07.

In Buckinghamshire the number of households receiving intensive home care (more than 10 contact hours and 6 or more visits during the week) during the sample week was 512 households. Households receiving intensive home care, per 1,000 of the population (aged 65 and over), was 7 and this places Buckinghamshire in band 2. The target is to increase them to 9/1000 by 2006/07.

In relation to the performance measures Buckinghamshire is performing well in two categories but receives poorer ratings in terms of 'helping people to live at home' and 'households receiving intensive home care'.

Figure 37: Buckinghamshire performance indicators (2004/05)

	Buckinghamshire	England
Weekly cost residential care (£)	458	405
Admissions to res. Care/10,000 65+	67	91
Intensive homecare/1000 65+	7	11.5
Older people helped to live at home/1000 65+	38	80

8. Extra care, mental health and disabilities

Extra care can potentially offer a good housing option in a suitable environment for people who have some needs in addition to any related to age.

Learning Disability

Careful analysis by Buckinghamshire County Council (paper to Leaders Advisory Group; “Future needs for accommodation based care of adults with a learning disability”, Peter Loose, 2005) indicated about 20 additional places are required each year. A small number of these will be for older people with a learning disability.

The requirements in Buckinghamshire are limited because of two major re-provision programmes which together will provide 150 places over the next 4 years.

Chronologically needs related to age may arise earlier than the general population. The average age of the onset of dementia for people with Downs Syndrome for example is 54 years. Accommodation should be accessible, usually to wheelchair standards, as a significant number of people with learning disabilities also have mobility problems. In line with the shift towards more independent, supported living in learning disabilities, accommodation which “allows the type and amount of support provided to be varied as individuals needs change or the type of need presented to Adult Social Care change”. Thus extra care may be a good option for some people with learning disabilities.

The demand to provide for older people with learning disabilities are rising as life expectancy of people with learning disability has increased dramatically over the last 50 years

There are a variety of approaches to caring for older people with learning disabilities in extra care housing:

- i. The Department of Health has funded a small pilot of 10 extra care schemes specifically for people with learning disabilities. These tend to be quite small developments of self-contained flats or bungalows with all the common features of extra care but fewer amenities. All have made use of Assistive Technology.

In North Buckinghamshire, because of the widely dispersed, low density, population characteristics at least one small specialist scheme of this type should be provided over the next 10 years.

- ii. Older people with learning disabilities can apply for places in any extra care scheme along with any other older person. The self-contained nature of extra care means if the individual requires additional or more specialist assistance this can easily be provided in a way that does not impact on other residents.

Experience elsewhere indicates that there can be additional management issues around the acceptance of residents with learning disabilities but equally other residents may volunteer to help befriend or support the disabled person. There are also such tensions over the “additional” help one person may be seen to receive.

- iii. In Buckinghamshire there are more than 50 people themselves over 70 still caring for a disabled relative. In some cases a recognised phenomena is that the younger, but disabled person, begins to become the carer for the parent (or other relative). Elsewhere some providers of extra care have experimented by providing a few larger properties in order to allow both to move into extra care and possibly even have their own additional carer or personal assistant.

Physical Disabilities

Most people with physical disabilities are supported in their own homes adapted if necessary. There is no need identified by Buckinghamshire County Council for any particular additional housing. Again, extra care can provide a better option for some people with physical disabilities because it is designed to at least mobility standards.

People with physical disabilities can apply for extra care on the same basis as any other person. It makes sense in any event for extra care to incorporate at least a few dwellings constructed to full wheelchair standards for those with a physical disability who use a wheelchair. Extra care also offers the chance to make additional adaptations within the property like any other ordinary family house or to have equipment installed.

Mental Health

The demographic changes imply a larger population of older people with mental health problems will gradually have to be catered for.

Recent analysis of the profile of existing service users within a day care, residential care and nursing care indicate that over 60% have dementia/mental health needs. The figures from the acute liaison services who work within Accident and Emergency, demonstrate that over 60% of admissions to Accident and Emergency have mental health needs.

This demonstrates a requirement that all service planning should incorporate design principles for dementia care.

Extra care can serve to offer individually based solutions to promote person centred care, which has been demonstrated to a key factor in promoting well being and reducing the adverse impact of cognitive impairment on day to day functioning.

It is a matter of debate as to the particular advantages of this model as a care and housing solution for people with more advanced dementia. This would depend on a variety of individual factors such as whether the tenant was already in situ and develops higher dependency but is known by carers and neighbours, or whether the person demonstrates a high degree of impairment upon admission/take up of tenancy.

There is some evidence that residents who enter extra care when well and build relationships but subsequently develop mental health problems are tolerated and supported better by fellow residents than those who move in when already unwell.

Some extra care providers attempt to support all residents, in their own homes, irrespective of other needs. In other models a separate unit or wing for older people with mental health problems has been incorporated with additional features particularly around security and risk.

There is no doubt that any future development of housing and care based provision needs to take account of the increasing prevalence of dementia and other mental health problems in the older population as there is evidence that current service models are under increasing strain.

9. Summary and Conclusion

- Demographic projections show significant growth in the population of older people, most notably those aged 80 plus, across the County. It is this category of the population who are most likely to benefit from extra care housing
- The County performs less well in terms of ‘helping people to live at home’ and ‘households receiving intensive homecare’. The provision of extra care housing using a ‘hub’ model where the scheme is used as a base to provide services into the community could assist in improving these performance measures and meet the needs of some older people better in a way they would prefer.
- There is evidence that demand for traditional sheltered housing is declining despite the growth in the population of older people and that the age of entry is now mid 70’s not mid 60’s. Equally there is evidence from the extra care already built and from some Abbeyfield societies of demand for extra care by older people
- The sheltered stock may not all be “fit for purpose” particularly as a good setting for frailer, older residents
- Policy is to reduce reliance on more institutional forms of provision and the County has been moving in this direction
- Extra care provision could assist in providing accommodation for more vulnerable older people and those with special needs, e.g. people with learning disabilities, people with mental health problems and those from BME communities. For example, we have identified in this section that:

- There is a growth in Buckinghamshire's BME communities among those aged under 60 and this suggests a future need for extra care provision adapted to meet specific cultural needs
- The lifespan of people with learning disability is increasing. This group also age more rapidly and may benefit from extra care provision earlier than those in the community as a whole

The next chapter looks at the different reasons for considering expansion of extra care as a means of meeting these challenges.

Chapter 5 The Case for Extra Care – Different Perspectives

The fundamental case for additional provision of services to support those whose abilities, mental or physical well being deteriorates in later life has been made in setting out the key facts and figures on need and resources available:

- There is a dramatic growth in the population of older people, particularly those over 80, above national norms
- Policy is to reduce reliance on more institutional forms of provision and the County has some way to go on this
- There is widespread desire for more choice to match the wish of some older people to enjoy a more active, healthy life, in a sociable setting but in their own home

1. What is the case specifically for extra care?

The aims of extra care are:

- To enable continued independence – own home, assistive technology, barrier free environment, working with residents rather than doing for them or “to them”
- Reduce social isolation – social activities, action to foster neighbourliness where carers are welcome and can continue to provide some support
- Provide an alternative to residential or more institutional models of care – own home but high levels of care available, based on individual needs
- Provide an opportunity to “age in place” for most – facilities, availability of 24 hour care, design features
- Improve quality of life of residents – greater opportunity for social contact, activity, barrier free environment, care, secure environment

The evidence on the extent to which these aims are achieved has recently been gathered together (Housing with Care for Later Life, K Croucher et al, JRF, 2006)

As explained, there is no single model of “extra care” so any review is limited by the fact that a comparison is being made between several different models of extra care. The reviewers conclude however:

- **High levels of satisfaction are consistently reported by residents of housing with care schemes**
- **It is the combination of independence and security that is most valued by residents**

Housing with care appears to occupy an area somewhere between sheltered housing (linked to independence and privacy) and residential care (linked to security and care). This combination of independence and security appears to offer an effective solution to some of the challenges and uncertainties of later life. A barrier free, purpose designed, warm environment, positive philosophies of care that emphasise the

maintenance of skills and abilities, whether or not to prepare your own food or eat in the dining room, having guests to stay – were integral to promoting independence. Residents' perceptions of security are complex. A sense of security was derived from a number of different elements of the schemes, in particular knowing staff were on-site 24 hours and that someone was at hand if people were unwell, the purpose designed environments that reduced risks of accident – especially falls – and made people feel more confident, and the reduced fear of crime and intruders.

- Housing with care **offers opportunities for social interaction and companionship**; however, the very frail and people with sensory and cognitive impairments are consistently reported to be on the margins of social groups and networks

Providers need to take a proactive approach to promoting the **social** well-being of frail older residents in housing with care schemes.

- In some circumstances housing with care **can provide an alternative to residential care**
- **“Aging in place” will not always be a reality** for some people
- People with challenging or high risk behaviours associated with severe dementia were not easily accommodated within the schemes evaluated
- **Housing with care can have a positive impact on the health and well-being of residents**
- Providers need to emphasise the additional benefits of housing with care, particularly in relation to quality of life, maintenance of health status and consistently reported high levels of resident satisfaction

Looking now at the gains from extra care from the perspectives of different agencies and interest groups:

Older Residents

- Positive lifestyle choice whereas moving to residential or nursing care is more often seen as the only option or a forced move
- More space and facilities than residential care and most older sheltered housing
- Secure – environment, financial, in an emergency, as health changes – support/care 24 hours in day, with people of similar age but not cut off
- Independence, control, choice
- Not isolated – a community
- A route to more manageable, suitable, well designed housing
- For owners a possible route to releasing equity and boosting income. For less well off owners a way of protecting limited assets that does not compromise entitlement to benefits.

Adult Social Care

- Reduce reliance on residential/nursing care
- Probably less costly alternative than residential care

- Helps with policy of supporting independence, at home and contributes to higher scores on key PAF indicators
- Can be used flexibly not exclusively for high or low needs
- Can cater for minority groups and particular or emerging needs such as older people with learning disabilities

Primary care and extra care housing

It is vital that any new models of housing, care and support play a crucial part in halting the rise of chronic diseases as part of an effective prevention plan and reduce the inequalities in health.

The living environment can have a powerful effect on well being and health at all ages. Older people are particularly vulnerable to the effects of poorly designed accommodation. The provision of well-designed communal areas in a scheme, for example, encourages social interaction thus reducing isolation and depression. Safe space to walk can improve mobility and blood pressure.

In addition to the potential to improve general health, extra care has significant implications for the delivery of health and social care services. Potentially redesigning care pathways to include telecare intervention and more effective distribution of information and improved nutrition can be well facilitated in this type of model.

The more effective management of chronic diseases is a priority for GPs and primary care. Self-management of these conditions is one of the keys to health service reform. Older people would like to see improved access to a range of healthcare and treatment interventions, which can be very effectively provided in scheme based settings and where clinical supervision can be more efficiently accessed. This model works in tandem with the availability of support and care over 24 hours.

It is also clear that the nature of care delivered via an onsite care team has greater likelihood of continuity, where care staff work as a cohesive team. The overall service response is therefore more person centred and can respond innovatively to ensure day to day health and social care needs are met.

Housing Provider

- Alternative to traditional sheltered housing
- Offers opportunity to re-model some schemes
- Possible additional capital funding from Department of Health
- Meet needs of some of own tenants or leaseholders better as they age
- Emerging market opportunity

District Council

- A new form of housing provision for older people for which there is support and some funding
- Meet needs of local residents as population changes continue

- For some an opportunity to re-model stock or re-provide in a positive way
- A route to releasing larger general family housing

In comparison with either residential care or traditional sheltered housing from almost every perspective, whether a potential resident, commissioner or provider extra care has clear attractions. It delivers on national policy objectives, themselves reflecting older peoples own preferences. It consequently meets the objectives of most of the agencies concerned; better health, more satisfied residents, and an additional option, less reliance on residential care placement.

Under this strategy it is envisaged most of those who live in extra care will already be local residents.

2. What are the negative consequences of extra care?

Three issues were consistently raised in discussions and interviews:

- Cost
- Impact on other provision
- Workforce

Cost

Comparing total cost of different types of specialist provision for older people is notoriously complex in itself. When trying to compare with extra care, as there is no single model, it is even more difficult. Added to which some assessment of quality gains should be made to give a like for like comparison. Finally there may be a range of external economies to be accounted for a proper cost benefit analysis. If for example extra care reduces accident and emergency admission, facilitates earlier discharge, contributes to health to the extent that there is lower drug usages, less demand on the continence service (there is some evidence for all these) then these “savings” should be incorporated in the assessment.

At its simplest the average capital cost of an extra care dwelling, in the same locality, will be higher than the average cost of a residential care bed because both personal living space and facilities are greater. It is likely to be marginally more than the cost of a traditional sheltered scheme because of the cost of more extensive facilities and amenities.

In terms of operating costs the evidence is contradictory but for similar needs and ignoring any quality or external benefits, extra care may be more expensive **overall** than residential care and cheaper than homecare.

From the perspective of Adult Social Care commissioning a service for someone extra care is likely to be cheaper than residential care or the equivalent care at home. This is in part because some costs shift from the local authority to a range of Central Government budgets and in part due to the intrinsic benefits of the facilities, design, support team and other features of extra care.

It is also likely to be cheaper than similar domiciliary care either at home or delivered in a traditional sheltered scheme. One of the key factors here is the saving in travel and unproductive time associated with mobile home care staff, carrying out a number of short visits, difficult to supervise, where there are often complaints about inconsistent staff compared with a stable, on-site, more easily managed care team.

The cost benefit equation will be altered by:

- The precise model of extra care
- The scale of development

How funding works is examined in detail in Chapter 7.

Impact on Other Provision for Older People

To some extent the impact on **residential care** will be influenced by decisions on the needs profile for each scheme. However, even if it was decided to target the higher care market, the effect on residential care of an extra care programme may be limited because:

- There is a substantial increase in the population, particularly older elderly, to cater for; almost doubling over the next 25 years. The market is growing. Not everyone will choose or be allocated extra care even if it were available
- The proposal in this strategy is in any event to only allocate a proportion of places to those needing residential care at the point of entry
- It may be 20 years or so before the scale of development hoped for can be completed. The intention is to shift to a longer term, strategic vision
- A significant number of residential care places are being re-provided in new contemporary buildings, to modern standards which should prove attractive to some older people. It is “Project Care” rather than a tentative extra care programme that will have most immediate impact on the residential/nursing care market although the intention is primarily to replace rather than increase residential care provision. In fact a reduction of 45 care home beds is planned
- There may be a further shift in supply of residential care in any event as other care home providers with sub-standard buildings and facilities leave the market. Converting to extra care may also be an option for care home providers. The growth in demand may also attract new entrants to the market
- The policy nationally and locally to reduce the number of care home places purchased is already well known and in place. New extra care provision makes no difference to the policy

There could be more impact on **sheltered housing**. Housing providers fear that new extra care provision will further reduce demand for traditional sheltered housing. Evidence from elsewhere is that an extra care programme may crystallise or hasten decisions on closing or changing schemes where it is already apparent a service has no long term future. Most commonly this is because the development no longer meets aspirations (in space, amenities, facilities or style), cannot match the requirements of an older and frailer group of new applicants or is poorly located. There is evidence

that all these characteristics are to be found in sheltered provision in Buckinghamshire.

A programme of extra care can also act as a catalyst to upgrade buildings, improve marketing, update services, and install new equipment so that the traditional sheltered housing can continue to play a useful role. The net effect can be to get a levelling up of the quality of provision for older people.

Workforce

Attracting sufficient staff to a relatively low paid care role is a national and local problem. The scenario is of continued, long term recruitment difficulty particularly in the South of England:

- As the proportion of older people rises so the proportion of the adult population of working age declines reducing the pool of workers while demand increases
- Domiciliary care has traditionally been a predominantly female occupation. In the south there are many employers competing for staff. High house prices in the South tend to make workers sensitive to wage rates.

Overall extra care may make little difference to the demand for care staff. It alters the setting in which care is provided not the underlying need for care and support.

To the extent that extra care is a substitute for care in other settings, it may have a generally beneficial effect making the demand for staff less than it would otherwise be (but it will rise in any event) or even increasing workforce supply because:

- Extra care is intended to help people maintain (or recover) independence longer, to do things for themselves as far as possible,
- Relatives and others can contribute, providing an element of care and support (if they are available), in a way not possible in residential or nursing care
- Delivery of care by an on site team is more efficient than peripatetic domiciliary care, delivered to people in different places, geographically spread. There is no “lost” travel time or other inefficiencies

In terms of staffing, compared to domiciliary care, extra care tends to be more attractive, other things being equal, and recruitment is consequently less difficult provided schemes are properly located:

- A significant number of potential care workers are not car drivers and consequently are unable to do normal domiciliary care work. A local extra care scheme located so it has good public transport will allow more people to take up this type of work
- Being part of a team, in a modern service is a draw
- Working in a building designed to be secure by design, with other people is safer and less risky than working alone, travelling about, particularly at night
- Opportunities for training, proper support, proper equipment and services and a possible career structure or a chance to develop and progress are characteristics of extra care providers that will appeal to some staff

Chapter 6 Models of Extra Care for Buckinghamshire

Extra care is a relatively recent form of specialist accommodation for older people. It has similarities to traditional sheltered housing but is designed and intended for older people who may need higher levels of care at some point.

Development has been supported by the Department of Health capital grants to local authorities of £147m and by the Housing Corporation directly funding Housing Associations.

The forerunners of modern extra care include “Very Sheltered Housing” and Anchor Trusts model of “Housing with Care” There are both public and private sector schemes. There are 30 larger extra care “villages” in England but most developments are 40 – 50 dwellings. Buckinghamshire has one extra care village under construction.

There is no one model of extra care. In this strategy we need to decide what role extra care should play in the county, the type of extra care we prefer and how much to plan for, and then how to go about making extra care happen. This is set out in later chapters, here we examine the different forms of extra care in more depth and explain the possibilities.

1. What is extra care housing?²

Extra care can play all these roles:

- **Replacement of rented sheltered housing** – modern sheltered housing only with more services and facilities. It may also be an acceptable basis for leasehold retirement housing.
- **An extension to sheltered housing** – hence sometimes the description “very sheltered” “category 2.5” providing for people who may not be suitable for traditional sheltered housing because of greater frailties, disabilities or behaviour
- **An alternative to residential care** – (or even nursing care) thus social care and therefore a Adult Social Care led provision
- An all embracing, **comprehensive alternative** to both sheltered housing and residential care providing for a wide range of needs and individual circumstances

Extra care does not have a precise definition or specification. It can be described and recognised by a set of features that characterise extra care:

- **Self-contained flats or bungalows** – a defining feature distinguishing extra care from residential care.

² This section draws on a fact sheet of “Models of Extra Care Housing” prepared by the Housing and Support Partnership for the Department of Health.

- Provision of an **appropriate package of care**, in the individuals own dwelling, to a high level if required
- **Catering facilities** with one or more meals available each day
- **24 hour care staff** and support available on site at any time
- More comprehensive and **extensive communal facilities** than traditional Category 2 sheltered housing – restaurant, lounge(s), activity room(s), library, health suite, computer suite, consultation room...
- **Domestic support services** including help with shopping, cleaning and possibly making meals
- **Staff offices and facilities**
- **Specialist equipment** to help meet the needs of frail or disabled residents – laundry, assisted bathing, sluice, hoist, also charging and storage facilities for electric wheelchairs/scooters
- **Design features and facilities** to make both individual dwellings and the facilities and environment accessible and easier to use including a range of assistive technology
- **Social and leisure activities/facilities** and additional individual or shared services – a shop, hairdressing, chiropody, massage, alternative therapies, cash machine, post box
- **Mobility and access assistance** – for example communal buggies or shared car pool

The first five or six items can be considered essential to come within the definition of extra care. Those lower down on the list will be found to varying degrees. All will be found in larger, contemporary retirement villages such as those at Denham Village.

More subtly, but significantly quality extra care should have a culture of supporting independence rather than creating dependence. Things are done with residents not to residents. Sufficient support is available but not excessive support.

Key features that distinguish extra care homes from traditional residential care homes are:

- Self-contained accommodation
- The provision of care can be separated from the provision of accommodation
- Care is based on an individual assessment of needs and can be more easily tailored to the individual

In retirement communities in addition:

- There is more likely to be a mix of ability amongst residents
- Under the Care Standards Act 2000, properties are not normally registerable although in some models aspects may be e.g. dementia care provision in a separate wing (see Department of Health toolkit/guidance at www.carestandards.org.uk)
- Residents are tenants or owners and not licensees. In each case they have security of tenure.

What distinguishes the extra care model from sheltered housing is:

- High levels of care available
- 24 hour staffing
- Extensive facilities

There are four key variables which define different models of extra care. It is which combination would best suit the circumstances of Buckinghamshire we must decide. The variables are:

1. Housing and care provider relationships
2. Buildings – this encompasses such characteristics as the origin of the building, scale of development, range and dispersion of facilities, type of accommodation
3. Allocation and eligibility criteria – and levels of care
4. Tenure and related to this the financial basis on which residents occupy their accommodation

Taking each element in turn starting with **housing and care provider relationship**, there are three key parties to delivering a service in extra care housing:

- Adult Social Care (and possibly Health) who commission and fund care services for some people
- A housing provider
- A care provider

In addition, the Supporting People Team may have a role if they contract for some support services.

The main options are:

- Housing and care provider to be the same organisation of different parts of a group structure
- Housing provider to be one organisation and the care provider a different organisation with a contract with Adult Social Care
- Housing provider one organisation, care provider Adult Social Care in-house team
- Housing provider and multiple care providers

In residential care, accommodation and care are provided together but in extra care separation between housing and care is possible.

The **landlord** function normally involves:

- Intensive housing management
- Low level support/preventative and liaison services (warden or estate management type help)
- Property maintenance service
- Resident involvement and participation

The **care provider** gives:

- Domiciliary care
- High level personal care
- Possible nursing care/specialist services depending in part on the role of extra care. For example, if it is considered a suitable option for those with dementia or other mental health problems.

Turning now to choices about **buildings**:

- Buildings vary in extent and mix of physical facilities. The range is from simply providing a restaurant and/or meals provision on top of the normal category 2 facilities to very extensive communal facilities including workshops, shop, health suite, therapy/consultation rooms, computer suite, library, greenhouse etc.
- The scale of developments can be small - around 40-50 people is a normal minimum although in Buckinghamshire there are smaller schemes or large, say 100-300 people.
- Larger retirement community scale projects vary in how facilities are located within the development. This impacts on support arrangements:
 - **Core and cluster** - a core central building contains most of the communal facilities like restaurant, library, reception, health suite and in some models, a residential care home. People live in their own properties scattered around the core building.
 - **Dispersed facilities** represent the other end of the continuum. Facilities are spread throughout the project.

Eligibility criteria and **Allocations** reflect the role of extra care. Lettings or sales maybe:

- Exclusively to those with high care needs
- Designed to maintain a mix of ability
- Target mix of dependencies – low, medium, high (e.g. basic care home). Some providers/commissioners have a more elaborate 5 or 6 point dependency range particularly in larger schemes or villages

The final variable to consider is **tenure**.

There are four basic possibilities:

- **Rented**
- **Mixed tenure** – which can include a combination of outright ownership and shared ownership along with renting
- **Ownership** and whether it is possible to consider both outright ownership and shared ownership where you buy part and rent part
- **Hybrid arrangements** - It is possible to develop quite complicated alternative financial arrangements to underpin the way property is occupied or care is funded

It is worth noting that some RSL and charitable providers, as well as the private sector, deliberately seek to attract a proportion of residents who pay for their own care for a variety of reasons including, for example, risk management and community balance. On average, in independent sector care homes around 30% of residents may be self-funders but this will vary from home to home.

In mixed tenure developments there are further decisions to take:

- Which combination of rented, leasehold and shared ownership to adopt and the proportions of each viewing shared ownership as a district tenure
- How to lay these out within the development, to keep the tenures separate, perhaps in different blocks or to completely mix them – a pepper pot approach. There are complex financial, legal and practical management considerations in reaching a decision

Dwellings Layout	Tenure		
	Outright ownership	Shared Ownership	Rented
Integrated			
Segregated			
Hybrid			

To conclude we can bring the four key variables together in a table which creates a “typology” of extra care forms of development.

Typology of Extra Care

Variable	Option			
Housing and Support Providers	Housing and care provider identical	One housing provider with One separate care provider	Housing provider with Adult Social Care as care provider	Housing provider with several care providers
Building i) facilities ii) scale iii) dwellings	One or two additions to Cat 2. including meals Small 40-50 Flats	Three or four additions to Cat 2 including meals Medium 51 - 149 Bungalows	Extensive facilities. Five or more additions including meals Large/community 150+ Mixture	
Allocations and eligibility criteria	Those in need of residential care	Managed lettings only some needing residential care	Letting to those seeking sheltered housing	
Tenure	Rented	Mixed Tenure	Owned	Special financial arrangements

Having explained the key decisions required about the type of extra care we look at the existing examples in the County.

2. Current extra care provision in Buckinghamshire

There are two types of modern extra care available in the county. Anchor Trust is creating a large retirement community while Heritage Care have a network of extra care schemes adjacent to four care homes. We consider each model.

Heritage Care

Heritage Care is a specialist care provider who has developed four small extra care schemes, each of 12 dwellings in Buckinghamshire.

The projects are described by Heritage Care like this:

“Heritage Care offers four small schemes in Buckinghamshire. Purpose built to a high standard for single or double occupancy, each flat comprises a small hall, large combined living room and kitchenette, a double bedroom and a walk-in shower room. There is an assisted bathroom for those who dislike showers). The flats are tastefully decorated with colour co-ordinated carpets and curtains, and a cooker and a fridge are also supplied. Tenants can bring their own furniture. Each tenant has their own key to their flat and to the building, and there is a door entry system. There is 24 hour support available in three of our services, and all of them offer emergency alarms and a call system for use when help is required.”

Source: Heritage Care, Best Practice Magazine, Spring 2006

In terms of our typology the model is:

Housing/Provider relationship	Heritage the care provider English Churches Housing Group landlord who provide most buildings maintenance
Buildings	Small scheme of 12 flats and limited communal facilities; communal lounge/kitchenette, assisted bathing and laundry. Hairdressing in adjacent care home.
Tenure	Rented
Allocation/eligibility criteria	Entry restricted to those with higher care needs

The distinguishing features of the Heritage Care provision are:

- Small scale
- Each is located adjacent to a residential care home.

Care is provided through a team of five or six workers including a co-ordinator. In order to be economic in such a small development entry is restricted to people who need at least 10.5 hours of domiciliary care per week. The implication of this is that these developments have to be restricted to people with higher needs rather than a range.

Co-location with a residential care home means that some services can be provided that would otherwise be difficult to deliver in a cost effective way. This includes hairdressing and meals. In the latter case tenants have a number of options:

- Making their own meals
- Assisted to make a meal
- Having a meal delivered to the lounge from the care home which is taken in the company of other residents
- Having a meal elsewhere – for example at a local Day Centre

There is a block contract with Adult Social Care for a given number of hours of care each week plus Supporting People funding for support. Sufficient trust has been built up between Adult Social Care for Heritage Care to be flexible in adjusting care on a daily basis as individual needs change.

This service is supporting older people with relatively high needs including those due to mental health problems or dementia. Consequently the Supporting People subsidy is much higher than at Denham. As at Denham, in the Supporting People review all tenants *“expressed their satisfaction with the quality of the support service and felt it was successful in encouraging and helping them maintain their independent lifestyle.”*

Typically each resident has:

- 8.25 hours of care per week
- 8 hours of support per week

The basic pattern is for 2 staff to be on site in the morning and one in the afternoon. The staffing is however flexible according to needs and some days there will be more staff present. Tenants are supported to do as much as possible themselves and to be self-sufficient.

In one scheme modern Assistive Technology has been installed and tested and in future is expected to play a bigger role in support packages particularly telecare in managing risk. The same Best Practice article outlines the devices installed:

“Assistive technology enables us to support those skills with additional safety and security features which add to the comfort and convenience of our service users. Extra Care incorporates ‘Eclipse’ assistive technology – an American invention which was originally devised for the highly automated homes with remote control of all manner of luxury fixtures and fittings.

Now it has a more serious and essential purpose – the ability of 24 hour, non-intrusive, interactive communication between service user and carer.

For the whole system is controlled through a central processor linked to portable devices that each carer has with them throughout.

The benefits include:

- *Nursecall – the facility to ‘talk’ to service users. For example, they can be reminded about an appointment or an expected visitor or simply hear a reassuring voice. This independent ‘memory’ can be even more supportive for those suffering from memory difficulties – especially where medication is concerned. In all cases, the service user is encouraged to confirm that they have received the message – offering further reassurance*
- *Bed sensors – which allow the light to gradually come on as the weight of the individual moves off the bed, and the slow dimming of the light as the sensor picks up that the person has returned to bed. Importantly, these sensors will also reveal if someone has NOT moved for an unusual period of time triggering an alarm to prompt personal investigation*
- *Alarm sensors – to alert staff when someone falls or if someone is wandering. Combined with the instant communication facility, it enables the carer to speak immediately to the service user to comfort them whilst on their way to attend*

In addition, Extra Care services have full CCTV in all communal areas. Every tenant has their own private front door and entry phone, but this CCTV adds to their secure environment by recording everyone who enters/exits for identification and acceptance. Flood detectors in each flat guard against accidental flooding problems possibly caused by running taps etc. Each service encourages tenants to meet up in the tenants lounge by putting forward ideas for social events, which staff will help them to organise. Tenants have the choice in this small community to join in if they wish to, and to share their interests with others; to be private or sociable, peaceful or active, the choice is theirs.

The review by the Supporting People team gives an insight into some of the difficulties in introducing extra care and also solutions:

- *“There had initially been cultural problems within the Council affecting referrals” – it had taken a long time to fill the first of the four schemes.*
- *Heritage Care have an Extra Care Manager who now sits on the Council’s Resident Panel (a lettings group) “that has proved very useful in getting across who could benefit from the extra care model”.*
- *It was important as the range of needs in referrals widened that “Heritage ensured they had the skills to work with the broader range of problems presented”*
- *There is still some perception that Heritage Care will not take more difficult referrals which “points to a need for better communication on this subject”*
- *There are concerns as to whether tenants social needs are being catered for but a recognition that staffing levels do not allow individuals to be accompanied outside the scheme*
- *Low staff levels also mean greater risk and pressure if temporary vacancies because of staff illness for example are not covered by agency (or other staff).*

Commentary

The co-location of self-contained dwellings alongside or in the grounds of a residential care home is commonly known as ‘close care’ in the private sector. These schemes have introduced Buckinghamshire to a model of extra care on a modest scale. They have allowed some experimentation, development of contracts, build up of skills in extra care style of supported services. Smaller developments, spread around allow access to different local communities.

The extra care properties ‘connect’ to the care home only in the sense that some facilities and services can be shared. In an emergency more staff are available on site based in the care home. The two parts are however operated separately, with their own staff team and a different approach; one of supporting independence and the other providing care.

There is similarly little connection between residents in the two buildings. Despite for example having large, attractive gardens there is little mixing of residents. There is perhaps surprisingly little transfer of extra care residents to residential care – although the extra care is only a few years old and this may come. There is also no transfer of those who have moved into residential care back to more independence in the extra care.

It is anticipated assistive technology will feature in any future development in a more central way and it is already recognised staffing levels could easily be reduced without risk, perhaps by 20%, even in such small schemes.

The limitations of these projects are that at 12 dwellings facilities are limited; they do not lend themselves to a range of needs but in order to be commercially viable have to restrict entry to people with higher needs. The limited staffing may also limit the scope for supporting individuals to pursue their own interests.

Heritage Care have themselves concluded that much bigger schemes are preferable and suggest around 60 dwellings.

Denham Garden Village

Denham Garden Village is a modern retirement village for people over 55. This is an unusual, £62 million redevelopment, of a long established village by Anchor Trust in partnership with the Licensed Trade Charity (LTC).

When completed in 2010 it will consist of 326 houses, flats and bungalows:

- 183 for outright sale – receipts are used to subsidise the village centre and rented housing
- 143 for rent to people nominated by LTC

The first phase was completed in April 2006 and demand has been high. Facilities include:

- Café bar, convenience store and Post Office
- Health and fitness club (including pool)
- Winter garden, village hall and residents' library
- Management base
- Woodland walks, memorial garden, allotments

Unusually there will also be a GP's surgery in the middle of the village.

Care and support services will be available from an on site team 24 hours a day. A menu of services is published covering everything from a handy person for odd jobs through to having help with cleaning, on to personal care. Each can be purchased on a hourly basis at a set rate.

Each property is equipped with a dispersed alarm unit to call for help from staff along with an array of passive monitors to detect fire, smoke, gas and other emergencies.

This approach means a care service is available to all without relying on a block contract with Adult Social Care. Supporting People provide some funding for eligible services and residents.

All the residents surveyed in the Supporting People review expressed satisfaction with the service they got and 89% said they felt safe in their homes.

Commentary

Denham is one of around 30 retirement villages in England. It is a significant investment and demonstrates many of the attractions of extra care with a wide range of amenities, well designed in consultation with older people and other agencies and incorporation of assistive technology at the outset.

It is unusual in actually replacing one of the earliest retirement communities. As a consequence there are features which are peculiar to Denham:

- There is an existing group of residents who already form the nucleus of the village
- Nominations and lettings via a Charity formed for the benefit of workers in a particular industry
- Sales of a relatively large number of properties – including houses, so the substantial capital costs can be met with little recourse to capital grant subsidy

The result of these features, in conjunction with the location of the site on the edge of the county, is that there is limited benefit for long standing, local residents. People have been prepared to move from neighbouring counties in order to live in Denham.

Issues for Adult Social Care (and to a lesser extent the District Council) are first that Denham cannot form part of a central pool of extra care housing with access managed for local people. Second, if Denham were a residential care home and an Adult Social Care authority elsewhere in the country placed someone in the home then the placing authority would remain responsible for meeting the fees. In extra care because people

are choosing to rent or buy their own property and move rather than being placed this may not be the case. The normal interpretation of the rules on 'ordinary residence' is that the receiving authority – the one in which the individual now lives – becomes responsible for both support (Supporting People Grant) and care for those eligible and who meet the relevant local criteria.

There are limited opportunities in Buckinghamshire to find sites large enough, affordable and suitable for a village scale of development on which planning permission would be granted, even if the amount of funding required for the social housing scheme were available.

For all these reasons Denham is of limited value to less well off local residents as a new option, although for some, particularly those seeking to buy outright it may add to the possibilities in the county. We do not envisage further villages of this scale forming a key part of the extra care strategy. The possible exception is to meet the planned growth in Milton Keynes which will impact on the North of Aylesbury.

3. Models of extra care for Buckinghamshire

As shown there is no one model of extra care. The concept is as yet not tightly and rigidly defined. Buckinghamshire encompasses different types of area. They range from small rural villages, to busy main towns like Aylesbury with significant business and industrial activity and significant deprivation. There are few big cities or towns characterised by high population density, but there is expansion from Milton Keynes to consider. Much of the county is relatively wealthy and house prices are amongst the highest in the England. The provision of sheltered housing is uneven.

People are often very attached to a particular local area and it is said older people would be unwilling to move out of these areas unless there was no alternative. Equally there will be an influx of people with no roots in the area while part of the working population is used to commuting into London. There is a small but significant black and Asian population in parts of the county. The cultural needs of older members of these communities are said not to be catered for very well.

Earlier analysis has pointed to a small but increasing need for older people with learning disabilities. Some of this group will develop mental health problems in their mid-50's more characteristic of people in their mid 80's. Extra care type provision could offer a good option. Similarly there will be increasing number of older people with a range of mental health problems. Again for some extra care could be a suitable choice if it becomes available.

As a consequence our strategy is that:

- There will need to be a variety of models and types of extra care – no one standard model is likely to do
- Schemes must address the needs of older people in smaller, rural communities

- A few (possibly all) schemes should also plan to accommodate a small number of people with learning disabilities and black and Asian older people. One or two very small extra care schemes exclusively for people with learning disabilities in more rural Chiltern and South Buckinghamshire areas should be considered
- Older people with dementia will be supported in extra care housing, but in the case of advanced dementia, particularly at the point of entry, it is less certain extra care is a good choice

This chapter introduced a typology of extra care and explained our strategy would require decisions of the type of model(s) to promote. There are four key variables:

- Housing-care provider relationship
- Buildings
- Allocation and eligibility criteria
- Tenure

We look at each in turn to develop a form for Buckinghamshire then consider the style of extra care.

4. Principle decisions on models

There are some key decisions to be made about models of extra care. While accepting there will be a variety of scale and type of provision, we expect to be common throughout Buckinghamshire's "extra care":-

- Buckinghamshire County Council is not ruled out as a care provider, but more commonly care will be provided by an independent specialist agency.
- The provision of housing will generally be separated from the provision of care. This is so that organisations who are most expert in housing development or management do not have to provide care and vice versa. Also, so that it is possible to change the contracted care provider where Buckinghamshire Adult Social Care or Supporting People Team are commissioning a care or support service.
- Where an organisation has real expertise as both a specialist housing and care provider we would expect there to be some separation internally between housing and care functions so that contracts for care can be varied without jeopardising housing.
- The scope for intermediate care will be considered in each scheme.

- An allocations and lettings or sales process should be agreed to operate across the county to be operated by the landlords. In principle the lettings policy will be designed to maintain a mix of abilities and not let exclusively to those who are already quite frail. This is to ensure a mixed, more vibrant community is maintained and older people continue to have a range of choices and options. Neither position on a waiting list or assessment of high physical or mental needs will guarantee access – lettings will be a managed process.

Provisionally, we propose needs are banded high, medium and low and in larger schemes about one third of residents at any one time would be in each band. The mix will be agreed on a scheme by scheme basis.

Drawing on experience elsewhere and locally our preference is to have new-build extra care averaging at around 60 dwellings with associated amenities in each project. The practicalities of land and cost may mean some schemes have to be considered down to 30 dwellings and a few more specialised learning disability (or possibly mental health orientated) projects much smaller than this.

- Developments will offer dwellings for rent or sale including sale on shared ownership terms. This is in order to meet the high level of owner occupation in the county, growth in elderly owner occupation and the needs of less well off older home owners – including those in poor condition or low value properties unable to buy outright.

It is possible some extra care developments will be exclusively for sale also that different innovative financial plans to enable less well off owners to move into extra care can be successfully developed and our plan is to positively encourage this kind of innovation

- In addition, in letting extra care, it is proposed to offer a small number of properties to older people with learning disabilities further extending the opportunities available to disabled people. It is possible that a few of these lettings will be to people whose chronological age is less than the norm for the development because they have similar impairments to some older residents despite being rather younger.

Schemes will incorporate design features to support people with dementia. For people with advanced dementia there is an ongoing debate as to the particular advantages of the extra care model and this will be kept under review.

- A frequent request was greater clarity on what kind of standards and specification and arrangements to aim at – a lead. In order to provide this an initial specification for extra care in Buckinghamshire appears as Appendix 2.

5. The culture of extra care housing

The buildings and technicalities of contracts are only part of the story of successful extra care. How services are provided is equally important. In this section we try to suggest the culture within which this new service should operate within Buckinghamshire. This builds up the policy and elaborates on the thinking behind the key decisions.

The ODPM report Preparing Older Peoples Strategies suggests, “*The Service Culture will determine how certain tasks are done and how services are delivered*” It is vital that the Service Culture is understood and accepted by all participating organisations and by all staff in direct contact with the service users.

The fact that occupiers have a tenancy or lease rather than a licence is significant. It suggests a range of rights and responsibilities both for the provider and the tenant/owner which are closely bound up with independence and privacy.

The enabling model

The “Enabling Model” of service delivery will set out to assist tenants to carry out day to day tasks of independent living for themselves rather than simply “doing” the tasks. Starting from this quite different perspective is challenging and time consuming, at least initially. However it has been shown to work in the interests of service users and service providers.

The assumption is that independence and dignity will be achieved by helping people to help themselves wherever this is possible and to maintain effort towards this objective over a sustained period.

The key areas in which people appreciate choice and control have been shown to be:

- No set times for getting up and going to bed
- When to have meals
- What to have to eat on any given day
- What to buy for the preparation of meals and snacks
- Whether to stay in the flat or join in with others
- The feeling of independence which comes from your own tenancy, furniture and possessions
- Being able to close the front door and be on your own

Consultation with older people in Buckinghamshire confirmed these. There was a strong feeling against a regimented lifestyle indeed some particularly ideally would wish to retain their own personal assistants. The Enabling Model sets out to maintain these basic assumptions about day to day living whilst providing an appropriate level of personal care which is flexible and tailored to the individual.

As early as 1999, an evaluation of extra care carried out for Anchor Trust by Helen Ogilvy showed a decrease in care costs overall as tenants begin to gain confidence

and either maintain personal capability or regain lost capability. Amongst the benefits to tenants she recorded were:

- A reduction of stress and improved mental health
- Improved physical health as diet and diabetes is monitored
- Better sleep patterns
- Feeling more secure and confident

Helens study group were a mix of people. Some of whom had been living in residential care and some who had been assessed as needing residential care. A purpose designed living environment solved a proportion of the difficulties faced by the group but the flexible way in which care was delivered played a very important part in her positive evaluation. (“Evaluation of Fairfield Court” Helen Ogilvy Associates, 1999.)

Of course beneficial progress towards regaining capability cannot be achieved by everyone, especially where medical conditions are progressive. However this does not undermine the basic assumption of support wherever possible.

Appendix 3 sets out in greater detail the thinking around the approach to care and support we would hope to achieve in Buckinghamshire. Bringing all the strands together – including the detail in the Appendix enables us to propose a ‘vision’ of extra care

Vision

The vision of extra care in Buckinghamshire – what we are looking to achieve is:

- Create a culture which puts older people at the centre of services
- Develop a culture in conjunction with care and housing providers that is committed to quality, supporting independence, being customer focussed
- Developing high quality buildings that are suitable for frailer older people
- Offer a range of facilities that are valued by older people, that contribute to an active, healthy and interesting life
- Offer and facilitate a range of leisure activities
- Develop ways of working which support independence and support a healthy and active process of ageing in the individual’s own home
- Offer applicants a range of options in terms of how they acquire their property and possibly also a range of options in how they fund care
- Deliver high quality meals
- Be able to operate a flexible care and support service that matches individual needs that is able to change on a day to day basis

Chapter 7 Resources and Funding Extra Care

The initial consultation workshop and subsequent interviews revealed wide disparities in knowledge of extra care finance.

Resources are essential to achieving a programme. Given the large increase in the very old population funding extra care will prove difficult for the public purse alone. Ownership models will need to develop and existing sheltered housing will need to adapt further to offer appropriate housing and care for more frail occupants.

We set out here some of the capital and revenue possibilities and indicate where the resources may come from.

1. Capital Resources

There are four principle types of resource for buildings:

- Land
- Core capital – public and private finance
- Sales
- Miscellaneous capital

Land

The land cost in Buckinghamshire could easily account for a third or more of the total capital cost of provision. In extra care the norm in the social housing sector has been for land and buildings to be provided free or at low cost by the housing authority, Adult Social Care or a housing association; the latter commonly as part of re-development of sheltered housing.

It appears land (surprisingly) may not be such a significant barrier to extra care. Potential exists within the assets of partner bodies:

- Adult Social Care have some sites
- One PCT volunteered it had sites it was prepared to make available for extra care without onerous condition
- Many of the housing associations contacted had one or more sheltered schemes to offer for re-modelling or re-development
- Some of the District housing authorities also have sites or buildings (including several sheltered schemes) they consider potentially suitable
- One private developer has already offered an excellent site

Not all the sites theoretically available will be suitable and some will have various alternative uses which may get priority.

Core Capital Funding

Most extra care developments rely on varying mixes of:

- Social Housing Grant (SHG) – mostly available to Registered Social Landlords but now possible for private developers as well
- Department of Health Grant – in recent years Adult Social Care have been able to bid for grant funding from the Department. The pot is quite small but it is possible to combine both SHG and DH grants. There is £40 million earmarked for extra care and unallocated for which bids have been requested.
- Private finance – the developer borrows part of the cost which is re-paid either from sales, the rental stream including any rents on shared ownership properties, or equities growth at point of resale or similar mechanisms

The majority of extra care schemes built in recent years have depended on combinations of these three types of finance. It is possible to have all three sources funding one scheme.

Sales

Extra care schemes built entirely for sale are by definition funded simply by the proceeds of sales.

It is increasingly seen as desirable to offer some extra care for sale in social housing:

- For demographic reasons as in Buckinghamshire
- To create a balanced community
- Meet demand
- Meet needs of asset rich, cash poor older owners
- Offer a choice

It may also be necessary to sell a proportion of dwellings to achieve financial viability.

The effect of selling some properties is twofold:

- The receipt from properties sold reduces the amount of borrowing required
- To the extent the market value of dwellings sold exceeds costs the ‘profit’ element can be used to subsidise the provision of dwellings for rent. How some social housing developers view this is that sales in effect provide a means of funding or part funding extensive communal facilities of extra care

Sales may be outright or on shared ownership terms.

Shared ownership allows sales to be tailored to the financial circumstances of individuals. For poorer owner occupiers, for example, moving from poor condition property, the attraction over renting is that if proceeds from the sale of their property

are reinvested in new property this does not count as an asset for the purposes of either IS/Pension Guarantee or HB thresholds.

Shared Ownership and Homebuy

Housing associations have been able to develop shared ownership with an element of Social Housing Grant Subsidy from the Housing Corporation for many years. It is however possible to offer shared ownership without subsidy. There have been some special shared ownership programmes for older person housing called Leasehold Schemes for the Elderly (LSE) and later Shared Ownership for the Elderly (SOFTE)

Shared ownership means you buy part of a property, typically 50% or 75% but this is flexible, and rent the other portion. This means if the market value of a flat in an extra care scheme is £120,000, but an individual can only afford £60,000 (normally from the proceeds of sale of the previous house) they can still afford extra care buying 50%.

The landlord owns and rents out the other half. If the shared owner has a lower income and less than £16,000 (19,000 for someone with Guarantee Pension Credit) in savings they will be eligible for Housing Benefit on the rented portion even though they are home owners.

If the lease puts the maintenance obligation on the landlord, the rent will include the cost of maintenance and subject to the normal rules; Housing Benefit will cover costs of management and maintenance.

There is also a Housing Association program called “Homebuy” which has to date been based on a fixed 75% of the equity being acquired with the balance of the cost being met by an interest free loan. This has recently been overhauled with additional Homebuy programmes being introduced in 2006. The 2006 budget also announced that the rented element in shared equity schemes by private developers would become eligible for Housing Benefit paving the way for new private sector providers.

Miscellaneous capital finance sources

Finally there are a variety of resources that usually play a more minor part in funding schemes but occasionally a large part. They include:

- Charitable donations – some organisations that specialise in care or housing for older people attract support for new developments, particular facility or equipment
- Developers own resources
- Section 106 agreements whereby private developers make available part of the site for social housing or make available a an equivalent resource
- Business activity – in very large developments some services may produce a modest surplus
- Primary Care Trusts – may fund health related facilities as at Denham Village

- Adult Social Care – can make grants for particular facilities for example telecare
- Combined/mixed use development – scale economies by tying together different but compatible building may help achieve a more economic development
- Cost effective procurement

Private Finance Initiative (PFI)

There have been a few attempts to fund programmes of provision for older people using PFI. These are complex arrangements where the private sector meets the capital cost of public sector housing and undertakes the development. The costs are met by payments from the public sector spread over a number of years.

Older people consulted were curious about how the costs of living in extra care would be met in different circumstances. In the following section we explore how the operational costs of extra care are met and how people in different circumstances pay for extra care.

2. Running costs and affordability

Extra care housing is housing and not a care home. The same rules generally apply to residents of extra care housing as apply to people living in any other form of ordinary housing of the same tenure type.

Extra care housing brings together a number of different funding streams in order to provide a range of services. The challenge in running extra care is to ensure disparate funding sources are well coordinated and cohesive at the point of delivery, i.e. occupants get a “seamless service”.

Costs of living in extra care and funding sources

The services provided in extra care housing can be broken down into the following categories:

- Accommodation
- Housing management and other accommodation related services
- Support services
- Care services

Each of these categories may be funded from a range of revenue sources including:

- Housing Benefit – to pay the rent on the accommodation
- Supporting People – to cover an element of support
- Adult Social Care – for care
- Residents themselves, including use of Attendance Allowance and Direct Payments or “individualised budgets” as well as their own personal resources

Housing Costs and Housing Benefit

Rents and Service Charges

Housing Benefit will cover the rent for those residents who are eligible and also some service charges. Eligibility depends on having a low income and limited savings. Rent includes the cost of managing and maintaining the building. The rent received meets the landlords costs of providing and running the accommodation. Where properties are provided by a Housing Association with a grant from the Housing Corporation the level of rent that can be charged is restricted by the Corporation. Rents will consequently fall within local housing benefit ceilings.

The accommodation related service charge is the charge made by the landlord for all aspects of the service provided as part of the tenancy which are not covered by the rent or Supporting People. Many of these services are eligible for funding from Housing Benefit. Appendix 5 gives examples of eligible and ineligible items.

Housing related support costs

Supporting People

In April 2003, Supporting People replaced Housing Benefit as the source of housing-related support services.

The primary purpose of housing-related support is to develop and sustain an individual's capacity to live independently in their accommodation. Supporting People services are those that support the most independent living arrangements and are not general health or personal care services.

There is no definitive list of tasks which are eligible for Supporting People. The driving principle is that these are services which enable people **to do things for themselves; to maintain a tenancy or lease**. They tend to exclude services which **do things for residents**.

In Buckinghamshire what role Supporting People will play is currently under discussion. Typically in traditional sheltered housing Supporting People has funded 1-2 hours of support per week for each resident; the support often coming from the warden or scheme manager. Consideration is being given to moving towards more "floating support" models whereby where you live does not influence eligibility for a support service. Support will move (float) from person to person as needs change.

Care costs

Adult Social Care Funding

In the social housing sector, it is usual for Adult Social Care to pay for the provision of domiciliary care in an extra care housing scheme for those eligible.

The core care service is currently purchased under a block contract, although it may be topped up by spot purchasing and/or Direct Payments/individualised budgets in future.

Primary Care Trusts

Primary Care Trusts may well contribute to any health services provided at an extra care housing scheme, and will almost certainly be involved in revenue funding for any units in an extra care scheme which are used for intermediate care. Intermediate care services do not count as housing and are not eligible for funding from either Housing Benefit or Supporting People.

Charges to residents

Housing-related Charges

In terms of housing-related costs, residents in an Extra care housing scheme will be responsible for paying rent, accommodation related service charge and support charge, and a care charge.

Residents on low incomes (with limited savings) are eligible for financial assistance with most of the above costs. They will need to pay themselves for any aspects not covered by Benefits. Like older people elsewhere, they will be eligible for a variety of state benefits including the state pension and Pension Credit.

Care Charges

In addition, they may have to pay a charge for care, depending on the local non-residential charging policy. This charge is usually based on the amount of care received (whether defined in terms of hours or bands) and ability to pay following a financial assessment under Fairer Charging. For further information on Fairer Charging and Fair Access to Care, visit the Department of Health's website at www.dh.gov.uk

Self-Funders

Extra care housing is potentially valuable and relevant to all older people. Some may have the resources to pay for themselves just as in residential care homes. Self-funders are expected to pay all the charges themselves. Some non-means tested benefits are available to those on means-tested benefits and self-funders alike, in particular Attendance Allowance, which some charging policies tend to count as available income.

In future, there will be also greater use of direct payments and/or individualized budgets to enable users of services to “buy in” the care they want or require, or have it managed on their behalf.

Bringing the strands together

The principle sources of revenue for someone eligible for Housing Benefit are illustrated in a slightly simplified form below:

Revenue and funding

COSTS	FUNDING
Rent (including some services)	—————▶ Housing Benefit
Council Tax	—————▶ Council Tax Benefit
HomeCare/Domestic assistance	—————▶ Attendance Allowance/Disability Premiums
Support to maintain tenancy/lease	—————▶ Supporting People Grant
Personal Care Care	—————▶ Care Contract Funded by Adult Social Care
Heat, light and power within dwelling and day to day living expenses	—————▶ Pension or other income

The next table sets out the range of costs and related financial assistance available for both tenants and owner-occupiers.

The cost components in extra care housing – tenants and owners

COSTS	TENANTS	OWNER OCCUPIERS
Property and property maintenance/management costs	Rent and some non SP eligible service charges – paid by the individual but may be covered wholly or partly by (means tested) Housing Benefit	Individual responsibility to be met from pension/other personal resources. A shared owner eligible for Housing Benefit or part rented can get management and maintenance costs met by their Housing Benefit
Individual heat, lighting, power, water charges	To be met from pension/other personal resources	
Council tax	To be met from pension/other personal resources – means tested council tax benefit may apply. Single person rebate and disability reduction will apply as appropriate	
Housing related support	Means tested Supporting People grant. Otherwise from pension/own resources	In theory Supporting People Grant available to owners who are eligible
Personal care and support	Care contract funded by Adult Social Care but subject to prevailing charging policy and the further development of direct payments	To be met from pension/other personal resources plus any attendance allowance/disability premiums etc, and the further development of direct payments
Help with housework	May be included within care package for more disabled people. Otherwise, to be purchased from pension/other personal resources which could include Attendance Allowance and the further development of direct payments.	
Additional services	Self purchase arrangements and/or subsidized through wider community use e.g. leisure and sports facilities, shops, pub and so on	

An example for an individual resident aged eighty and with a high dependency and a low income and savings of less than say £3,000 is shown below.

It can be seen from this that the net cost to Adult Social Care is in the order of £62.40 per week as opposed to perhaps twice this figure for purchased residential nursing care places. As compared with residential care, it also leaves the individual with considerably more disposable income (but also with more expenses to set against that income) - £69.25 for food, clothes, household bills, personal items, entertainment etc as compared with the £19.60 personal allowance left after meeting Adult Social Care charges.

Indicative example of high care model of extra care (£/week)

TYPE OF EXPENDITURE		HOW EXPENDITURE IS MET	
	£		£
Rent (including some housing services)	115.00	Housing benefit	115.00
Council tax	8.00	Council tax benefit	8.00
Heat, light, power	15.00	Pension	84.25
Food, clothes, household bills, personal items, entertainment etc	69.25		
Housing Related Support	20.00	Supporting People grant	20.00
Personal care and support	159.65	Pension Credit/severe disability addition	76.65
		Attendance Allowance (higher rate part)	20.60
		Adult Social Care contribution	62.40
Help with housework	41.65	Attendance Allowance (higher rate part)	41.65
TOTAL	428.55		428.55

The position for someone who is above benefit thresholds and making a “lifestyle” choice to enter extra care is that:

- they would be able to claim whatever State and other pension they are entitled to
- irrespective of financial circumstances, they may claim Attendance Allowance - this is a non-means tested benefit
- they will be responsible for their own rent, service charges and council tax,
- depending on the specific arrangements for the scheme:
 - ~ Adult Social Care may still provide/arrange care under a contract - in which case the individual would be means tested and asked to contribute under Buckinghamshire’s prevailing charging policy
 - ~ Alternatively, the individual may purchase their care and support package direct from the provider or conceivably an alternative provider e.g. funded all or partly by a direct payment.

Someone who was asset rich but income poor could protect their asset by purchasing. If they purchased outright, they would then have no rent to pay. They might, however, be required to make some contribution to overall scheme maintenance and the communal services, included in the rent in the above example, which are incurred irrespective of tenure. The precise arrangements would be determined by the model/providers.

One approach particularly relevant when a lot of residents will be meeting charges themselves is to have a menu of services which people pay for as they need them. This allows extra care to be tailored on a daily basis. The extra care village at Denham

uses this method and provides a useful illustration for Buckinghamshire set out in Appendix 4.

More detail on the funding of extra care is contained in Technical Brief 2 “Funding Extra care Housing” prepared by Housing and Support Partnership for the Department of Health and can be found at:

http://www.changeagentteam.org.uk/_library/docs/Housing/TechnicalBriefs/Technical_brief_02.pdf

Extra care for less well-off home owners

Organisations involved in extra care have also been able to develop or offer a variety of imaginative financial arrangements that allow less well off home owners access to schemes.

This box explains how older owners with limited capital or income may be able to afford extra care. Our strategy envisages using these or similar mechanisms to help some older or disabled people access extra care by purchasing despite having limited capital.

Benefits help for buying and living in leasehold extra-care housing

The general view of Leasehold Extra-Care Sheltered Housing is that people must have to have sufficient capital to buy the property and sufficient income to pay the Service Charge of approximately £80 a week and have enough left over to live comfortably. In practice, there is assistance both to purchase the property and have sufficient income to pay the Service Charge.

The pre-requisite is that they are eligible for Attendance Allowance, at either rate, if they are over 65 years, or Disability Living Allowance (Care), at the middle or higher rate, if they are under 65 years. For a single person this is straightforward. For couples, it is straightforward if they both have Attendance Allowance. It is less satisfactory, if only one has Attendance Allowance.

Purchasing the Property

The current Pension Credit regulations allow for the payment of interest on a mortgage up to £100,000. The significance of this is that it enables the owners of less valuable properties to sell their existing property and buy purpose-built Extra Care Sheltered Housing. The conditions are that all, or almost all of the capital assets have to be invested in the higher priced specialist housing and it has to demonstrate that the higher priced property has features which meet the needs of the disabled occupier. In practice, qualification for Attendance Allowance is generally accepted by the Pension Service as demonstrating the need for Extra-Care Sheltered Housing.

On-going Expenses

The minimum income which a single person, in receipt of Attendance Allowance in Extra Care Leasehold Sheltered Housing would have is as follows (2005/06 rates) and to the extent that they did not have it from their ordinary income, it would be topped up to these amounts from Pension Credit and Supporting People grants.

Single Pensioner in receipt of Attendance Allowance in Extra Care

- Personal Allowance £56.20
 - Pensioner Premium £53.20
 - Attendance Allowance £40.55
 - Severe Disability Premium £45.50
- £195.45

PLUS

- Service Charge (say) £80.00
 - Interest on a mortgage (say) £50.00
- £325.45 a week

PLUS - Anyone in receipt of even 10 pence Guarantee Pension Credit, it entitled to full Council Tax Benefit i.e. they do not pay Council Tax.

There are additional sums available to Couples who are both eligible for Attendance Allowance, as they are also eligible for Carer's Premiums.

With thanks to Bob Bessel of Retirement Security Ltd who have a number of schemes in adjoining counties.

There are also the statutory provisions that allow some older or disabled people to get additional help from Income Support to meet the interest payments on a mortgage. This might be to buy a share of a property or to meet repayments on a loan taken out for adaptations. These mechanisms have particularly been used by older people with learning or physical disabilities.

The Income Support Mortgage Interest

Entitlement to benefit

1. Initially, help can only be provided when a claimant is entitled to one of the income related benefits - either Income Support or income-based Jobseeker's Allowance for those of working age, or State Pension Credit for those over 60.

No Guarantee

2. First and foremost, the Department cannot provide a guarantee that any interest on a loan can be met, prior to a loan being taken out. We obtained legal advice:-

"Unfortunately the Secretary of State cannot guarantee payments of any benefit prior to a valid claim and award being made. All payments made by the Secretary of State have to have a legal justification or power to make those payments. If the Secretary of State guaranteed payment of a benefit, and after assessment of the claim it proved that the person who had applied was not entitled to the level of benefit that he had guaranteed, the Secretary of State would be forced to abandon the guarantee as the alternative would be to make an unlawful payment or vice versa".

3. Below are some of the general provisions of the Income Support General Regulations 1987, Schedule 3, which a Decision Maker in the local office would need to consider on any benefit claim.

Loan taken out whilst on benefit

4. Generally no help can be provided where a loan has been taken out when a claimant is receiving benefit. However there are some limited specific circumstances where help can be met.

5. One instance when help may be provided:-

- Where a loan was taken out to purchase a dwelling or an existing loan increased to acquire alternative accommodation more suited to the special needs of a disabled person than the accommodation which was occupied before the acquisition by the claimant. (ISGR, Schedule 3, para 4(9)).
- However, the £100,000 limit would still apply to any loan taken out to purchase alternative accommodation.

6. Other circumstances include:-

- Where a loan has been taken out to pay off an earlier loan which had qualified under para 15 and 16 (wholly or in part) (i.e. taken out either to purchase the

property or for specific home improvement loans); the loan could not be met above the previous loan amount. (ISGR, Schedule 3, para 4(6)).

- Where a claimant takes out a loan on the property where they are living, and in the week before the loan is taken out, they were in receipt of housing benefit. The amount that can be met in housing costs is restricted to the level of housing benefit that was in payment in the week before the loan was taken out. (ISGR, Schedule 3, para 4(8) (a) + (b)).

£100,000 limit on loans

7. There is a limit on the ceiling to which a loan can be met -i.e. £100,000. (ISGR Schedule 3, para 11(5)).

8. The only exception where the limit does not apply is where a home improvement loan is taken out to adapt **an existing dwelling** to meet the special needs of a disabled person. (ISGR Schedule 3, para 16(2) (k) and para 11(9)).

9. All decisions on benefit entitlement are the responsibility of Decision Makers in Jobcentre Plus and The Pension Service. Decisions are made on facts of each case based on the legislation in force and case law and guidance when the claim is made.

Source: Guidance on ISMI obtained in correspondence with DWP.

Contemporary, high quality, Extra Care Housing is at present a scarce commodity so dwellings for sale may carry a premium. In one development currently being sold sales prices typically exceed the cost of the dwellings by over 20%. This will not always be the case and research needs to be done to establish the price differential between values of properties being vacated by owners and the cost of providing extra care dwellings as part of the financial assessment.

Occasionally it may be relatives who buy property on behalf of parents/grandparents or another relation. Again, shared ownership allows a wide range of purchasers to access the scheme in a affordable way. It has been a little surprising to find that some of the purchasers in extra care have bought with a mortgage rather than only using proceeds of the sale of the previous property.

3. Summary

Bringing the funding ideas together

Building Cost

The capital cost of construction will be met by varying combinations of:

- SHG via Housing Corporation who have said funding for re-modelling sheltered housing is in principle available. The Corporation has also funded a number of new extra care schemes elsewhere
- Department of Health - £40 million available. Buckinghamshire has not so far had any of the DH pot
- Free land – various sources identified but sites to be assessed for suitability
- Sales receipts – both to reduce overall borrowing and if land is provided, to effectively subsidise rental units and/or fund communal facilities

The Anchor Trust extra care scheme demonstrates a combination of available land and sales can deliver a high quality scheme without additional public subsidy in Buckinghamshire.

If necessary additional sources of funding may be available and in extremis a PFI package is not ruled out but is complex. Some form of public-private partnership is also conceivable.

Revenue

In 2005-06 Buckinghamshire Adult Social Care spending on older people was:

Nursing homes	£ 5,725,128
Residential care	£ 7,909,822
Domiciliary care (external)	£ 5,835,422
Internal home care	£ 8,715,717
Direct Payments	£ 731,824
Day care	<u>£ 1,968,116</u>

The total older person spend was £32,732,974

- Our strategy assumes about a third of places in extra care will be for people who would otherwise enter residential care. Thus some of the £7.9m currently used for care home places will instead fund extra care
- The explanation of revised funding above explained how costs to Adult Social Care of placements fall in extra care so there will be an additional gain in funding available of perhaps £3000 or more per place per annum available for extra care
- The study of residents in ordinary sheltered housing found about 1 in 6 already received some level of domiciliary care. To the extent extra care simply replaces outmoded sheltered housing this part of the £14.5 million domiciliary care budget will shift instead into extra care

- As with the switch from residential care there should also be an additional efficiency gain. If 20% of the domiciliary care staff time is lost in travel alone this, at least in simple terms, should translate into a 20% productivity gain in an extra care setting. Put another way £14.5 million would in effect buy another £2.9 million of care
- The Supporting People budget in Buckinghamshire is a little over £5million. Typically residents in sheltered schemes get 1-2 hours of support per week from this source. Changes in approach are under discussion and it is not clear at this stage what level of SP funding will be available for people living in Extra Care schemes.
- Buckinghamshire's share of the national Supporting People pot is generally recognised to be low. Proposals for re-allocating funding between authorities may eventually mean an additional £1 million comes to the County. This is not of course for older people alone but it is clear the needs of older people elderly in particular are going to rise markedly and measurably whereas the position for many other needs groups is relatively more stable
- Buckinghamshire is a relatively well off area with, as shown, considerable wealth represented by property. To the extent people can self fund from income or fund by releasing capital in the process of moving to more appropriate housing with care revenue funding is not a big issue for this group

Attracting a proportion of self-funders, as commonly found in residential care homes, is one element of this strategy. It helps to spread risk, give an economic scale, and ensure amenities like a restaurant are supported.

Appendix 5 provides more detail on Housing Benefit eligible expenditure while Appendix 6 considers Supporting People.

Chapter 8 Implementing an Extra Care Programme

1. Partnership and Project Management

A theme at the initial workshop, repeated by many of the stake holders interviewed, was doubts about the ability of the County, Districts and all the different interest groups to actually collaborate to deliver a strategy; no matter how desirable...

- *“I have been asking for this for 10 years – nothing happens”*
- *“There have been many discussions but no action”*
- *“South Bucks approached us in 1999 but I don’t think anything happened”*
- *“There is little evidence of the joint work necessary to make it work”*
- *“The County works in isolation; Denham Village is refreshing”*

A way of implementing this strategy is required.

There is currently a programme to re-provide 600 residential home places across the county called ‘Project Care’. Up to 8 large homes of 60-90 beds will replace old Adult Social Care homes that no longer meet current standards or requirements. This has been proceeding well with the first scheme awaiting planning consent. There are three parties:

- Buckinghamshire Council who will assess individuals and fund places
- Housing Solutions (a registered housing association based in Berkshire) who are carrying out the development
- Fremantle Trust who are the care provider

This partnership approach is judged effective and has been successful in achieving a scale and type of programme similar to that envisaged for extra care. Lessons from ‘Project Care’ and other extra care programmes elsewhere suggest the following are important to achieve a program:

- The will and enthusiasm to make things happen
- Evidence base for action
- Adequate resources to deliver – whether sites, revenue funding or staff to manage process
- A partnership – each party has to see what is in extra care for them. Includes officers and elected members in Councils and Boards of RSL’s
- Providing information to improve knowledge of something relatively new. Show people other developments, use a variety of media. Show and publicise good practice examples
- Large scale makes programmes more important and get attention as a result
- Local communities involved
- Specific sites and clear progress so the different interest groups see something is happening
- Action to bolster interest and enthusiasm – a competition was one suggestion

In the case of “Project Care” two practical aspects were:

- The formation of a board of 6 people drawn from the County Council, Housing Solutions and Fremantle Trust at a senior level
- An independent individual consultant to manage and drive the project at an early stage with access to senior staff in each organisation

Taking these points and translating them into practical steps to get a programme of extra care in place across Buckinghamshire.

1. Partnership has been underlined as central to implementation and a past weakness in the county.

We propose an extra care project group is created but with a different composition to the “Project Care” board to oversee, deal and coordinate the programme of:

- County Adult Social Care/Supporting People
- Each District Council
- PCT(s)
- A voluntary sector representative

This group would be lead and serviced by the County Council. One of the group’s first tasks will be to agree an initial 5 year implementation plan. In some other authorities the creation of an extra care programme has had the positive but unintended consequence of improving partnership working more generally

2. As each large scheme (or series of developments) takes shape a District led project group is formed to deal with the difficulties and decision at a District level of:

- The District Council
- The housing provider/developer if different
- Adult Social Care
- The care provider if/when identified
- Community/local representation

3. A dedicated post at county level to project manage the extra care programme on a daily basis. This would include servicing the county level group, dealing with or assisting funding applications, liaison with Districts, housing and care providers, becoming an expert source of guidance on extra care

This would be the equivalent of the consultant employed on “Project Care”. Project management is a condition of Department of Health grant funding for extra care.

Turning to the other aspects of lessons from “Project Care”:

- There is a good deal of support for an extra care programme. Very few of the people interviewed or at the various workshops had any real doubts about the general desirability of extra care. Reservations tended to be based on lack of detailed knowledge, concerns about resources or the possible impact on existing sheltered housing. To the extent that a District Council lacks enthusiasm, willingness to be a partner or grant planning permission on suitable sites it makes sense, initially at least, to concentrate on achieving success on sites in those District who are most committed to extra care with a provider organisation also enthusiastic or already experienced in extra care housing.
- This strategy has provided some of the evidence for action also explained what resources may be found
- This document has to a degree outlined possible gains for the different interest groups
- Action to improve information could include:
 - Visits by officers, members and older people to nearby extra care development
 - Session at relevant workshops/conferences, including those that involve older people on extra care particularly using films of extra care and sessions presented by residents of extra care
 - Production and distribution of a simple explanatory leaflet about extra care based on a template available from Department of Health
 - Publicity and articles in the in the Buckinghamshire Times
- One of the early actions of the “Project Manager” and “Project Group” should be to generate a list of potential extra care sites, carry out a shortlisting exercise and then appraise the sites for extra care. The list would be obtained by asking the PCT and Adult Social Care to propose sites, a review with planners and leads on older peoples housing in each District Council and an invitation to all RSL’s with sheltered housing in the county to put forward sites for re-modelling or re-development.
- The overreaching Project Group should also consider what activities might engender enthusiasm and sustain interest in extra care, also how best to involve local communities when initial sites to progress are agreed.

2. Scale of extra care provision

A central strategy issue is how much extra care should we plan for? There is no simple, accepted method of deciding this.

Often strategies simply say for example “we should aim for an extra care scheme in each district of around 50 units over the next 5 years. There are two key drivers; residential care substitution and sheltered housing.

We set out below one approach to give an indication of the scale that may be justified building the case in stages drawing on the data provided:

1. Adult Social Care fund about 750 older people in residential care. Policy is to reduce reliance on institutional types of service. If we assume a 2% reduction per annum (15 places) over 25 years, 375 less places will be commissioned. In fact last year the reduction was twice this rate. At least one study has suggested as many as two thirds of people in residential care homes could be accommodated in extra care. However remembering Buckinghamshire starts with a below average level of residential care placements, a target of half may seem more realistic or cautious.
2. The aim is to support people at home. The ratio for Buckinghamshire is 7/1000 of those over 65 compared to a national average of 11.5 receiving intensive home care.
To get to the normal level therefore implies an additional 310 people being helped to live at home rather than in alternative placements. This is based on 69,600 people over 65 in Buckinghamshire the calculation is $((11.5 - 7) \times 69.6)$ If we deduct this from the 375 reduction in residential care the net addition to be obtained through extra care is 65
3. Some of the rented sheltered stock will become unlettable over the next 10 years or be judged unsuitable for an older, sometimes frailer group of new applicants. As a rough estimate from the interviews and surveys of sheltered housing providers we assume around 1 in 5 of the total sheltered housing stock will fall into this category. This means a reduction of about 750 dwellings in total
4. Extra care can replace them. However Buckinghamshire has a relatively healthy population, high earning and high property values, with fewer people claiming Attendance Allowance. The data shows the supply of sheltered housing to rent is slightly higher than expected and several of those interviewed thought there was an over supply. Therefore we assume Buckinghamshire would be adequately served by a lower, indeed slightly below average level of sheltered and extra care housing. A reduction of 7 dwellings/1000 over 65 or 483 would put Buckinghamshire's ratio marginally below the national average of 51/1000 rather than marginally above as at present. Therefore the net replacement of sheltered housing would be 267 (750 - 483)
5. This gives a baseline of 332 extra care properties. (267 + 65).
6. The County has (or will shortly have) 143 additional properties for rent not counted in the statistics so the net new provision required is around 189 (332 - 143) dwellings
7. Over the next 20 years the population over 65 will rise by 36% so the longer term target should be 257 properties (189 x 1.36) for rent to take account of growth
8. The estimate does not yet take account of demand for extra care to buy only sheltered for rent and those funded by Adult Social Care in residential care. Leasehold provision is currently very close to national norms (12/1000 65+ including Denham) and there is no obvious evidence of falling demand. Indeed given the tenure profile for Buckinghamshire we might anticipate an above national average level of leasehold provision.
Erring on the side of caution we assume the market has responded to meet current demand and we simply need to allow for the 36% increase in population 65+ over 20 years. The net leasehold addition, ideally in the form

of specialist accommodation with higher care is therefore 305 (848 x .36) properties

9. In round terms the conclusion on the assumptions made, is it would be appropriate to plan for approximately 560 extra care dwellings; a little over half for sale (including some low cost home ownership) and just under half for rent. These should be provided to meet demand over the next 20-25 years.

Summary table

		Extra Care Units Required
1	Residential care places 750 Reduce by half over 20 years	375
2	Number of those people supported at home instead of residential care	<u>-310</u>
		<u>65</u>
3	Gross reduction in traditional sheltered housing	750
4	Adjustment for excess of sheltered rented stock, Reducing ratio from 53/1000 65+ to 46/1000 less units required	<u>-483</u>
		<u>267</u>
5	Base line extra care requirements	332
6	Less new provision under development	<u>143</u>
		<u>189</u>
7	Increase to allow for 36% population growth	257
8	Plus extra care to buy 848 (present provision) x 1.36 (population growth)	<u>305</u>
	Extra care dwellings to plan for	562

This figure must be read as a ball-park figure only. It is based on the assumptions, forecasts and adjustments made. It will be a matter for the implementation group to consider how this translates at a more local or District level taking into account a host of local circumstances and opportunities to be reconciled. The considerations include:

- Higher growth rates in Aylesbury and Wycombe (4-5%) than Chiltern and South Buckinghamshire (3%)
- The treatment of Denham Village in south Buckinghamshire and the extent to which this is accessible to local people
- Differences in under and over supply of lettable and suitable sheltered housing between districts.

Simply apportioning the target figure of 560 according to the population over 65 living in each district gives the spread below:

District	Population 65+	%	Extra care portion (units)
Aylesbury Vale	21,298	30.5	171
Chiltern	15,034	21.6	121
South Bucks	10,843	15.5	87
Wycombe	22,507	32.3	181
Total	69,682		

This becomes the starting point and target for the implementation group. There are also expected to be a few small extra care type developments for specific needs such as learning disabilities. The estimate will alter if it is found more or less existing sheltered housing for rent does not have a long term future or if it is an even lower level of long term demand for sheltered housing for rent is thought wise to plan for.

Appendix 1 Specifications and Standards for Extra Care in Buckinghamshire

It is not desirable or possible to give highly prescriptive standards for extra care in Buckinghamshire at this stage. A process of continuous improvement should lead to standards evolving. Schemes should be tailored to meet local circumstances and take into account the views and wishes of all the relevant local interests.

Developments as explained in the body of the text are expected to vary in scale. Some will be new build, others based on remodelling existing buildings. Learning from experience elsewhere it is important that the latter approach does not lead to compromises in construction designs that undermine the purpose or sustainability of extra care. As one safeguard we propose at least a basic set of standards are set down to test proposals against.

We recognise where extra care is entirely privately funded with no public subsidy developers will wish and need to take commercial decisions on the best arrangements.

Buildings

Very broadly we expect developments will:

- Meet or exceed current, relevant Housing Corporation Scheme Development Standards for Frail Elderly – essential where the Housing Corporation or DH are part funding and desirable for private developments³

³ Housing Corporation Circular 03/04, April 2004 says: “**Housing for older people (all special design features)**. Remodelled or purpose built grouped housing that has all the basic facilities and all special design features intended to enable people to live there for their lifetimes. All of the following requirements have to be met:

- *Basic facilities: the scheme or main building must have basic facilities of a laundry for resident and/or washing machines in living units or provision for washing machines to be installed. The scheme must also have a communal lounge.*
- *Special Design Features:*
 - *The whole scheme including the entrances and the buildings that comprise it must be designed to wheelchair user standards*
 - *Living units must have walk in showers or bathrooms adapted for people with mobility problems or wheelchair users*
 - *Bathrooms in living units that are wheelchair standard must meet the criteria for adapted bathrooms*
 - *Living units must have kitchens that are designed to wheelchair standards*
 - *The scheme must have a bathroom with provision for assisted bathing*
 - *If there is more than one storey there must be a lift*

- All dwellings are designed to be wheelchair accessible and a proportion to full wheelchair standards⁴
- Meet or exceed:
 - Lifetime Homes Standards
 - Secure by Design Standards
 - Part ‘M’ of the Building Regulations for supported housing
- Incorporate or allow for future use of a wide range of assistive technology (See Housing LIN DH Fact Sheet 5). This will normally include EIB cabling for transfer of electronic data, provision of at least power sockets in the right place for environmental control equipment such as door and window openers/closers, curtain openers/closers. A comprehensive range of telecare will be incorporated at the outset including an array of passive monitors and emergency alarm alerts. Additional devices will be supplied according to individual needs such as bed sensors, fall detectors, epilepsy alarms, wanderer alerts, enuresis detects
- Dwellings will meet the kind of space standards set out in Housing LIN DH Fact Sheet 6. One person, one bedroom properties should be around 50m² as a minimum and 2 bedroom 2/3 person properties around 68 – 70 m². Buildings will be designed for flexibility in use possibly with demountable partitions in some dwellings to allow a variety of configurations and larger dwellings to be formed. This might be particularly relevant when catering for people who may share and/or have a live-in carer
- Dwellings will incorporate design details to make them easier to use by individuals with limited strength, dexterity or mobility. For example suitable door handles, tap levers, cupboard heights. If white goods are supplied these must be selected with the needs of the frailer resident in mind e.g. floor standing cookers may not be the best device

⁴ Mobility housing is ordinary housing built to a certain basic standard so that it can be adapted to be lived in by most people with disabilities. Even amongst those who use wheelchairs more than half can manage without them inside their homes. Its principle features are:

- A level or ramped approach and flush threshold at the main entrance
- Corridors and doors sets to the principle rooms (including a bedroom) wide enough for wheelchair use
- A bathroom, WC and at least one bedroom at entrance level

Wheelchair housing is needed by people permanently confined to wheelchairs. It generally needs to be on one level and in addition to easy access; it has above average space standards in order to allow for full wheelchair manoeuvre throughout. The principle features are:

- A level or slightly ramped approach and flush threshold at the main entrance
- Internal planning for wheelchair manoeuvre in all principle rooms, with 1200mm passageways and 900mm door sets or sliding doors
- Bathrooms and toilets large enough to permit lateral transfer from wheelchair to bath/wc

For contemporary guidance see for example “Wheelchair housing design guide”, Stephen Thorpe and Habinteg Housing Association, BRE, 2006. In the Scheme Development Standards (HC, April 2003) The Housing Corporation requirements for extra care housing are “Individualised dwellings to wheelchair user standards” (... , 1.2.1.80). This publication also contains details of wheelchair user standards.

- Incorporate a mix of one and two bed properties. Possibly a few three bed properties where a local need, demand or circumstance suggests this provision. Alternatively some bungalows or homes designed to allow for easy conversions of roof space or extension
- Built to high energy efficiency standards to minimise energy costs in use for residents and energy efficient equipment such as boilers and white goods where supplied
- Environmental impact should be explicitly considered including for example external water collection and re-use
- Bigger schemes with larger lounges or restaurants will be constructed so that facilities can be made accessible to the wider community. Security and privacy for residents will however be paramount and “zones of privacy” may be incorporated to control or limit access by outside visitors/users to parts of the building
- Normally offer properties for sale and rent where public subsidy is used unless the local market conditions are very unfavourable to sales. Sale would include shared ownership or other financial arrangements to permit access to extra care by less well off owners. Some schemes may be purely for sale.
- Provide a range of facilities commensurate with the scale of development but as a minimum will normally include:
 - lounge/activity space
 - provision for meals
 - assisted bathing
 - provision for hairdressing
 - guest suite
 - office accommodation for staff and sleep in facility including ensuite bathroom
 - garaging/charging facilities for electric buggies
 - laundry where dwellings do not incorporate washer/driers
- Bigger schemes will have more extensive facilities likely to include in addition/instead:
 - restaurant/café/bar
 - separate multi-activity/hobby rooms
 - landscaped grounds with green house
 - IT suite
 - health/fitness suite possibly incorporating assisted bathing and jacuzzi
 - therapy/treatment room
 - shop
 - cinema
- Communal areas and circulation areas should incorporate design detailing to make easily useable by frailer older people. This will include provisions to assist those with sensory impairments or confusion like use of colour, texture, floor finish, light, Braille, handrails, scent and other cues to help orientation around the building or gardens. See for example guidance produced by RNIB or “Design for Special Needs”, Harker and King, RIBA, 2005.
- In schemes which include a separate wing or part of the building specifically for people with dementia contemporary guidance on design should be researched and incorporated, see for example “Opening Doors to Independence,” S Valletly et al, Housing 21, 2006. This is likely to mean a smaller domestic scale grouping of facilities, with additional design and

technology features along with some additional security measures on entry and exit. It will mean careful consideration of design to minimise risk to individuals or staff including assistive technology, replacement of glass by alternative material, siting of controls like thermostats etc.

- Quality of buildings and appearances is important. The standard should attract people with some equity currently occupying family housing. As a guide the communal areas, finishes, furnishings should resemble standards achieved in a good quality hotel. The external environment is equally important and should be attractive, usable by those with limited mobility, have interest of those with sensory impairment
- Schemes should be sited in a location that would be good for a traditional sheltered housing scheme. This means:
 - A level site
 - Near to amenities like shops, café, places of worship
 - Good public transport links

Isolated sites in small villages or sloping sites are unlikely to be suitable

- Consideration, on a scheme by scheme basis, of incorporation of dwellings for specific needs and additional design, equipment or layout requirements for example:
 - High dependency dwellings on the ground floor or a separate block
 - Intermediate/respite care dwellings on ground floor or separate blocks near to community facilities
 - Provision for people with mental health problems
 - Specific cultural requirements or preferences of black and minority ethnic communities
- The preference is for larger developments around 40-60 dwellings but a range of sizes to serve different local communities are expected. With smaller developments it would be essential to establish early on that a flexible, high level of care and support can be provided in a cost effective way. This may be by incorporating an outreach service, some specialist service or links to other provision in adjoining buildings or contracting for care with a local domiciliary provider already active in the area. It is anticipated that one or two smaller developments for people with learning disabilities, physical disabilities or mental health problems may be built.

Services care and support

Again we cannot be prescriptive but set out broadly what we expect to see at this stage:

- Clear arrangements set out in management agreement/service agreements between care providers and housing providers detailing where responsibilities lie for all aspects of running a modern extra care service. (This applies particularly to situations where the housing and care provider are different organisations.) On the housing side this should cover maintenance, housing management and tenancy matters, key staffing responsibilities, marketing, voids management, training, accounting and budgets, resident involvement, liaison/co-coordinator arrangements

- All residents to have a clear, easy-read individual support/care plan. Support/care to be provided flexibly to best meet each individual's needs on a daily basis. As a minimum this will be a support plan to satisfy Supporting People requirements and where a formal care assessment has been compiled to show that the assessed needs are being met
- Whatever the precise formal housing management/support/care distinctions required for legal, financial, contracting or other reasons from the resident's perspective the service they receive should meet their individual needs, comprehensively in a simple, straightforward manner – a “seamless service”. Organisational, budget or other differences must not undermine a quality service
- Schemes may receive both Supporting People and Adult Social Care funding based on the number of individual eligible residents plus additional contracted hours to be used flexibly to meet changing needs and specific needs. Care and support will be provided flexibly on a daily basis to meet the residents' actual, current needs. Contracts will recognise this flexibility is important and not simply rely on care providers good will
- Supporting People has traditionally funded a base line level of support (as opposed to care) for all eligible residents of around 1 – 2 hours per resident per week. This may be higher for individuals who higher levels of support, up to 12 hours as the maximum. Policy on leaseholders receiving Supporting People funding is currently under review as is the overall approach to allocating Supporting People funding including possible shift to floating support. For leaseholders Supporting People will be claimable by the individual not the care provider.
- Access and allocations will be managed through a panel drawn from Adult Social Care, the District Housing Authority, the housing and/or care provider and relevant scheme based staff – normally a person able to cover both care and housing matters. Needs will be assessed through an application for Extra Care housing supplemented by a care needs assessment where required. In the future, if individualised budgets progress, this may mean greater reliance on self assessment.

Applicants will be categorised for the purpose of ensuring a mixture of abilities into:

High	10 + hours of care/week
Medium	5 – 10 hours of care/week
Low	4 or less hours of care/support per week

Lettings will be managed to ensure roughly a third of residents fall into each category. Adult Social Care contracts will provide the opportunity for additional care purchasing if individual assessed needs increase

- An implication of this is that a high level of needs will **not** guarantee access to the next available place also that lettings will be managed to ensure they are always some new residents with lower needs to balance the needs of tenants who reach a stage of higher dependency

- The culture and philosophy of extra care will be to support people to be as independent as possible. This includes:
 - Support to make a meal if required
 - Social activities
 - Activities to encourage, maintain/improve health and mobility
 - Supporting people to use a direct payment/individualised budget if this is their choice
- Care and support will be available 24 hours a day, seven days a week

Organisations providing care in extra care housing settings will be registered with CSCI under domiciliary care arrangements. Organisations will also be required to work in compliance with BCC Care Specification – The provision of Domiciliary Care for Adult Service Users.

The following is a synopsis of the key requirements under the specification.

Synopsis of BCC’s Care Specification – The Provision of Domiciliary Care for Adult Service Users.

Service definition

Domiciliary care means homecare services, which enable individuals to maintain an independent life within their own home and community and can range from essential cleaning to personal care. Providers will be contracted to provide services as follows:

- Personal care including assistance and/or prompting and supervision, instruction, direction and encouragement with bodily needs such as eating, bathing, toileting, dressing and undressing
- Practical daily living support, which maintains and supports service users independence communication e.g. reading letters, assistance with shopping
- Undertake directly essential domestic tasks (as part of a personal care package) such as cleaning, laundry and ironing

Service values

The following principles will underpin planning and service delivery of domiciliary care for vulnerable adults assessed as needing social care support:

- Privacy – the right of the individuals to expect sensitivity in the handling of personal matters and confidentiality in dealing with information about them
- Dignity – recognition of the intrinsic value of people, regardless of circumstances, by respecting their uniqueness and their personal needs, treating them with respect
- Independence – promoting the individuals right to control the way care is delivered for them. Supporting the individual’s right to independence. This would include a willingness to incur a degree of calculated risk whilst having a regard to the safety of the individual and others

- Competence – the domiciliary care organisation is run by appropriately qualified managers and employs care workers competent to do the job. The organisation complies with legal requirements and operates safe working practices
- Reliability – the organisation delivers what it agreed to provide, gives the service user and carer information about the individual services to be provided and has policies to keep service users and carers informed of any changes in services
- Equality – services should be responsive and sensitive to ethnicity, gender, disability, sexual identity and religion. The organisation should ensure it and its workers do not discriminate against people on any of these grounds
- Courtesy – the organisation ensures that service users and carers are treated with respect and has a code on how carer workers conduct themselves in the service users home
- Review service user plans on a regular basis to ensure they continue to be appropriate and effective.
- Work in partnership with the Council to plan and develop services; negotiate risk sharing and mutual roles and responsibilities.

Quality assurance

It is expected that contract monitoring by the commissioning authority will include reference to all current inspection information, however the standards set in the Care Specification provide the means for evaluating performance and outcomes for service users in a uniform manner across all providers.

Methods of measurement

The methods of measurement that will be used to evaluate and monitor service quality and performance are as follows:

- Individual Care Review
- Individual Service User Feedback
- General Service User Feedback – e.g. questionnaires, advocacy reports
- Provider Reports
- Annual Monitoring Review
- Spot checks by the Commissioning Authority
- Complaints and Compliments

The following is a synopsis of the key Activities and Service Outcomes required under BCC Care Specification – The Provision of Domiciliary Care for Adult Services Users. These are supported by comprehensive Standards and a range of Performance Indicators.

User Focused Services	
Activity	Outcomes
Assessment of need and meeting need	<p>Service users, their relatives and representatives know that the agency providing the personal care service has the skills and competence required to meet their care needs.</p> <p>Each service user has a written individual service contract (service user plan) for the provision of care with the agency.</p>
Responsive services	Service users receive a flexible, consistent and reliable personal care service.
Contingency planning	Sufficient contingency plans are in place to support the service user in the event of an unexpected interruption to the service.
Personal Care	
Activity	Outcomes
Offering Personal Care	Service users feel that they are treated with respect and valued as a person and their right to privacy and dignity is upheld.
Bathing and Full Body Wash	
Medication, Access to Health Care and Health Related Activities	
Activity	Outcomes
Administration of Medication	The agency's policy and procedure on medication and health related activities protect service users and assists them to maintain responsibility for their own medication and to remain in their own home, even if they are unable to administer their medication themselves.
Access to Health Services	Service users get full access to Health Services and appropriate monitoring for specific medical conditions.
Health Care	<p>Personal Care staff that become involved in health related activities are trained and competent to do so and have the full permission of all concerned.</p> <p>Care staff are protected from coming under pressure to undertake health related tasks for which they are not fully trained.</p>

Communication between Commissioning Authority and Service Provider	
Activity	Outcomes
Contact between Service Provider and Commissioning Authority	<p>Service users' needs are met promptly.</p> <p>There is a positive partnership in the delivery of service.</p> <p>A safe service is assured.</p> <p>Clear and effective communication with family members, care management and other agencies e.g. the Health Service.</p> <p>Providers enhance service delivery by identifying service deficiencies.</p> <p>The health, rights and best interests of the service users are safeguarded by maintaining a record of key events and activities undertaken in relation to the provision of personal care.</p>
Protection and Managing Risk	
Activity	Outcomes
Risk Assessment	<p>The health, safety and welfare of service users and care and support staff is promoted and protected.</p> <p>The risk of accidents and harm happening to service users and staff in the provision of personal care is minimised.</p>
Security in the home	<p>Service users are protected and are safe and secure in their home.</p> <p>The money and property of service users is protected at all times whilst providing the care service.</p> <p>Service users are protected from exploitation</p> <p>Care staff operate comfortably and hygienically whilst carrying out the care tasks and there is explicit understanding of working practice in the service users home by both worker and user.</p>
Identification and management of abuse	<p>All incidents of abuse or suspected abuse are detected and systems are in place to protect vulnerable service users.</p> <p>Service users are protected from abuse, neglect and self-harm.</p>

Administrative and Domestic Tasks	
Activity	
Household skills	Housework is provided as part of a care package required to maintain essential cleanliness and hygiene. Service users are enabled and encouraged to maintain their home environment.
Clothing and Laundry	Service users unable to wash their own laundry are ensured of the right to cleanliness of clothing and personal laundry. Users have less risk of infection and are able to remain in their home despite incontinence and other problems.
Equality and Diversity	
Activity	
Equality and Diversity	Service is provided in an equitable way that ensures the service users dignity, privacy and rights are maintained at all times. Cultural and ethnic expression is encouraged.
Staffing and Employment Policy	
Activity	Outcomes
Recruitment	Safe and effective recruitment processes are in place, which protect vulnerable service users from exploitation or abuse.
References	References ensure service provider recruits staff of an acceptable standard.
Qualifications	Compliance with standard set. Employing and retaining good quality staff to improve standards of care.
Training and Staff Development	Individual staff skills, knowledge and experience is enhanced. Staff have an understanding of the aims and objectives of the organisation. A sense of common purpose is promoted.

Service objectives

We will commission domiciliary care services that:

- Promote the independence of adults assessed as needing social care support by placing them at the centre of decisions that have an impact on their lives
- Enable adults receiving domiciliary care to live as safe, full and as normal a life as possible
- Take account of the particular needs of working age adults and their carers who may also be of working age by providing services which take account of and as far as possible, maximise their capacity to take up and maintain employment
- Promote close working with NHS, PCT and Trust colleagues and other relevant agencies including housing providers, to avoid unnecessary admission to hospital and inappropriate placement within a residential/nursing care setting
- Enable service users, carers and families to take a full and active part in planning, monitoring and reviewing the services provided to them

Other matters

- In mixed tenure developments consideration must be given on a case by case basis as to whether it is better to “pepper pot” different tenures or separate tenures in different areas of the building(s)
- In mixed tenure the tenancy and lease must be considered together so as far as possible tenants and leaseholders receive the same service and contribute to operating and care costs on an equitable basis
- A variety of financial arrangements for entry to extra care are possible. Where public subsidy is provided either directly or donation of land from public sector body the financial arrangements should enable schemes to be entered by less well off older homeowners who may not be able to afford the full capital cost of outright ownership

Appendix 2 Defining “Fit for Purpose” in Sheltered Housing

“Fit for purpose” means sheltered housing which provides an appropriate enabling, environment, for older people over retirement age with an associated support service.

Schemes which are fit for purpose will be judged to aid independence of frailer and more vulnerable people and offer security.

Quantative Indicators

Signs that sheltered housing is not fit for purpose include:

- High voids – say 10% or more
- Above average re-let times – say in excess of 4 weeks
- Some dwellings which take a considerable time to re-let – say 3 months or more
- Some dwellings which are repeatedly refused prior to re-let – say 4 or more offers
- Low/no waiting list
- Policy decision to lower qualifying age below 60
- High turnover rates

Physical attributes

Buildings which are not fit for purpose may have one or more of these characteristics:

- Lack of amenities, these should normally be - lounge of sufficient size for all residents to meet, assisted bathing, guest suite, scheme managers/wardens office, buggy store/re-charging, laundry
- Bedsits or very small 1 bed flats
- Shared facilities
- Absence of design features to make buildings more easily usable/suitable for a frailer or disabled resident
- Not built to mobility standards
- No lift or lift which serves only part of the building
- Access or other barriers to independence, for example steps in or around building, building on different levels, narrow corridors, poor lighting, heavy doors

Location

Characteristics of areas which may contribute to schemes no longer being judged fit for purpose include:

- Long distance from amenities like shops, café, pub, places of worship
- Steeply sloping area/site
- Lack of public transport nearby
- An area perceived to be (or actually) threatening; residents report feeling unsafe
- An anti-social neighbouring activity for example a supermarket with noisy deliveries through the night

Note

These are indicators only – the scheme has to be judged in the round taking all the circumstances into account. It is conceivable that all the quantitative indicators look acceptable in a flat block clearly inappropriate for older people with no lift or amenities because there is no other choice.

Conversely, poor décor, an inadequate/unfriendly scheme manager, poor reputation of landlord, poor marketing, maintenance, can equally contribute to apparently low performance as measured on the indicators of what would otherwise be an acceptable building.

Aspirations are rising, most noticeable around space and style of buildings. Buildings currently considered adequate because they do not have any adverse indicators listed above may still steadily become unpopular because for example units are too small.

Appendix 3 – Culture of Extra care

Flexible care

The current specification for domiciliary care in Bucks is based on an outcomes approach to service delivery which lends itself to a flexible approach to the delivery of personal care. The commissioning arrangements within an extra care scheme would need to be modified to ensure flexibility within the scheme on behalf of individual tenants however kept within a costed framework.

The overall care budget for the scheme could be based on a minimum number of personal care hours for each tenant, say 10 hours per week including night time cover. The care inputs could be commissioned in terms of weekly rather than daily time slots and measured by outcomes. A flexible budget could be set aside to ‘top up’ care packages where more flexibility was required and the purchases over and above the 10 hours would be costed according to the agreed schedule of rates.

The reviewing protocols would be agreed as part of the scheme and would be in line with standards within the current specification for communication between the commissioner and provider about changes or variations to the care plan which were assessed as needed.

The care needs of residents in this model need very close attention and this is possible because of the level of knowledge the care manager will have about the tenants, their preferences and their priorities. A certain amount of risk attaches to the Enabling Model. The experience of extra care housing is that these risks are mostly undertaken by tenants who wish to remain in control of their lives and of their personal care. The risks are mitigated by the availability of care staff 24/7, the provision of personal alarms and Assistive Technology which can be tailored to individual needs e.g. fall detector, epilepsy alarm, wanderer alert...

For a carer it is often quicker, and it may appear safer, to simply complete a task, for example making a pot of tea. However if the tenant can be encouraged to do the task initially under discreet supervision this may lead to regaining this capability. Perhaps just a part of the task could be attempted initially, like filling the kettle and putting the teabags in the teapot. It is a positive approach aimed at regaining lost life skills rather than assuming they can never be regained. Of course there is intended to be no compulsion and carers need to steer a careful path between encouragement and coercion. If a tenant really does not wish to attempt a task the staff will provide the support required.

In terms of this model of personal care, the current specification is based on an enabling approach and this could be further promoted through the training offered at the County Domiciliary Care Training Centre and embedded in the outcomes based approach to care planning.

Leisure and entertainment

The greatest risk in the management of extra care is that of social isolation especially for dementia sufferers. It is easy to see how the benefit of having your own front door could turn into the peril of being alone for too long each day and feelings of isolation. To counteract this risk the overall number of care hours allocated to the unit should allow for unspecified social contact with the more vulnerable tenants. This could amount to just calling in to say hello or for a coffee, or it could extend to organising and joining in social events in the central meeting area. These events could include exercise classes, fundraising activity or parties. The type of events would reflect the wishes of the tenants but be organised by the staff. Assistance would be available to move around the building if requested. The provision of a mid day meal is in itself a social event and some tenants may choose to take lunch together in a central dining room.

Management and supervision

This approach requires positive on site management of both the Housing and the Care elements which make up the total extra care service to tenants. Regular dialogue with tenants and with staff is needed to identify and maintain the uniqueness of the service. Management includes monitoring, discreetly the impact of care inputs and motivating care workers to understand and achieve the objectives of the tenants themselves. The overall objective is that tenants feel happy and fulfilled and positive about their lives and their futures.

From the providers perspective, containing care costs within an agreed annual budget and at the same time accommodating frail and vulnerable people who might otherwise be placed in more expensive forms of care, will register as successful management of the extra care Housing scheme.

These issues require monitoring so that schemes can be compared and so that providers can be sure that the original objectives are continuing to be achieved.

Management and care

For each individual extra care development there will be two active participants, the building provider and the care provider. Although in some developments these roles have been carried out by a single specialist organisation, as explained at the start of this chapter we feel that separation of these two functions is to be preferred (but we have not ruled out there being a single organisation providing the care and housing function can be satisfactorily separated internally). The reasons for this conclusion are as follows:

1. There are potential building providers who could not provide care and we wish to include these organizations not exclude them.
2. We would not wish to exclude good care providers if they were not able to compete successfully as building providers.

3. Although there is a need to coordinate the activities of two managers on each site there is also some advantage in not placing the whole range of responsibilities in one pair of hands. Recruitment of a single manager is often quite difficult because it is such an unusual range of skills.
4. Whereas the building provider role is a semi permanent function carrying with it the responsibilities of building owner and landlord, care provision needs to be the subject of regular review and re-tendering to ensure value for money. Commissioning bodies would need the flexibility to separate the roles at a later date and this may create a redundancy situation as the joint management is ended.
5. In the future, greater use of direct payments and potentially new "individualised budgets" currently being tested also mean the resident must have the ability to choose who provides support or care.
6. We are playing to the strengths of both types of provider. The care management function is subject to registration and external supervision by the Care Commission. The building provider by the Audit Commission and the Housing Corporation.
7. A strong building provider role will tend to reinforce the different relationship compared to residential care and will emphasise the rights and responsibilities of tenants.

The joint commissioners of each extra care scheme are Buckinghamshire Adult Social Care and the District Council. The providers will be appointed by the joint commissioners.

The building provider role

Where developers are seeking grant aid from the Housing Corporation or Department of Health or some undertaking to provide revenue funding from Supporting People or as part of care packages, we envisage organisations will wish to work with the County Council and District.

The building providers will be selected as preferred partners following a joint selection process. They will be Registered Social Landlords or private developers and will bid jointly for funding to provide schemes in line with this strategy.

The evaluation of preferred providers will be through a transparent and standard format, which will allow other providers/ developer to approach Buckinghamshire County Council and partners should other opportunities present themselves.

They will receive the capital grant monies, procure the building and subsequently own the resulting buildings. The design will be agreed jointly by parties to the individual scheme, including the Commissioners.

They will then manage all the housing functions including:

1. The employment and line management of a Scheme Manager.
2. Repairs and maintenance
3. The provision of building based services for example cleaning of common parts and gardening
4. Through the Scheme Manager, supervise the provision of facilities for example the Shop and Fitness Suite including the management and recruitment of volunteers.
5. Implement the letting procedures following the joint selection process.
6. Participate in and lead joint liaison meetings with the care provider.

7. Maintain a close working knowledge of the circumstances of all tenants in conjunction with the care provider.
8. Setting and collecting rents and service charges.
9. Provide all tenancy documentation
10. Carry out best value monitoring of the housing service

Where RSL's are the housing provider, they will be required to follow Housing Corporation. "Scheme Development Standards", have rents restricted by the Corporation rent regime and have to fit within a variety of financial and other restrictions. A limited amount of funding from the Corporation in the form of Social Housing Grant (SHG) may be available.

The care provider role

The Care provider role is subject to annual review by the commissioners, this review will set the target level of frailty and the resulting number of care hours to be allocated to the scheme. The review should be carried out in cooperation with the housing provider.

The contract for the delivery of care should be for a three year period subject to the annual review. Re-tendering should occur six months ahead of the expiry of the contract. Continuity of the care provider role has a significant value so wherever possible the council should be seeking a long term relationship with a care provider.

The care provider could be an "in house" service or a private sector service. Not for profit organisations are part of the private sector.

The role is to cooperate with the building provider to meet the agreed purpose and objectives of the scheme. This must incorporate maintaining on site management and meeting a written service specification which is tailored to the extra care scheme and which reflects this strategy.

The care provider should:

1. Employ a dedicated manager to be based on site
2. Employ dedicated staff to work solely at the scheme
3. Work closely with the Scheme Manager to ensure the "Enabling Model" of care.
4. Be responsible for the day to day deployment of carers to meet the changing needs of tenants.

The joint selection process

Selection of tenants or owners at initial letting/sales and for all subsequent re-lets/resale's should be a collaborative function involving the building provider and the care provider. The criteria will need to be agreed with the joint commissioners and should reflect the agreed purpose of the extra care scheme. This should prioritise on the basis of care needs rather than housing needs or tenure.

Individual decisions need to be taken in the light of the current level of frailty at the scheme bearing in mind the available care resource. This will be a product of the frailty mix agreed at the annual review and the current assessment of care take up by existing tenants.

Appendix 4 – Summary of Core Costs

Summary of the core cost of living at Denham Garden Village

Service	What you receive	Frequency	Price
Domestic help and support	<ul style="list-style-type: none"> ▪ Cleaning ▪ Laundry/ironing ▪ Shopping ▪ Collecting prescriptions ▪ Preparing light meals ▪ Home valet service (spring cleaning) ▪ Oven cleaning ▪ Help with reading/writing letters ▪ Paying bills ▪ Facilitating contact with family and friends ▪ Escort to and from social events, appointments etc 	As required	£10 per hour
Personal care	<ul style="list-style-type: none"> ▪ Assistance with mobility ▪ Help to get in and out of bed ▪ Help with toileting, washing and bathing ▪ Food preparation and help with eating and drinking ▪ Assistance with medication ▪ Assistance with personal hygiene 	As required	£10 per hour
Handy person	The handy person service is available to help with jobs around the house, for example hanging pictures, decoration or facilitating other individual works	As required	£15 plus VAT per hour
Service Charge	<ul style="list-style-type: none"> ▪ 24 hour emergency support ▪ Dedicated customer services team ▪ Enjoyment of well kept grounds and communal facilities ▪ Laundry facilities ▪ Window cleaning ▪ CCTV security 	Budgeted annually in consultation with residents	Approximately £85 per calendar month

	<ul style="list-style-type: none"> ▪ Monitored emergency, burglar and smoke alarm ▪ Buildings insurance ▪ Access to satellite TV ▪ Use of health and fitness centre ▪ Village “golf buggy” transportation 		
Repairs and maintenance fund	Cyclical works (e.g. external re-decorations), reactive repairs and technical inspections (e.g. gas boiler servicing)	Budgeted annually in consultation with residents	Approximately £28 per calendar month
Sinking fund	Major property related repairs, replacements, renewals and improvements. Includes all works to roofs, windows, buildings structure, gas boiler etc	Deferred cost payable on re-sale or re-let	Calculated as 0.25% of purchase price plus Retail Price Index (inflation) for each year of occupation
Ground rent		Annual invoice	£150 per annum

With thanks to Anchor Trust – edited extract from published purchasers information pack.

Appendix 5 – Housing Benefit Eligibility

Examples of *eligible services* include:

- Scheme manager (though some aspects might be defined as rent)
- Services to communal areas such as cleaning, lighting and heating
- Refuse removal
- Maintenance and servicing of equipment such as lifts, fire detection equipment
- Repair of equipment
- Renewal of equipment, e.g. furnishings in communal areas
- Radio and television relay
- Portering
- Entry phones
- Emergency or social alarm system

Examples of *ineligible services* include:

- Water and fuel (except to communal areas)
- Personal services such as nursing or care
- Cleaning (except for communal areas)
- Laundry (except for provision and maintenance of facility)
- Window cleaning (except for communal areas and outside of windows where no-one in household capable)
- Emergency alarm system (except for hardware)
- Counselling and other housing-related support services are no longer covered by Housing Benefit, but fall within the remit of Supporting People
- Leisure items including TV rental and licence
- Transport

Although the latter list is **not** eligible for Housing Benefit payments this does not mean the landlord cannot provide them, just that the residents will have to pay this part of the service charges themselves (or it is met by some other agency on their behalf).

Appendix 6 – Supporting People Eligible Service

The range of services which may be eligible includes:

- Help in setting up and maintaining home or tenancy
- Developing domestic/life skills
- Developing social skills/behaviour management
- Advice, advocacy and liaison, signposting to other services
- Help in managing finance and benefit claims
- Emotional support, counselling and advice
- Help in gaining access to other services
- Help in establishing social contacts and activities
- Help in establishing personal safety and security
- Supervision and monitoring of health and well-being
- Supervision and monitoring of medication
- Peer support and befriending
- Help finding other accommodation
- Provision of community or social alarms
- Help in maintaining the safety and security of the dwelling
- Cleaning of own rooms (as defined under THB)
- Risk assessment
- Advice and support in repair work/home improvement work
- Help with shopping, errand running and good neighbour tasks
- Access to local community organisations
- Management of handyperson services

Within these categories lies some considerable qualification which cannot be covered in detail.

Glossary

BME Black and minority ethnic groups.

Commission for Social Care Inspection Regulatory body with responsibility for inspecting and reporting on care services and Councils to improve social care and stamp out bad practice.

Direct Payments Money given to individuals by Bucks County Council Adult Social Care, for the purchase of care services, e.g. home care or use of day centres.

Domiciliary Care Care provided in a person's own home. The terms Home Care and Domiciliary Care are used interchangeably.

Extra Care Housing for people requiring support and care, usually a group of flats and/or bungalows with communal facilities. Such schemes have staff on site and care is available on a 24 hour basis.

Floating Support Support provided to people in individual housing and **sheltered** housing schemes by a mobile service.

Handyperson Schemes Services offering assistance with small jobs, usually in the homes of low income householders, particularly older and disabled people in the private sector.

HIA's Home Improvement Agencies – these are not for profit organisations that assist vulnerable homeowners or private sector tenants who are older, disabled or on low incomes, to repair, improve, maintain or adapt their homes.

Housing Corporation National Government agency that funds new affordable housing and regulates Housing Associations in England.

Intermediate Care Care provided at home or in designated care settings to prevent unnecessary hospital admission, and rehabilitation services to enable early discharge from hospital and prevent unnecessary admission to long term care.

Mixed Tenure Schemes where some of the properties are for sale and/or shared ownership, and some for rent.

Nursing Care The same as **Residential Care** but with registered nurses who can provide care for more complex needs.

PAF Performance Assessment Framework. This is a set of indicators used by the Department of Health to measure the performance of social care services delivered by local authorities.

PCT Primary Care Trust - Buckinghamshire previously had three PCT's, now amalgamated into one covering the whole of the County.

Residential Care Homes providing accommodation, meals and personal care, with 24 hour staff cover.

Respite care Short term periods of care provided to frail or disabled people, in order for their regular carers to have a short break or holiday.

RSL Registered Social Landlord. These are generally Housing Associations registered with the **Housing Corporation**.

Shared ownership This is where part of the property is purchased and the other part rented. Typically 50% or 75% is purchased, but this is flexible.

Sheltered housing Usually a block of flats with communal facilities, supported by a scheme manager/warden either living on site or visiting.

SHG Social Housing Grant available via a bidding process from the **Housing Corporation**.

Smart Technology A range of aids to help people control their environment in their own home – e.g. pressing a button to turn lights on and off, and projecting the image of callers to their front door on their TV screen.

SP Commissioning Body Decision making group, including representation from District Councils, County Council, Probation and PCT, overseeing the commissioning of services and administration of **Supporting People Grant**.

Stay Put schemes Another term for **Home Improvement Agencies**, helping people to maintain or adapt their homes to prevent unnecessary moves.

Supporting People (SP) Grant Various streams of funding, primarily the support element of Housing Benefit, were brought together into the Supporting People Grant in 2003. The administration of the grant is overseen by the **SP Commissioning Body**.

Supported housing This is commonly used to describe housing where support is an intrinsic part of the tenancy or leasehold, e.g. **sheltered** or **Extra Care** housing.