



# “The Best of Both Worlds”

## Staffordshire FlexiCare Housing Strategy 2010-2015



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# Introduction

***'We have finally landed on our feet. We have the best of both worlds - our own flat with our own front door, but with the added security of the 24-hour flexicare team'***. – Flexicare scheme resident

***'Flexicare is the best way I have seen for keeping people as independent as possible'*** – local scheme resident with years of experience as a lay inspector of care services.

***'It's like one big family here, there is always someone there'*** - resident of a local scheme

This strategy sets out the framework for the future development of FlexiCare Housing in Staffordshire, our approach to extra care housing. We already have several schemes in the county and many more in development. For people who live in flexicare schemes, for carers and for staff in housing, health, care and support services, flexicare in the county has already been a very successful innovation. Huge enthusiasm and commitment have brought it about, as well as considerable financial investment from the County Council and other sources. We were delighted though not that surprised to see that services in Staffordshire won no less than four of the EAC (Elderly Accommodation Counsel) Housing for Older People Awards in 2010, including Best UK Flexicare Housing Scheme and Best Housing With Care scheme 60-99 units. This strategy aims to steer the continuing enthusiasm and investment which will make flexicare a resource for many more people in Staffordshire.

The strategy sets a framework, tied to the needs of the more vulnerable people in the county, which will shape and support development in the varying Districts of our County. The Council and our partners in District and Borough Councils and the NHS will often be leading the development of new services, but we also welcome developers who independently choose to invest in Staffordshire and trust this strategy will help them to plan their schemes and to build partnerships with our statutory organisations in Staffordshire.

Flexicare provides unique opportunities to live in your own accommodation with the security of knowing that care and support are available when you need it. It allows people to lead the life they want in a supportive community, and to choose the activities and services which they want. It provides care and support to adapt as needs change. Flexicare housing will become an increasingly important element of the 'whole system' approach which will be in place by 2012, bringing together that range of supportive services which together form 'Staffordshire Cares'. We are transforming care services in the County: we want people to stay independent as long



as possible and be able to get the support that helps them. With the implementation of this strategy, flexicare housing will become increasingly central in achieving that.



Councillor Matthew Ellis

Cabinet member for Adults and Wellbeing  
Staffordshire County Council





# Executive Summary

This strategy provides the framework for the future development of Flexicare Housing (FCH) in Staffordshire, our approach to Extra Care housing. There have already been several award winning developments in Staffordshire. With this strategy, over the years ahead, it is planned to make FCH an increasingly well known and chosen form of specialist accommodation in every District of the County. It will be available for people who want to purchase a leasehold or for people who choose to rent. The Council will take a leading role in developing some, but for others we are encouraging developers to come to Staffordshire. Flexicare provides the security that support and care services are on hand when you need them, whether now or later in your life.

The strategy describes the reasons for developing Flexicare. Flexicare puts services on the ground which are in line with national, regional and local strategies for the wellbeing of our communities, for housing, health and social care. It provides that balance of social, active opportunities and available support which many people want as they grow older or live with a disability. The growing body of research evidence indicates that Flexicare can provide well for people with a wide range of expectations and needs.

The strategy includes the outcomes of a review of existing local FCH services which has given many pointers to how services should be developed. It also includes an analysis of needs, based on the model developed by Oxford Brookes University. This indicates a potential need for 9,541 units of FCH accommodation by 2030, compared to the current provision of some 634. This will require continuing innovation and developing the art of the possible, which may involve, as well as new schemes, redevelopment of some existing sheltered housing and 'hub and spoke' models of outreach in to nearby communities to create 'virtual' FCH there. For rental accommodation, good progress towards the target is continuing, but for the majority of accommodation which is needed – leasehold which allows people to invest their capital – there is a growth area to be encouraged. A range of tenure options should be developed to assist this including shared ownership and shared equity.

This large number of developments needed reflects the growing proportion of older people in the County – most of them property owners. It also reflects ambitious targets for people who otherwise could be in care homes, to continue to live in their own homes. This would be with the support and care they choose and need, including enablement services at point of admission or critical change, and health care. We will monitor these targets closely to ensure that they continue to reflect actual demand. Development will also need to be phased over the period to match the development rates indicated.

The strategy contains a statement of 'What Staffordshire expects' for people in FCH, drawn together by an informed and mixed group of local staff and residents. This sets the values and principles and standards which Staffordshire expects to be delivered through FCH, putting the people who will live there at the centre of this strategy. The strategy also includes a framework for relationships between Flexicare schemes and the NHS, so that the best use can be made of the Flexicare setting to sustain the well-being and health of people who live there, with the aim that it will usually offer 'a home for life', supported by strong partnerships between housing, social care and



health organisations. We will also need to work with neighbouring authorities to develop admissions criteria where people are looking to move across administrative boundaries.

As well as being good for residents, FCH is also good news for both the County Council and the NHS. The preventative nature of schemes, together with the ability to concentrate resources in one area means that significant efficiencies can be achieved.

Funding for new schemes can come from a variety of sources, and we will need to be increasingly innovative due to the impact of the recession and public sector savings. This is likely to increase the need to develop leasehold units rather than those available at a social rent, but we will also need to rationalise the amount of communal space included within schemes. This should also help to limit service charges within schemes.

The County Council will seek to prioritise its investment in areas of greatest need where the market is least likely to respond independently.

A 'logic chain' brings together the impact the strategy aims to achieve, the outcomes sought and measures which arise from these and the actions and leadership which will cause them to happen. The aims and progress of this strategy will be kept under review, under the leadership of the Staffordshire Joint Commissioning Unit.

The strategy is supported by information in detailed appendices which are available online.



# Our definitions

## What is Flexicare Housing (FCH)?

Flexicare housing is:

- ◆ accommodation (of your own – as a leaseholder or a tenant);
- ◆ with care and support available ‘round the clock’; and
- ◆ some provision of communal facilities.

Within this simple definition there are many variations in practice. The following more detailed definition is taken from a recent document from the Housing LIN (Learning and Improvement Network of the Department of Health):

Flexicare Housing ‘is a type of housing which provides choice to adults (usually older people) with varying care needs and enables them to live as independently as possible in their own self contained homes. Round the clock access to care and support should be available, tailored to each resident’s needs, and other services, such as meals, domestic help, leisure and recreation facilities may also be provided.’ Flexicare Housing ‘should provide a genuinely safe environment for its tenants, or owners. It can also provide a base for out of hours or outreach services to the local community.’ (Housing LIN workshop report 26.02.2010)

Care provision is an important factor for people who live within a Flexicare Housing scheme. The majority of people will be over the age of 55, but it may also include some younger people with disabilities. People will be assessed for financial assistance through a Fair Access to Care assessment and some people may pay for their own care costs. It is all part of Staffordshire Cares, the new vision for adult social care in Staffordshire that will improve access to information and make the care system much easier for people to understand.

Flexicare provides longer term care solutions to meet a range of needs, including care and social activities and nursing care should this ever be needed. The Flexicare approach is intended to provide a home for life for most people.

In this strategy, we use the terms ‘FCH’ and ‘Flexicare’ to mean this complete package of accommodation with care and support from a range of providers including the NHS.



# Why develop Flexicare Housing?

## Strategic benefits

Flexicare Housing can assist with the following key strategic benefits:

- ◆ Providing quality housing and communities that are suitable for the needs of older people and some other more vulnerable groups
- ◆ Providing a wider range of choices for housing and support
- ◆ Freeing up larger properties in the housing chain
- ◆ Promoting independence, choice and control
- ◆ Reducing social isolation and enabling social inclusion and fulfilment
- ◆ Early intervention and prevention - of avoidable deterioration and use of higher dependency services
- ◆ Improving the quality of life for people who use the service
- ◆ Improving the health and wellbeing of people who use the service
- ◆ Reducing depression
- ◆ Reducing the demand on community and acute health services
- ◆ Enabling more effective, co-ordinated and integrated service delivery
- ◆ Providing an alternative to residential care for many people and nursing care for some
- ◆ Keeping carers and the person they care for together
- ◆ Providing most people who use the service with a 'home for life'
- ◆ Providing an environment for safety and dignity
- ◆ Supporting people at their 'end of life'
- ◆ Achieving benefits from partnership working across housing, social care and health
- ◆ Assisting organisations in delivering priorities and meeting key Performance Indicators (see Appendix 1 for examples)



## Reflecting national priorities

This approach is very much in line with national and local strategic priorities, as reflected in various key documents, such as the following: (see Appendix 2 for more information about the relevant content of these documents)

- ◆ Lifetime Homes, Lifetime Neighbourhoods – a national strategy for an ageing population (CLG 2008)
- ◆ Our Health, Our Care, Our Say: a new direction for community services (Department of Health 2006)
- ◆ Putting People First - Concordat (Department of Health 2007) and the linked Transforming Adult Social Care (Department of Health 2008)
- ◆ Living Well With Dementia – A National Dementia Strategy (Department of Health 2009)
- ◆ Under Pressure – Tackling the financial challenge for councils of an ageing population' (Audit Commission 2010)
- ◆ The West Midlands Regional Housing Strategy (West Midlands Regional Assembly 2005)
- ◆ The West Midlands Regional Supporting People Strategy (West Midlands Regional Housing Board 2005)
- ◆ The West Midlands Health and Well Being Strategy (West Midlands Regional Assembly 2008)
- ◆ Staffordshire Sustainable Community Strategy 2008-2023
- ◆ Staffordshire Social Care and Health Directorate Improvement Plan 2010/11 – 2014/15
- ◆ Staffordshire Local Area Agreement and its targets
- ◆ South Staffordshire PCT Strategic Plan 2008 - 2013
- ◆ NHS North Staffordshire Strategic Plan 2009/10 - 2013/14
- ◆ The Staffordshire Supporting People 5 year strategy 2005 - 2010
- ◆ The eight Staffordshire District Council Housing Strategies, Local Development Frameworks and Strategic Housing Market Assessments
- ◆ The Staffordshire Joint Commissioning Strategies 2008 – 2012 for Older People, for Services for People with a Learning Disability and for People with Physical and Sensory Disabilities



## Reflecting what people say they need and want

Some of the factors identified from feedback that make older people feel socially excluded and act as barriers to quality of life are:

- ◆ Living in inappropriate or inadequate (non-decent) housing
- ◆ Lack of housing related services
- ◆ Low incomes
- ◆ Lack of access to leisure facilities
- ◆ Lack of accessible transport
- ◆ Fear of crime
- ◆ Age discrimination

(from 'Excluded Older People' – Social Exclusion Unit, ODPM 2005, quoted in 'Delivering Housing for an Older Population' HOPDEV 2005)

Similar barriers are also often experienced by people with disabilities.

Evidence quoted in the Audit Commission's 'Under Pressure' (2010) cites four main factors that reduce quality of life in later years:

- ◆ Financial hardship
- ◆ Health and mobility problems
- ◆ Lack of trusting relationships with family and friends
- ◆ Low opinions of neighbourhoods

'More Choice, Greater Voice', the Department of Health Housing LIN toolkit (2008) reviews changing aspirations and summarises that Accommodation and Care should ensure:

- ◆ Real options for people in a range of personal and housing circumstances
- ◆ Locations that provide access to a range of facilities and services
- ◆ Provide actual and perceived security in the scheme and its surroundings
- ◆ Recognise and provide for a diversity of lifestyle choices
- ◆ Provide a flexible offer of service that is built on positive presumptions about old age
- ◆ Offer the best available financial arrangements on entry and for the future



## Reflecting research evidence

### Strategic Review of Flexicare Housing in Staffordshire

During 2009, the Strategic Housing Unit of the JCU undertook a very thorough review of the six then running schemes in Staffordshire, where the development had been led by the County Council. They are in four of the County's Districts, operated by various providers using different service models. People living in the schemes told us that:

- ◆ they enjoy living in a flexicare scheme and like having activities to take part in, although some would like more social events in the evenings and at weekends;
- ◆ more information is needed to give to residents before they make a decision to move into a flexicare scheme;
- ◆ they were not always sure what they were paying for and they should receive the same sort of service as in a residential care scheme e.g. constantly pressing the buzzer in non-emergency situations;
- ◆ staff working in the schemes generally provided a good care and support service, although at a couple of the schemes support was not delivered as efficiently as care;
- ◆ Many service users cited the main reasons for moving into a flexicare schemes were feeling alone and vulnerable, experiences of anti-social behaviour and inappropriate or insecure accommodation.
- ◆ housing management issues such as repairs can take at least two weeks to be carried out – usually because Scheme Managers wait for at least two repair jobs before reporting them;
- ◆ at a couple of the schemes greater resident participation is needed especially to offer feedback on how services can be improved;
- ◆ there are some inconsistencies between schemes regarding the allocations process and more work is needed to ensure that all schemes have a robust system in place for allocating properties.
- ◆ being able to preserve (financial) equity is important; and
- ◆ choice about how their needs are met is paramount.

The strategic review concluded that for Staffordshire:



- ◆ Flexicare housing offers a real alternative (to current residential and domiciliary care options) for older people with care and support needs. However the model needs to be fit for the future and adapt to meet changing needs, aspirations and expectations. In particular Flexicare housing should be developed to support a wider group of people than older people
- ◆ FCH buildings have been developed to a high standard but it is recognised that the majority of provision is social rented. More tenure options need to be developed to reflect the fact that in Staffordshire 77% of people over the age of 55 are owner occupiers and will have equity to invest in their future housing and care needs
- ◆ There are concerns expressed about whether Flexicare housing is normally a home for life as people who have developed more complex conditions have not been able to be supported within schemes
- ◆ The current charging policy for Flexicare is unpopular and confusing for service users and families, in particular the “spot charge” for the two care bands is seen as unfair to those people receiving low packages of care
- ◆ The support costs within schemes vary considerably and show no positive correlation between staffing ratios and costs applied
- ◆ The current models of commissioning do not support personalisation
- ◆ Commissioners and operational teams value the Flexicare housing schemes where they have been able to shape and influence the service model and have a direct influence on allocations within the scheme
- ◆ There is little evidence of outcomes being achieved in Flexicare housing; however this is predominantly due to the care contracts not being outcome focused
- ◆ Development to date has been opportunistic and for the future a strategy for Flexicare housing in Staffordshire should be developed to identify areas where development should be prioritised and options for pump-prime investment should be capitalised on
- ◆ There is little evidence of involvement of the NHS in the commissioning and development of Flexicare housing
- ◆ There is low public awareness of Flexicare housing developments and what they can offer people
- ◆ Front line staff are sometimes unclear as to the role of Flexicare housing and the context in which people should be referred
- ◆ Although all the schemes reviewed knew the differences between tasks delivered as housing related support, and those of care, it was sometimes unclear who was delivering which elements and that these were being done in the appropriate proportions in relation to the contracts in place
- ◆ Allocations policies and processes were found to be inconsistent, and in some cases there were no formal arrangements in place which lead to difficulties ensuring appropriate nominations were made and that there was an appropriate care mix within schemes





The review was subject to a 12 week public consultation between March and May 2010, including meetings with residents of seven existing schemes. The recommendations of the review garnered wide support through the consultation process, and have been incorporated within this strategy. A fuller summary is included in Appendix 5.

### **National research**

Recent research evidence, although in some areas contradictory, still overwhelmingly indicates many benefits from FCH. As FCH developments are fairly recent in this country, and vary considerably in their approach, emerging research evidence will continue to inform the implementation and review of this strategy. Some key findings (quoted at greater length and attributed in Appendix 3):

- ◆ Residents value the independence, security and social interaction offered by FCH.
- ◆ Most residents feel well connected, value social activities and make new friends.
- ◆ Some residents can be socially isolated, particularly those in poorer health and receiving care. Moving around the scheme can be a problem for them which can be resolved with flexible staff and volunteers.
- ◆ 'Village' schemes and smaller schemes have different benefits and limitations for different people.
- ◆ The average level of dependency and of cognitive impairment is lower in FCH than care homes.
- ◆ Flexicare housing is not operating as a direct alternative to care homes but providing for a rather different population, who are making a planned move rather than reacting to a crisis.
- ◆ People have transferred from care homes to FCH and 'thrived' and people with nursing care needs successfully live in some schemes.
- ◆ In some places there has been tension between 'the fit' and 'the frail' residents.
- ◆ Most people live in FCH through to the end of their lives and there are examples of schemes that have been able to increase significantly the opportunity to end your life in the FCH scheme where that is the resident's choice.
- ◆ FCH can support people with cognitive impairment such as dementia but it is advisable for people to move in before this has developed significantly. Some people may live to the end of their lives in FCH but 'disruptive, worrying, annoying' behaviours which are detrimental to others in the scheme are likely to be difficult to sustain.
- ◆ FCH is particularly valuable for couples with different levels of need.
- ◆ Economic recession has encouraged a 'mixed economy' of provision, often within developments, and greater attention to costs. 'Flexibility in partnership is the way forward.'



- ◆ Design of schemes is of crucial importance and evidence of what achieves the best outcomes is increasing.
- ◆ Social care costs have been found to increase with the move to Flexicare but with improved outcomes (less unmet need) but health care costs have reduced, with better access to services and reduced call on them.

## Key factors in Staffordshire

- ◆ Staffordshire covers an area of 2,623km<sup>2</sup> in size: 80% of the land is rural
- ◆ Three quarters of the population live in urban centres
- ◆ Staffordshire has the 8th largest population of the shire counties in England with an estimated 833,600 people living in the County, projected to rise to approximately 904,500 people by 2030.
- ◆ The number of people aged 65 and over in Staffordshire is estimated to increase by 84,100 (54.0%) by 2030
- ◆ The number of people aged 85 and over in Staffordshire is estimated to increase by 25,700 (139%) by 2030
- ◆ There is variation within each district in Staffordshire; the estimated number of people aged 65 and over is increasing at different rates, ranging from 41% in Newcastle-under-Lyme to 75% in Tamworth
- ◆ The estimated number of people aged 85 and over in each district is also increasing by varying rates; from 100% in Newcastle-under-Lyme to 194% in Cannock Chase
- ◆ It is estimated that 119,551 people aged 65 and over in Staffordshire will suffer from a limiting long-term illness by 2030 , an increase of 46,374
- ◆ It is estimated that 19,673 people aged 65 and over in Staffordshire will suffer from dementia by 2030, an increase of 9,710.
- ◆ Home ownership ranges from 87.5% in people aged 65-74 in Staffordshire Moorlands to 53.9% in people aged 85+ in Tamworth
- ◆ Although there is variation across the districts, those currently aged 55-64 are about 20% more likely to own their own home than those aged 85+
- ◆ 1.86% of East Staffordshire's population aged 65-74 state their ethnicity as being Asian or British Asian, the highest proportion in Staffordshire
- ◆ There are currently 35,565 pension credit claimants in Staffordshire; by 2025 it is estimated that 53,163 people aged 60 and over will be claiming credits.



The County Council has adult social care responsibilities including the lead on Supporting People, the eight District Councils have strategic housing responsibilities, and the NHS is led by the two Primary Care Trusts, South Staffordshire PCT and NHS North Staffordshire, commissioning a range of provider NHS Trusts, some of which are outside the County's boundaries. The city of Stoke-on-Trent is a unitary Authority totally within the County boundaries.



# What Flexicare Housing do we need?

The development targets which follow are based on recent work by the Institute of Public Care, based at Oxford Brookes University (CSIP, Housing Learning Information Network, 2007), in developing a model of the need for FCH units applicable across all local authorities.

The figures produced are larger than those considered in the Staffordshire draft needs analysis circulated in December 2008. This change flows from adopting a 'whole population' approach as opposed to focusing on the people that the County Council expects to fund in respect of care costs, which that needs analysis was based on. An FCH Strategy should provide for both mixed tenure and mixed dependency schemes. The scale of new provision required is deliverable assuming the stimulation of a private sector market. The local authorities in the County cannot and should not meet all the needs, but should help provide the information and stimulus to other developers to see and take opportunities.

Some elements of the 2008 Staffordshire draft needs analysis have been retained, however - in particular the assumptions for diversion from residential and nursing care. These were widely circulated for consultation and accepted at the time, i.e. that 60% of those currently accessing residential care could be diverted to FCH as an alternative and that 20% of people in nursing care could live in Flexicare as it could prevent or delay the need for nursing care in a care home. These are ambitious assumptions which will require testing over time as the quality and amount of FCH develops in the county.

The distribution of population by age, tenure, living alone and living with a limiting, long term illness are key factors in determining need and demand for a range of health and social care services. Accommodation and care and support are central elements of this provision. The estimate of future FCH need has to be tempered by the reality of what it is practical to deliver over certain time scales, but a well evidenced estimate is needed as the basis of planning and prioritisation. In considering FCH needed, the core elements required can best be delivered in existing and new FCH schemes but also through some existing or adapted sheltered housing to make it fit for purpose and through innovative outreach schemes based round flexicare hubs.



## Population Growth

The 65+ population in Staffordshire is projected to grow from around 154,700 in 2010 to 241,900 in 2030, an increase of more than 50%. There will also be the consequences of an increasing proportion of very elderly people as can be seen from the fact that the 85+ population will grow by 146% over the same period.

The table opposite shows the projected growth in the population of older people in Staffordshire. Population growth will not be evenly distributed across the County with the lowest projected increase seen in Newcastle-under-Lyme and the largest increase in Tamworth. It is striking that there is a substantial increase in just this 20 year period expected in those over 85, the age group who are the greatest users of health and social care services. In addition, these figures indicate that there is also a marked increase in the newly retired population who will, in effect, become the next generation of FCH residents.

In addition to simple population growth, demand for services will also be influenced by changing standards of acceptable quality of life amongst older generations and changing service policies

Total population of Staffordshire 65 and over (by age-band)					
Age Bands	2010	2015	2020	2030	% change 2010-2030
65-74	85,800	101,200	103,300	111,100	29%
75-84	50,100	57,300	68,400	84,600	69%
85+	18,800	22,700	28,000	46,200	146%
<b>All 65+</b>	<b>154,700</b>	<b>181,200</b>	<b>199,700</b>	<b>241,900</b>	<b>56%</b>

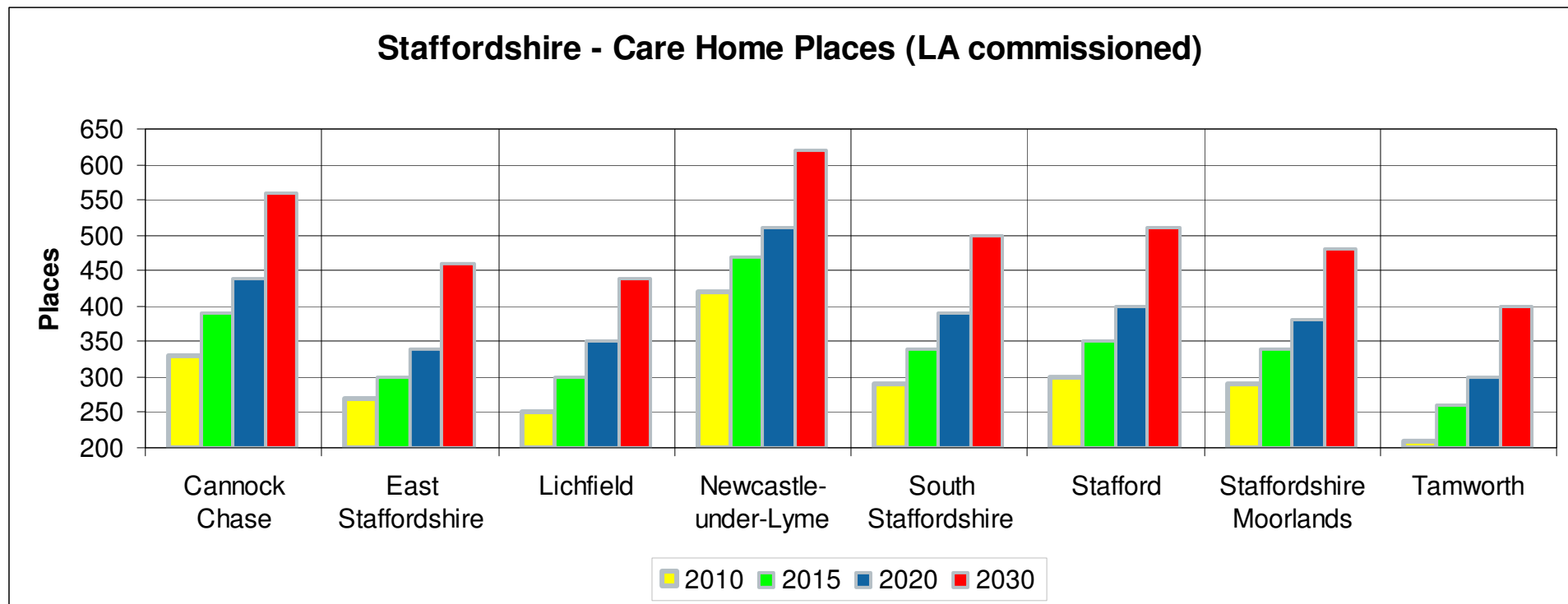
Total population of Staffordshire aged 65 and over (by District area)					
District	2010	2015	2020	2030	% change 2010-2030
Cannock Chase	15,200	17,600	19,400	23,700	56%
East Staffs	19,000	21,100	24,500	31,100	64%
Lichfield	19,700	23,700	26,300	31,600	60%
Newcastle	22,600	25,500	27,300	32,300	43%
South Staffs	22,300	26,000	28,700	34,500	55%
Stafford	24,800	29,000	32,200	39,000	57%
Staffs Moorlands	20,000	23,800	26,000	31,000	55%
Tamworth	11,000	13,400	15,500	18,900	72%

Source: Office for National Statistics (ONS)

Notes about this data: **Figures are taken from Office for National Statistics (ONS) sub-national population projections by sex and quinary age groups. The latest sub-national population projections available for England (and down to district council level) are based on the 2008 mid year population estimates. Long term population projections are an indication of the future trends in population by age and gender. The projections are derived from assumptions about births, deaths and migration based on trends over the last five years. The projections do not take into account future policy changes.**



The table below shows the projected increase in publicly funded care home places over the next 20 years. This would equate to a 68% increase in Local Authority commissioned care home places if the relative provision of residential and nursing care per population, demand and thresholds of eligibility remained the same.



Source: Planning4Care

**Notes about this data:** Residential care refers to people who receive care with housing in residential or nursing homes. Take-up rates for people currently receiving residential and nursing care are derived from local authority statistical returns. This is the latest available NASCIS data on the numbers of supported residents aged 65+ that are long stay in residential care and nursing care (return S2, Adult Social Care Combined Activity Returns data).

The projections are based on the PSSRU study of cognitive impairment in older people, which assumes 85% of people with severe cognitive impairment to be supported in residential and nursing home care; the proportion of those with primarily physical impairment supported in institutional care is then deduced from the national total and calculated as 45%; local calculations assume the same relative proportions (85%:45%).



<b>Tenure of population of Staffordshire aged 65 and over (by District area)</b>					
<b>District</b>	<b>All over 65</b>		<b>Over 75 with LLTI</b>		<b>Increase in rented for people with LLTI</b>
	<b>Owned</b>	<b>Rented</b>	<b>Owned</b>	<b>Rented</b>	
<b>Cannock Chase</b>	75%	25%	58%	42%	17%
<b>East Staffs</b>	80%	20%	68%	32%	12%
<b>Lichfield</b>	82%	18%	68%	32%	14%
<b>Newcastle</b>	77%	23%	62%	38%	15%
<b>South Staffs</b>	81%	19%	63%	37%	18%
<b>Stafford</b>	80%	20%	69%	31%	11%
<b>Staffs Moorlands</b>	87%	13%	77%	23%	10%
<b>Tamworth</b>	74%	26%	56%	44%	18%

Notes about this data: Figures are taken from Office for National Statistics (ONS) 2001 Census, Standard Tables, Table S017 Tenure and age by general health and limiting long-term illness. The most recent census information is for year 2001 (the next census will be conducted in 2011).

Whilst this is a good estimate for future demand of people in need of care it assumes current care methods will remain unchanged. However, more initiatives, such as the development of Flexicare Housing, to support older people at home could reduce the projected increase in care home demand. This will also apply to the choices made by those who currently fund their own places in care homes, without Local Authority financial support.

The picture of a high level of owner occupation applies to older people just as much as it does to the general population. In every local authority, between 75% and 87% of the retired population are now owner-occupiers. However, for people with a limiting long-term illness the proportion of people renting generally increases by 10 to 18%. This has implications for the type and location of the models of Flexicare Housing which will be appropriate to different parts of the County.

Household size and composition will also affect the need for housing. National projections by the Department of Communities and Local Government (CLG) suggest that 50% of older people live alone, with the remainder living with their spouse or partner.

A good indicator as to the need for FCH provision, both now and in the future, is the number of people with a 'long term limiting illness'. This indicates some level of enduring disability or sensory impairment. The importance of this group is that it represents a good proxy indicator of those vulnerable older people living in the community for whom FCH offers more appropriate housing with care to meet their increasing care and support needs. This Table shows that this affects around one in two of the 75+ population. The picture by District area of the number of older people aged over 75 years, who are living alone and who have self reported a long-term limiting illness is set out in the table for 2010 to 2030. FCH offers a proportion of this group a way of avoiding or deferring the need for more intensive care and support in future. These are people, who have probably not yet reached the point at which residential care or its alternatives are necessary, but nevertheless have an emerging or imminent need for support or care that can be organised and delivered more effectively in an FCH scheme.



## Demand for Flexicare Housing

While population data gives a good indication that there will be a growing need for FCH, further modelling is required to arrive at a figure for the number of units of accommodation required. The Institute of Public Care, Oxford Brookes University model bases demand on the following four factors:

- ◆ A high-level dependency needs stream based on diversion from residential and nursing home care
- ◆ Vulnerable older people living in the community;
- ◆ People choosing to move in later life seeking accommodation with care; and
- ◆ Allowing for a 5% void level in schemes.

### Total Projected Number of Flexicare Housing Units - 2010 to 2030

The target number of units to keep pace with population growth in Staffordshire by 2030 will be 9,541 based on a whole population projection model. The more detailed breakdown of how these figures were calculated is set out below.

Using the Oxford Brookes model the core projections for 2010-2030 are built up in the tables below as follows:

- A. The County Council demand for residential care home places or alternatives is projected to grow by 16% within five years, 32% percent within ten years and by 68% percent by 2030. The strategic assumption is that by 2030 60% of the older population that currently enters residential care will be diverted into FCH schemes.
- B. Staffordshire SCH believes that a proportion of the older people entering Nursing Home care could be diverted or delayed from admission if they were in FCH. The development of FCH, particularly with appropriate back up from tele-care and tele-health facilities, and with scope to develop innovative ways of providing nursing support to FCH, could divert or delay some 20% of

### Population of Staffordshire aged 75+ Living Alone with Limiting Long Term Illness (by District area) 20 year projections.

District	2010	2015	2020	2030	% change 2010-2030
<b>Cannock Chase</b>	3,200	3,954	4,581	6,061	61%
<b>East Staffs</b>	3,289	3,880	4,456	5,893	63%
<b>Lichfield</b>	3,009	3,760	4,430	5,652	54%
<b>Newcastle</b>	4,743	5,377	5,929	7,370	41%
<b>South Staffs</b>	3,421	4,161	4,875	6,223	52%
<b>Stafford</b>	3,881	4,649	5,405	6,996	53%
<b>Staffs Moorlands</b>	3,340	3,938	4,546	5,800	53%
<b>Tamworth</b>	2,030	2,572	3,096	4,127	75%

Notes about this data: Figures are taken from Office for National Statistics (ONS) 2001 Census, Standard Tables, Table S017 Tenure and age by general health and limiting long-term illness. The most recent census information is for year 2001 (the next census will be conducted in 2011). The latest sub-national population projections available for England (and down to district council level) are based on the 2008 mid year population estimates





nursing home admissions. To achieve this diversion rate will require predictive methods to identify those people who are likely to require nursing care, which could be delayed by living in FCH.

- C. Vulnerable older people – By 2030 across Staffordshire there will be some 63,075 over 75 living alone of whom just over 58% or 36,706 older people will report a limiting, long term illness. FCH will provide accommodation for 15% of these households (using the Oxford Brookes formula).
- D. Accommodation choice – according to a recent MORI survey of The Aspirations of Older People (MORI, 2004) 30% of the over 65 population choose to move to different accommodation of whom 12% seek accommodation with care (equivalent to 3.6% of the total population in the block). According to recent research (KnightFrank, 2010) the average age upon moving into housing with care is 75, so the calculation is based upon the population aged 75. In order to avoid the risk of double counting we have discounted those people entering residential care and nursing home care and those people over 75 living alone against this block of the model. The total is reduced by a third to allow for married and co-habiting couples.
- E. A 5% void level is applied to the net total.

The assumptions that these projections are based upon will need to be kept under review during the life of this strategy and beyond.

#### Staffordshire needs by 2020:

- ◆ 6,975 units of FCH, with an indicative need for 9,541 units by 2030.
- ◆ 2,396 units of FCH at social rents will account for between 23% to 44% of the above. The remainder would be leasehold – within which there can be a range of options for achieving.
- ◆ Roughly 435 units per annum from 2010 onwards.

#### District Tables: Whole Population Needs Model

The detailed breakdown of the pattern by each District Housing Authority area is shown in the tables below. If Staffordshire adopts a planning norm based on the Oxford Brookes model then it will need to commission some 3,282 units and encourage the development of over 6,259 new household units of Flexicare Housing by 2030. This will amount to some 14% of the new housing to be developed in the County, but of course has the major planning and housing gain of freeing up family housing as people move on.



CANNOCK CHASE	Diversion Rate	Net Population				FCH Places Needed			
		2010	2015	2020	2030	2010	2015	2020	2030
A. Residential Home Places	60%	198	234	264	336	119	140	158	202
B. Nursing Home Places	20%	132	156	176	225	26	31	35	45
C. People with LLTI, over 75, living alone	15%	1,809	2,029	2,470	3,532	271	304	371	530
D. Population over 75	2/3 of 3.6%	4,791	5,471	6,530	8,668	115	131	157	208
<i>Sub Total</i>						<i>531</i>	<i>606</i>	<i>721</i>	<i>985</i>
E. Voids	5%					27	30	36	49
<b>TOTAL</b>						<b>558</b>	<b>636</b>	<b>757</b>	<b>1,034</b>
<i>Owned</i>	<i>58%</i>					<i>324</i>	<i>369</i>	<i>439</i>	<i>600</i>
<i>Rented</i>	<i>42%</i>					<i>234</i>	<i>267</i>	<i>318</i>	<i>434</i>
<b>Number of units per 1,000 of the population aged 75 or over</b>						<b>85</b>	<b>85</b>	<b>84</b>	<b>94</b>

EAST STAFFS	Diversion Rate	Net Population				FCH Places Needed			
		2010	2015	2020	2030	2010	2015	2020	2030
A. Residential Home Places	60%	162	180	204	276	97	108	122	166
B. Nursing Home Places	20%	109	121	137	185	22	24	27	37
C. People with LLTI, over 75, living alone	15%	2,055	2,423	2,892	4,055	308	363	434	608
D. Population over 75	2/3 of 3.6%	6,745	7,777	9,108	12,245	162	187	219	294
<i>Sub Total</i>						<i>589</i>	<i>682</i>	<i>802</i>	<i>1,105</i>
E. Voids	5%					29	34	40	55
<b>TOTAL</b>						<b>618</b>	<b>716</b>	<b>842</b>	<b>1,160</b>
<i>Owned</i>	<i>68%</i>					<i>420</i>	<i>487</i>	<i>573</i>	<i>789</i>
<i>Rented</i>	<i>32%</i>					<i>198</i>	<i>229</i>	<i>269</i>	<i>371</i>
<b>Number of units per 1,000 of the population aged 75 or over</b>						<b>70</b>	<b>70</b>	<b>70</b>	<b>80</b>



LICHFIELD	Diversion Rate	Net Population				FCH Places Needed			
		2010	2015	2020	2030	2010	2015	2020	2030
A. Residential Home Places	60%	150	180	210	264	90	108	126	158
B. Nursing Home Places	20%	101	121	141	177	20	24	28	35
C. People with LLTI, over 75, living alone	15%	1,837	2,303	2,971	4,203	276	345	446	630
D. Population over 75	$\frac{2}{3}$ of 3.6%	6,363	7,897	10,029	13,297	153	190	241	319
<i>Sub Total</i>						539	667	841	1,142
E. Voids	5%					27	33	42	57
<b>TOTAL</b>						<b>566</b>	<b>700</b>	<b>883</b>	<b>1,199</b>
<i>Owned</i>	68%					385	476	600	815
<i>Rented</i>	32%					181	224	283	384
<b>Number of units per 1,000 of the population aged 75 or over</b>						<b>69</b>	<b>69</b>	<b>68</b>	<b>75</b>

NEWCASTLE	Diversion Rate	Net Population				FCH Places Needed			
		2010	2015	2020	2030	2010	2015	2020	2030
A. Residential Home Places	60%	252	282	306	372	151	169	184	223
B. Nursing Home Places	20%	168	189	205	249	34	38	41	50
C. People with LLTI, over 75, living alone	15%	2,876	3,124	3,529	4,828	431	469	529	724
D. Population over 75	$\frac{2}{3}$ of 3.6%	7,824	8,476	9,471	12,272	188	203	227	295
<i>Sub Total</i>						804	879	981	1,292
E. Voids	5%					40	44	49	65
<b>TOTAL</b>						<b>844</b>	<b>923</b>	<b>1,030</b>	<b>1,357</b>
<i>Owned</i>	62%					523	572	639	841
<i>Rented</i>	38%					321	351	391	516
<b>Number of units per 1,000 of the population aged 75 or over</b>						<b>79</b>	<b>80</b>	<b>79</b>	<b>87</b>



SOUTH STAFFS	Diversion Rate	Net Population				FCH Places Needed			
		2010	2015	2020	2030	2010	2015	2020	2030
A. Residential Home Places	60%	174	204	234	300	104	122	140	180
B. Nursing Home Places	20%	117	137	157	201	23	27	31	40
C. People with LLTI, over 75, living alone	15%	2,185	2,681	3,347	4,633	328	402	502	695
D. Population over 75	$\frac{2}{3}$ of 3.6%	7,515	9,119	11,153	14,467	180	219	268	347
<i>Sub Total</i>						635	770	941	1,262
E. Voids	5%					32	39	47	63
<b>TOTAL</b>						<b>667</b>	<b>809</b>	<b>988</b>	<b>1,325</b>
<i>Owned</i>	63%					420	510	622	835
<i>Rented</i>	37%					247	299	366	490
<b>Number of units per 1,000 of the population aged 75 or over</b>						<b>69</b>	<b>69</b>	<b>68</b>	<b>76</b>

STAFFORD	Diversion Rate	Net Population				FCH Places Needed			
		2010	2015	2020	2030	2010	2015	2020	2030
A. Residential Home Places	60%	180	210	240	306	108	126	144	184
B. Nursing Home Places	20%	120	140	160	204	24	28	32	41
C. People with LLTI, over 75, living alone	15%	2,504	2,893	3,570	5,149	376	434	536	772
D. Population over 75	$\frac{2}{3}$ of 3.6%	8,596	10,007	12,230	16,351	206	240	294	392
<i>Sub Total</i>						714	828	1,006	1,389
E. Voids	5%					36	41	50	69
<b>TOTAL</b>						<b>750</b>	<b>869</b>	<b>1,056</b>	<b>1,458</b>
<i>Owned</i>	69%					518	600	729	1,006
<i>Rented</i>	31%					233	269	327	452
<b>Number of units per 1,000 of the population aged 75 or over</b>						<b>68</b>	<b>67</b>	<b>67</b>	<b>75</b>



STAFFS MOORLANDS	Diversion Rate	Net Population				FCH Places Needed			
		2010	2015	2020	2030	2010	2015	2020	2030
A. Residential Home Places	60%	174	204	228	288	104	122	137	173
B. Nursing Home Places	20%	117	137	153	193	23	27	31	39
C. People with LLTI, over 75, living alone	15%	2,032	2,347	2,859	4,082	305	352	429	612
D. Population over 75	$\frac{2}{3}$ of 3.6%	6,868	7,953	9,541	12,718	165	191	229	305
<i>Sub Total</i>						597	692	826	1,129
E. Voids	5%					30	35	41	56
<b>TOTAL</b>						<b>627</b>	<b>727</b>	<b>867</b>	<b>1,185</b>
<i>Owned</i>	77%					483	560	668	912
<i>Rented</i>	23%					144	167	199	273
<b>Number of units per 1,000 of the population aged 75 or over</b>						<b>70</b>	<b>71</b>	<b>70</b>	<b>77</b>
TAMWORTH	Diversion Rate	Net Population				FCH Places Needed			
		2010	2015	2020	2030	2010	2015	2020	2030
A. Residential Home Places	60%	127	157	181	241	76	94	109	145
B. Nursing Home Places	20%	85	105	121	161	17	21	24	32
C. People with LLTI, over 75, living alone	15%	1,248	1,446	1,818	2,871	187	217	273	431
D. Population over 75	$\frac{2}{3}$ of 3.6%	3,452	4,054	4,982	7,329	83	97	120	176
<i>Sub Total</i>						363	429	526	784
E. Voids	5%					18	21	26	39
<b>TOTAL</b>						<b>381</b>	<b>450</b>	<b>552</b>	<b>823</b>
<i>Owned</i>	56%					213	252	309	461
<i>Rented</i>	44%					168	198	243	362
<b>Number of units per 1,000 of the population aged 75 or over</b>						<b>81</b>	<b>82</b>	<b>81</b>	<b>94</b>



## **Social rented units**

The Local Authorities will be directly concerned with planning for the socially rented accommodation as either part of a single or mixed tenure scheme. The projection of the need for socially rented FCH units has been estimated taking into account the relevant District level of owner occupation among people with a long-term life limiting illness and the demographic growth amongst the older population.

2,396 units are required across Staffordshire by 2020, at a gross average of 300 units per district.

The requirement for socially rented units will be subject to future trends in owner occupation and the projected estimates should be reviewed in the light of those trends. It can be seen that there is a significant shortfall to be made good and substantial and early investment is required to begin to provide sufficient units to meet the need for FCH before future population growth is taken into account. The tenure trends will not impact on the total requirement for FCH units but may in future reduce the number of socially rented units required.

## **Leasehold and shared ownership units**

Leasehold and Shared Ownership units may be provided either as part of a mixed tenure development, or as a private scheme where all residents own a stake in their home. We estimate that 4,579 units will be required across Staffordshire by 2020, at an average of 572 units per district. The potential benefit for the County Council is in owner occupiers releasing capital, which would allow them to self-fund their care. The table over shows the number of years that a new resident could self-fund their care for based upon their current property type and value and the stake that they purchase in the development. The full leasehold cost of a new Flexicare unit is assumed to be roughly equivalent to the price of an average semi-detached house in the area.

With tenures in FCH lasting around 7 years on average there is clear potential for residents to self-fund for the majority, if not all, of their stay. However, leasehold purchasers do not face the same issue of having to prove a local connection that can hinder those seeking to rent. This increases the risk of 'importing' people whose care needs would have to be met by the Council at some point in the future.

Providing options for residents to own a stake in their home, also offers a way of preserving equity and an inheritance for their children. As leaseholders can find it difficult to secure equity release at a later date, flexible shared ownership, where a resident can incrementally increase or decrease their share, is a worthwhile option. The complexity of these decisions makes it vital that appropriate independent financial advice is available to potential residents.

Leasehold and shared ownership can contribute towards the financial viability of developing a scheme, particularly where grant funding is restricted. Meeting the target will be reliant upon Local Authorities creating an environment that is attractive to developers, as discussed in the chapter on delivering FCH.



## Analysis by District of potential for existing home-owners to release equity by moving into FCH

District	Sell semi-detached house to purchase 50% stake in a Flexicare unit					Sell detached house to buy full leasehold in a Flexicare unit				
	Sale	Purchase	FC Limit	Balance	Years of Care	Sale	Purchase	FC Limit	Balance	Years of Care
<b>Cannock Chase</b>	£108,969	£54,485	£25,000	£29,485	<b>4.2</b>	£195,607	£108,969	£25,000	£61,638	<b>8.8</b>
<b>East Staffs</b>	£134,613	£67,307	£25,000	£42,307	<b>6.0</b>	£248,773	£134,613	£25,000	£89,160	<b>12.7</b>
<b>Lichfield</b>	£173,463	£86,732	£25,000	£61,732	<b>8.8</b>	£361,361	£173,463	£25,000	£162,898	<b>23.3</b>
<b>Newcastle</b>	£119,348	£59,674	£25,000	£34,674	<b>5.0</b>	£214,241	£119,348	£25,000	£69,893	<b>10.0</b>
<b>South Staffs</b>	£166,048	£83,416	£25,000	£57,632	<b>8.2</b>	£285,843	£166,832	£25,000	£94,011	<b>13.4</b>
<b>Stafford</b>	£166,832	£83,024	£25,000	£58,808	<b>8.4</b>	£255,980	£166,048	£25,000	£64,932	<b>9.3</b>
<b>Staffs Moorlands</b>	£122,148	£63,759	£25,000	£33,390	<b>4.8</b>	£201,636	£127,517	£25,000	£49,119	<b>7.0</b>
<b>Tamworth</b>	£127,517	£61,074	£25,000	£41,443	<b>5.9</b>	£198,569	£122,148	£25,000	£51,421	<b>7.3</b>

**Notes about this data:** Average house prices by Land Registry of England and Wales, Crown copyright. The information above is based on figures provided by the Land Registry of England and Wales. Figures are for the period January to March 2010. The capital limit for Fairer Charging is currently £25,000 and the assumed average annual cost for care is around £7,000 based on 10 hours per week.

### FCH and people with a disability

Sensitivity analysis suggests that the overall requirement for 9,541 units by 2030 is towards the higher end of the projected range. This allows for more flexibility in the allocation of units for other groups, for example people aged between 45 and 65 with a learning disability or physical disability, so no additional figure has been added for these groups. Again this needs to be kept under review to meet the needs within each district and locality.



## Ethnicity

The older population of Staffordshire are predominantly White British, accounting for 98.7% across the county. This compares to 94.6% of the population under 65. The highest proportion of BME elders currently live in East Staffordshire, and particularly around Burton upon Trent.

The data also shows that people from an ethnic background may be more likely to suffer from a limiting long term illness, and may therefore be more likely to benefit from FCH.

These figures are based on the 2001 census, but the Black and Minority Ethnic (BME) population is ageing and this will have implications for a range of different service providers. The importance of joining up services for older people at a local level will be critical and emphasis needs to be given to the needs and requirements of this population.

There are a number of issues we need to consider for the provision of FCH for BME elders, including consulting with diverse communities to establish their housing and care aspirations.

We also need to be aware that existing residents in schemes are not all open to an equalities and diversity agenda. Measures must therefore be put in place to ensure that proper support is given to BME elders living in Flexicare accommodation.

## Ethnicity of Staffordshire aged 65+ by District And proportion of each ethnic group with limiting long term illness

District	White	Mixed	Asian	Black	Chinese or Other
<b>Cannock Chase</b>	99.1%	0.1%	0.5%	0.2%	0.1%
<b>East Staffs</b>	97.6%	0.1%	1.4%	0.8%	0.1%
<b>Lichfield</b>	98.6%	0.1%	0.8%	0.4%	0.1%
<b>Newcastle</b>	99.1%	0.1%	0.4%	0.2%	0.2%
<b>South Staffs</b>	98.8%	0.1%	0.7%	0.4%	0.1%
<b>Stafford</b>	98.7%	0.2%	0.6%	0.5%	0.1%
<b>Staffs Moorlands</b>	99.4%	0.2%	0.3%	0.1%	0.0%
<b>Tamworth</b>	98.4%	0.2%	0.6%	0.6%	0.2%
<b>Staffordshire</b>	<b>98.7%</b>	<b>0.1%</b>	<b>0.6%</b>	<b>0.4%</b>	<b>0.1%</b>
<b>% with LLTI</b>	<b>57%</b>	<b>75%</b>	<b>40%</b>	<b>65%</b>	<b>0%</b>

Notes about this data: Figures are taken from Office for National Statistics (ONS) 2001 Census, Standard Tables, Table S107 Sex and age and general health and limiting long-term illness by ethnic group. The most recent census information is for year 2001 (the next census will be conducted in 2011).

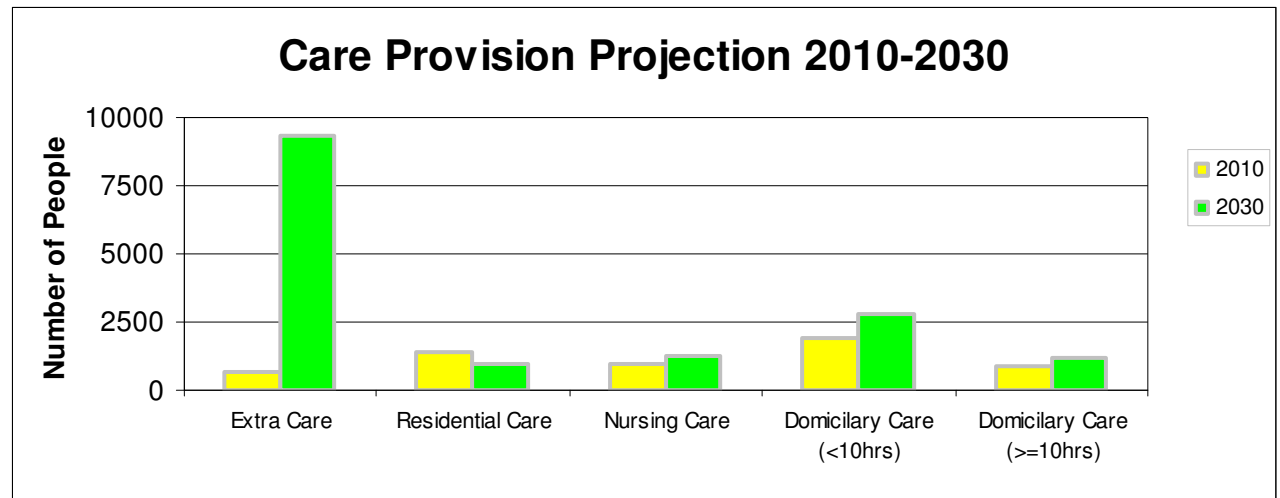




## Impact

The projected growth in the provision of Flexicare housing will have a major impact in the pattern of care provision by 2030.

The projected diversion from residential placements would reduce the number of residential care beds required by around 50% from 2010 levels and limit the potential growth in nursing beds to around 25%.



## How does existing and planned Flexicare Housing compare to what is needed?

The County Council's commitment to FCH has over recent years led to an extensive programme of development of new schemes with partner organisations. The table below shows the number of units in place as at June 2010.

The following charts bring together the number of units which are already in place or planned in each District, including any FCH schemes which have not involved the Council in development, set against the numbers indicated by the above needs assessment. The second and third tables break this information down in to social rented and leasehold information, where very different pictures of the gap between current planned reality and need appear.

The number of proposed units shown in each of the charts below is based on knowledge of schemes at some stage in the development process as of June 2010. While most are likely to proceed, some schemes are more speculative and may fall by the wayside.

It can be seen that there is a significant shortfall to be made good and substantial and early investment is required to begin to provide sufficient units to meet the need for FCH before future population growth is taken into account. Tenure trends will not impact on the total requirement for FCH units but may in future reduce the number of socially rented units required. The gap between the rented units already in place and proposed compared to what is needed makes East Staffordshire, Lichfield and Newcastle the priorities for the next stage of planning and development.

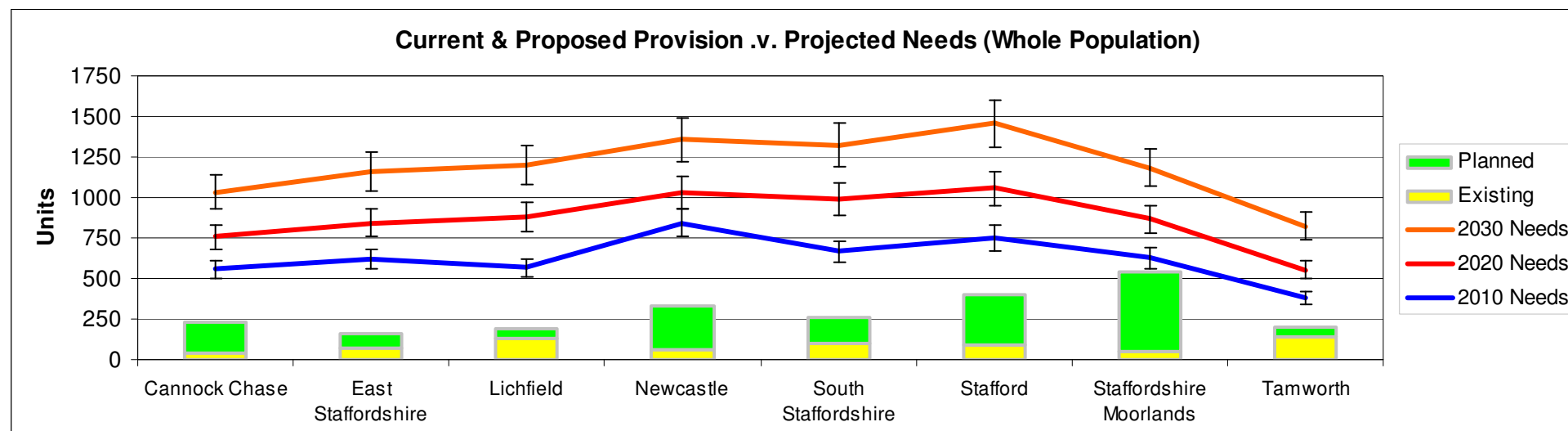


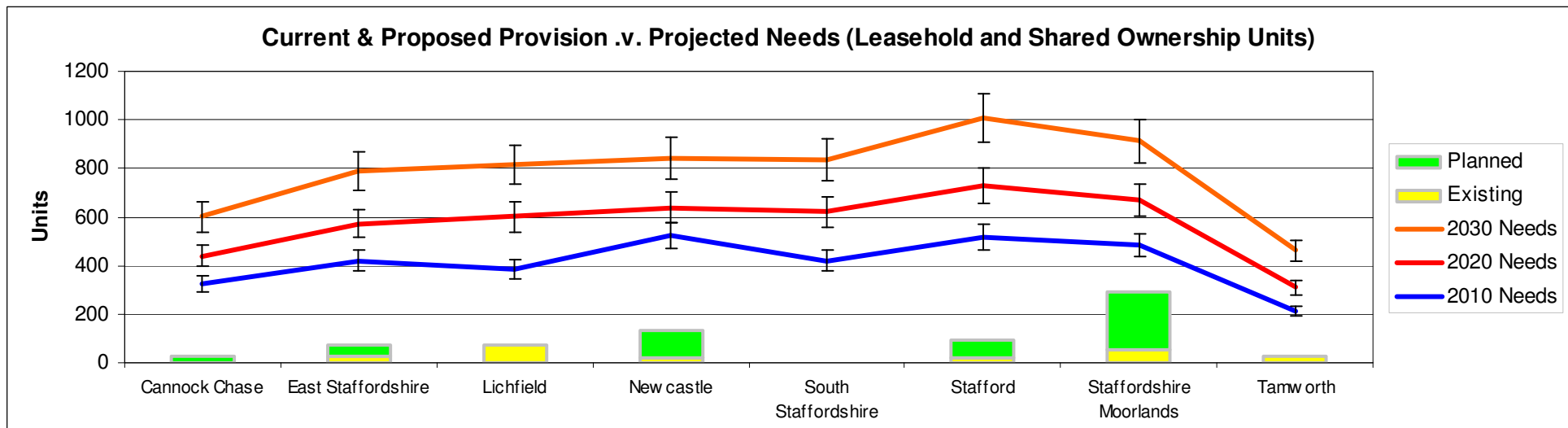
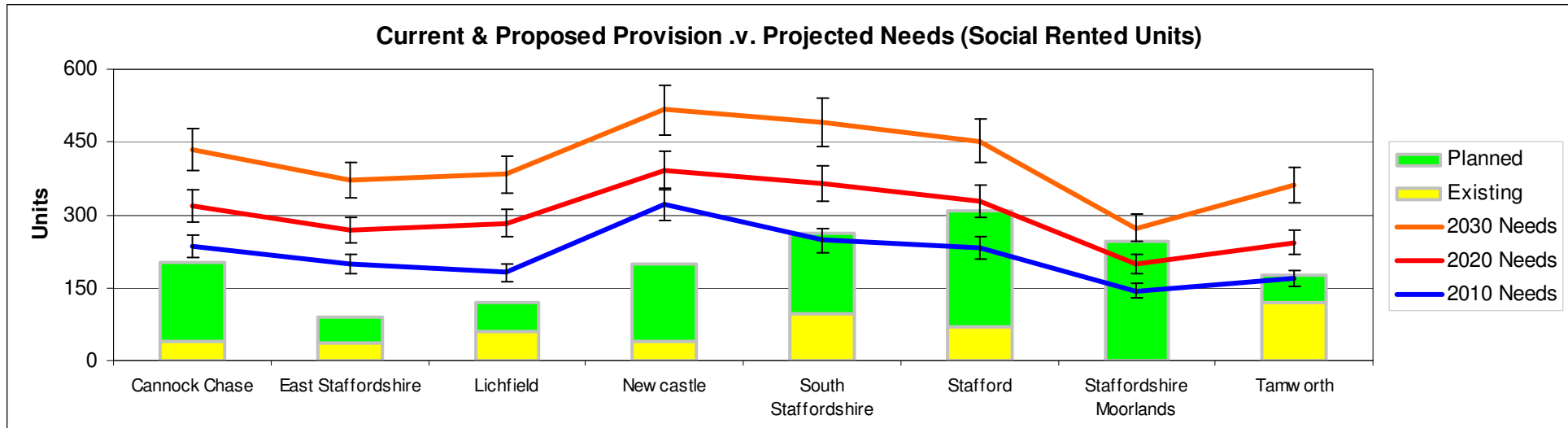
However, the rate of development in other districts, like Staffs Moorlands and South Staffs are already approaching the targets for rented units, and we need to be careful that we do not create a surplus of supply.

This will also allow the County Council to prioritise its future investment in areas of greatest need where the market is least likely to respond independently.

Net requirement for new FCH units by 2020

District	Existing Provision			Needs 2020			Net Needs 2020		
	Rent	Own	Total	Rent	Own	Total	Rent	Own	Total
<b>Cannock Chase</b>	41	0	41	335	463	798	294	463	757
<b>East Staffs</b>	38	29	67	257	547	805	219	518	737
<b>Lichfield</b>	65	50	115	273	581	854	208	531	739
<b>Newcastle</b>	40	20	60	394	643	1,038	354	623	977
<b>South Staffs</b>	97	0	97	355	605	960	258	605	863
<b>Stafford</b>	73	12	85	322	717	1,039	249	705	954
<b>Staffs Moorlands</b>	0	51	51	193	647	840	193	616	809
<b>Tamworth</b>	118	0	118	232	295	526	114	295	409





The gap between the owned units already in place and proposed compared to what is needed is huge in each District. South Staffordshire and Tamworth stand out as Districts with no such provision, followed by Newcastle and Stafford. The County Council will work with District Councils to establish how these targets may be achieved and what land may be available and suitable.

## What related services are in place?

Even if these target numbers are achieved, FCH will be part of a range of services and options for people in Staffordshire. In considering FCH needed, the core elements required can best be delivered in existing and new FCH schemes. But some may also be developed through some existing or adapted sheltered housing. It is recognised that much sheltered housing cannot be fit for purpose as it is relatively dated and small compared to the expectations and needs of many people entering FCH, and it is also predominantly rented property. Each District and the County Council will need to review the potential to assist in meeting the needs for FCH this way. For many people, one of the main attractions of FCH is reliable care and support outside ‘normal’ care hours. Assistive technology and a range of ‘on call’ services allow for a wider view to be taken of how needs can be met; FCH schemes will often have the potential to act as ‘hubs’ for innovative outreach schemes or part of the development of a blanket of integrated emergency and maintenance support services, which may be across social care and health. It is becoming increasingly practicable to offer on call support and close monitoring of people’s safety and welfare while they continue to live in their existing housing. There is much already to build on.

The following services are in place across the County, funded by Staffordshire Supporting People:

Sheltered Housing Services per District	Number of services	Number of units
Cannock Chase	10	296
East Staffordshire	12	357
Lichfield	8	270
Newcastle Under Lyme	23	751
South Staffordshire	16	643
Stafford	24	1,064
Staffordshire Moorlands	6	214
Tamworth	15	507
<b>Total</b>	<b>114</b>	<b>4,102</b>



Service type	Primary client group	Number of units
Sheltered housing	Older people with support needs	4,102
Community alarms	Older people with support needs	10,449
Floating support	Older people with support needs	784
Floating support	Older people with mental health problems	65
Home Improvement Agencies and Handyperson Services	Older people with support needs	6,094

More information is provided in Appendix 4, where there are maps for each Staffordshire District indicating the location of new and proposed FCH schemes. Maps also show the distribution across the County of people over 75 who live alone or have a limiting long term illness. Together these give the framework of key services in each District and linked needs for FCH.

Neighbouring authorities are also developing new FCH, and while allocations policies actively seek residents with a local connection there will inevitably be some movement across boundaries. Working with other authorities to set admissions criteria will become increasingly important.

## Development Options

The development of additional Flexicare Housing in Staffordshire can be taken forward in four different ways:

### Developing ‘core and cluster’ models of Flexicare service delivery in the vicinity of existing FCH

Flexicare offers an opportunity to develop ‘core and cluster’ service models into local communities. Intensive home care can be provided as part of a local system of enhanced support, both to people living within the Flexicare Housing scheme, and for people remaining at home in the local community.

This model not only enhances the delivery of care at home, but also opens up opportunities to link older people into other services provided in Flexicare schemes, such as meals provision and social activities. The ‘core and cluster’ model for Flexicare can be used as a vehicle for social engagement and community cohesion. This again will impact by reducing the numbers of people needing to move into residential care.

It is anticipated that this model will not only help maintain more people in their own homes, but will help minimise unit costs of services, therefore contributing to better affordability.



## **Identifying sheltered housing schemes that could be upgraded through capital investment to enhance the building to provide the necessary infrastructure to deliver Flexicare**

There are a number of schemes that fit into this category, but progress has been slow due to three fundamental reasons:

- ◆ The lack of capital funding opportunities to invest in upgrading.
- ◆ The pragmatic issues of disruption to residents during the upgrading works.
- ◆ Many schemes are not large enough to be viable as FCH

Significantly, the priority Districts for social rented FCH development identified above because of the gap between current and planned services and needs are also ones which have the higher levels of existing sheltered housing, perhaps linked to deprivation and the choices of previous District administrations. Particular attention should be given in these Districts to exploring and exhausting the potential for re-development or enhancement of sheltered housing to raise it to FCH levels.

## **Identifying suitable development sites for new build initiatives**

Work has been progressing to identify County Council land that would be suitable for development as FCH, as well as working with District Councils, through their strategic housing and forward planning functions, to identify possible suitable development sites. This can be a difficult process as many sites identified have been problematic, usually because of poor location. However, forward planners are now considering Flexicare Housing as a requirement in their local planning frameworks, and are taking a proactive role in identifying suitable sites.

## **Encouraging private development of Flexicare**

Private sector developers are also active in new build initiatives, and a number of possible developments are currently being discussed or have gained planning consent. They may already own parcels of land, or have the right contacts to identify suitable sites. This will become an increasingly important delivery method as we seek to meet the identified need for leaseholder accommodation.

Planning rules currently make it difficult for private developers to offer a mix of high, medium and low support needs in a single scheme. The County Council will work with each of the Districts to develop more local understanding of the needs for this type of accommodation.

Whichever development option is chosen, the location and design of the scheme will be of vital importance. In recognition of these factors, the County Council will produce a design guide to help deliver excellent developments that people will want to live in.



# What do we want from Flexicare Housing?

In preparing this strategy, we have taken account of national and local evidence of what FCH and its care and support are valued for and what people say they want. Using this, we have also worked on the aspirations, values and principles which we would expect to shape the development of FCH services. This has led us to define 'What Staffordshire Expects' for people who live in FCH. We have done this with a multi-agency group of colleagues and have refined this further with some local older people with wide experience and some members of the Council's Adult Care Panel.

'What Staffordshire Expects' will form the basis of a quality mark for FCH in Staffordshire.

## Flexicare Housing Schemes

### What Staffordshire expects for people who live in FCH (both leaseholders and tenants):

- ◆ People can usually expect a 'home for life' (recognising that in exceptional circumstances this will not be possible in FCH) and: -
- ◆ Security of tenure, for example - if one of a couple no longer lives in the scheme
- ◆ Clarity over what you are paying for as a resident – publication of transparent costs for every payment needed, clear definitions of what is housing management and what is housing related support
- ◆ A scheme which encourages mutual support and empowerment
- ◆ Good design, including communal space that can be used flexibly
- ◆ The scheme balances a safe environment including 'progressive privacy' with accessibility to the wider world and of the wider world to the scheme – it is not isolated, makes connections with facilities in the neighbourhood and provides new facilities for the local community.
- ◆ A scheme which aims to support people with progressive conditions such as dementia for as long as possible
- ◆ For smaller schemes, potential also to service a wider community of need in a limited radius ('Virtual Flexicare')



- ◆ Equipment in the accommodation which can be easily - and at minimal cost - adapted for wheelchair users
- ◆ Health professionals available and involved in shaping the service
- ◆ Restaurant or other food facility some of the time, with quality and nutritious food available
- ◆ Residents able to inform and affect how collective services are delivered and their money is used in the most effective and locally appropriate ways.
- ◆ New schemes which involve potential residents in the planning and detail of the scheme being developed
- ◆ Transparent allocations policies and processes which maintain an appropriate needs profile of residents.

FCH needs to provide for a wide range of people. One of the reasons that make it a chosen option is that it provides a valued living environment for people enjoying very good health, and also for the same or other people when they need more support and care. This balance can make it an attractive and supportive place to live but it may also bring some tensions which need consideration in the way the service is managed. Most FCH accommodation will be for [older people](#), with a minimum age of 55, and as explained in the needs analysis above, this should provide a mixture of tenures, across socially rented and leasehold options. We would want these options to be as financially attractive to as wide a range of individual circumstances as possible and will continue to explore and develop the offer of tenure options, including shared ownership and shared equity. For those units of accommodation which are rented, we will start from the norm of 1/3:1/3:1/3 high:medium:low care and support needs but this should be kept under local review by the allocation panel for each scheme. These will be reserved initially for residents of that District and failing that, other Staffordshire residents. However, as the tables previously indicate, the greatest need for the future is for leasehold services. These allow people with property to maintain their equity and sense of ownership, and give scope for more mixed communities. Local decisions will need to be made about how far to limit access to leasehold properties to people who have a clear local connection, recognising the need not to have properties lying empty.

FCH is also an attractive option for some people with particular needs. As indicated in the research quoted above, FCH can provide very effective care for [people with dementia](#). Dementia is rapidly increasing with our ageing population and increasing life expectancy, with one in twenty people over 60, rising to one in four people over 85, expected to develop the condition and currently no cure. Indeed, many existing residents may have dementia but no formal diagnosis. The condition can develop over five to fifteen years and in its later stages can be accompanied by serious risk through memory loss and confusion, and behaviour that can be dangerous and aggressive. But





living with dementia can be made much more tolerable and manageable through suitable environments and support. A third of people with dementia are now in care homes.

To enable the benefits of Flexicare living to continue to be available to people with more developed dementia, in each Social Care and Health District there will be a flexicare unit which will contain a part which will be commissioned to provide for people with more advanced dementia. This will meet specifications for design, assistive technology and staffing which can provide high quality care for people with dementia as a direct alternative to care homes.

For older [people with a learning disability](#), mainstream FCH is a good option for people with moderate support needs, although this may require specialist support and staff training. We will consider the level of provision on a scheme by scheme basis based on local needs. For those who need more intensive support, a small dedicated scheme (3-12 units) would be more appropriate.

FCH can also provide accommodation of choice for [younger adults with a disability](#). Where the environment suits younger adults with a physical disability or learning disability, they will be encouraged to consider the option. For adults with a learning disability, we will plan for inclusion within some schemes, building on the learning from developments already going forward within Staffordshire. This integration needs to be carefully managed and may be more suited to a 'core and cluster' model. We would see up to 10% of socially rented accommodation being available for younger adults with a disability. In developing these options, the implementation of this strategy will take place with the implementation of the parallel JCU led 'Prevention and Independence Strategy'.

## Services for residents of FCH:

### What Staffordshire expects for care and support services in FCH

- ◆ An integrated care and support service in each scheme, to be paid for by the residents through an individual budget or their own means. The Council will then work with residents to assess and arrange their additional personalised care and support through their individual budget and a menu of options.
- ◆ Help is available when you need it, with care services available on site 24/7 capable of meeting unplanned/reactive needs incorporating up to date use of assistive technology and access to community based health services.
- ◆ Services able to meet residents' reasonable aspirations, provide a good quality of life and promote a healthy lifestyle.
- ◆ Residents are treated with dignity and respect in the way help is delivered, and are kept safe from all forms of abuse.



- ◆ Staff and trained in end of life care and supporting people with dementia.
- ◆ Personalised services, within your own home – e.g. you don't have to leave your own flat if you need support during the day.
- ◆ Robust providers

Flexicare Housing offers a real alternative to residential care by providing individually tenanted/leased and self contained accommodation and services that are tailored to be flexible and responsive to changing need.

Whilst older people may not always have the same expectations and aspirations as younger disabled people in terms of choice and control they will require access to a flexible range of supports to enable them to continue living safely in the community. In addition experience has shown that that older people often do not feel by virtue of their age that they have any further aspirations or goals in life. It takes particular skills in drawing out what may be important and often life enhancing outcomes for them. The concept of choice and control is equally important to the support of older people as it is to younger disabled adults.

The Council recognises the unique nature of Flexicare Housing and the need to ensure that an integrated care & support service is available to all residents. The Council is also committed to enabling those living in Flexicare schemes to self-direct their support and provide opportunities for citizens to either:

- ◆ plan and arrange their own support;
- ◆ be supported to plan and arrange their own support; or
- ◆ be fully included in the planning and arranging of their own support.

A key principle is that citizens know what their individual allocation of resources (or 'individual budget') is before they begin planning their support. Once they know what their individual budget is, there are various pathways that a person can choose to plan their own support.

The integrated service must be built around an enabling and proactive ethos which is person centred and supports individual residents to access opportunities within the scheme and in the wider local community whether this is in relation to personal care, support, leisure activities, social networking or lifelong learning. We are looking for staff in FCH to work flexibly and go that extra mile for the residents.

Staff working in Flexicare schemes will be expected to be trained to understand the symptoms of dementia and how to assist people with mild or moderate symptoms of dementia. Some residents may receive Continuing Healthcare funding and staff will be expected to work alongside specialist domiciliary care providers with expertise in dementia. as the condition becomes more severe staff should assist people with dementia and any relevant family carers to consider longer term options including moving to a more specialist Flexicare unit.



In the South Staffordshire PCT area a dementia advice service is available to assist in these cases. Appendix 3 reports in more detail on research of relevance in developing services to include people with dementia.

As the government seeks to devolve more responsibility for healthcare to GP's, it will be important that each scheme has a strong link with its local practice. In future, this may involve the Flexicare scheme being seen as a hub for more community bases services or units utilised for intermediate care.

### **Partnership Working**

It is also expected that providers will work with third sector / voluntary organisations to offer residents, and the local community, other support opportunities. There may also be opportunities to develop a social enterprise or user-led organisation to provide services within a scheme, at a reasonable rate for the residents, for example: running a shop, window cleaning, or garden maintenance.



# Delivering Flexicare Housing

There are clear planning, development and operational phases which will require different skills and contributions but ‘What Staffordshire expects...’ will require effective partnership between Social Care, Health and the District Council in each area to ensure that there are maximum benefits from any scheme.

## Planning phase

In a large and diverse county like Staffordshire, ‘one size’ will not fit all. There will need to be local assessment of the current context in each District to determine development and implementation, taking account of:

- ◆ The needs analysis information and outcomes
- ◆ Needs information for specialist groups, particularly dementia, learning disability and physical disability
- ◆ Mapping of other local facilities and services – Existing Flexicare schemes and their nature, sheltered housing and its potential for development, amount and uptake of retirement housing, Supporting People funded services, care homes and their registration categories
- ◆ Need as experienced by local social care, health and housing commissioners/assessors and providers, including avoidable care home admissions
- ◆ Need as experienced by local people, identified through representative groups and wider engagement
- ◆ Available sites and whether these will be subsidised or open market: sites may come from a range of directions, including remodelling or replacing care homes, sheltered housing schemes or community hospitals; new build on a site with a now redundant building, or surplus land, or through planning gain for affordable housing development; or from private sector development on a private sector site.
- ◆ Planning issues for potential sites and the priorities for the local District Council (see information in Appendix 2)
- ◆ Suitability of available sites – size, accessibility, whether they would be seen as attractive to potential developers, purchasers and other residents, access to community facilities and likely community engagement, likelihood of staff being recruited
- ◆ The likely catchment area the potential sites would draw from and the needs, resulting scheme size and likely tenure options for those areas



- ◆ The value of developing different forms of accommodation on the site e.g. linked bungalows, specialist dementia or learning disability units
- ◆ The scope for developing an outreach approach to the local community areas, with the FCH scheme acting as a 'hub' to provide emergency or unplanned support and making best use of assistive technology for health and social care support
- ◆ Sources of funding that may be particularly available in that area or for the purposes planned
- ◆ The scope to develop these considerations from existing forms of provision.
- ◆ Appendix 3 Section 11 includes information about the range of different forms of FCH which are possible.

### Development Phase: Preferred Development Partner Framework Agreement - Flexicare Housing Providers

The Council undertook a competitive tendering process for FCH development partners, where the County Council is commissioning a scheme with land and/or capital funding. The following organisations were successful in becoming a preferred partner for developments in at least one District in the County.

- |                          |                               |                                     |
|--------------------------|-------------------------------|-------------------------------------|
| ◆ Aspire Housing         | ◆ Heantun Housing Association | ◆ Prime Life                        |
| ◆ Bromford Support North | ◆ HICA Group                  | ◆ Staffordshire Housing Association |
| ◆ Carr Gomm              | ◆ Housing 21                  | ◆ Trent and Dove                    |
| ◆ Housing Plus           | ◆ Midland Heart.              | ◆ Waterloo Housing Association      |
| ◆ Contour Homes          | ◆ Moorlands Housing Limited   |                                     |

Social Care and Health and the Joint Commissioning Unit are currently working on ways in which future developments will be taken forward with these partners. A Property Panel oversees all Flexicare housing arrangements that have an impact on the Directorate Capital Programme or property portfolio. The panel ensures that business cases are robust and that developments fit into an overall strategic framework and match our strategic needs assessment. The process provides a framework with check points to ensure due diligence of investment decisions. Each project has a business case, which includes the consideration of; capital investment, life cycle revenue consequences, value for money, risks, outcomes and benefits.

Decisions have been underpinned by District Strategic Property Reviews that have collected and aggregated Social Care and Health district aspirations for property development based on current and projected service needs. The reviews follow a standard format and



ensure a consistent approach to development planning. One of the most important elements of the review process was the locality Value Management Workshop stage, where existing and potential partners were invited to consider the draft report and identify collaborative, mutually beneficial development opportunities.

To ensure that other potential developers are aware of this strategy and the enthusiasm in Staffordshire for increasing Flexicare, the JCU will develop a marketing strategy to promote the attractions of Staffordshire as a development area. The JCU will also explore opportunities for multi-purpose developments and business models which will be attractive to potential developers/providers. These processes need to be promoted so that further progress can be made as quickly as possible.

Design of future schemes should involve local people and partners with an interest and make best use of current research.

## Implementation and Operational phase

‘What Staffordshire expects..’ makes clear how important the way any scheme runs will be. In giving ‘the best of both worlds’ people look for their independence and opportunities to live their life the way they want, but they also want the benefits of being part of a supportive community with flexible support and care available. FCH is individual and communal, independent and supportive. The balance is not always going to be easy.

The advent of Personalisation in social care (and to some extent health) has been significant for FCH. Previously, in Staffordshire and elsewhere, contracts for provision of support and care tended to be let on a ‘block’ basis so the whole service was delivered by one or two providers. This is counter to the spirit and opportunities which Direct Payments, Personal Budgets and ultimately Individual Budgets bring, in allowing people to purchase their care from whoever they wish. However, one of the main attractions in Flexicare is the reassurance that there will be care available if needed, 24/7. To ensure this service is part of any scheme, there has to be a framework for Assistive Technology structured in to the building to ensure that the benefits of Assistive Technology can be provided for each person according to their needs and that there is a way of summoning or alerting the need for help. Technology in this field improves continuously. There also has to be a funded care service from a specific care provider to achieve this.

These benefits and services will require financial contributions from residents of the scheme. The marrying of the benefits of FCH and personalisation is a live national discussion (see for example ‘Flexicare Housing and Personal Budgets’, Housing LIN workshop report 26.02.2010, and House of Commons CLG Select Committee Supporting People Report 2009 Recommendation 6: ‘Careful consideration must be given to how to balance personalisation with important commissioned services for people who need emergency support, or who are unable - or unwilling – to choose. Careful consideration is particularly needed of how personalisation will work in accommodation-based facilities’, which a Government working group has been considering). The intention in Staffordshire is that a ‘core care and support



service' should be tendered for. This would provide a service for unplanned needs during the day and night. Individual planned services required would be purchased separately using personal budgets and the core provider should be well placed to be the provider of choice.

Working relationships between the housing provider and the core care and support provider are very important in making any scheme run well. Staffordshire will set clear expectations and providers will be expected to maintain constructive working relationships with the quality of life of the people living in the scheme their prime consideration.

Cost transparency and affordability are part of 'What Staffordshire expects...: We expect any organisation providing services in FCH in Staffordshire to be clear and open about the costs any resident can expect to pay now and as their needs change.

Experience tells that any new scheme will need good promotion among potential residents and among staff in many agencies who can advise of the nature of the opportunity and may refer some people. This will need to start well before the scheme opens and may need reinforcement at times during the operation of the scheme. There will need to be a steering group which brings together key organisations to ensure effective planning and operation and works with local people and organisations. Where there are rental properties there will need to be a continuing allocations panel which ensures that a suitable balance of needs is maintained in the scheme.

FCH should stimulate and maintain independence and wellbeing and we would expect any organisation providing services in Staffordshire to work to promote this. Staff need to be managed and trained to achieve this way of operating. Residents will have between them many skills to help make the scheme work well and we would expect schemes to engage and involve users to the fullest extent possible.

For people living in FCH who need care services, we expect a flexible approach. As people enter FCH, or if there is a major change in their circumstances, where appropriate, Staffordshire enablement services will work with the resident to develop their potential for independent living as far as possible. Care services should be built round the reality that people's needs change – they may fluctuate from week to week, they may change steadily or dramatically over time. There may be a need for different services to be involved as needs change. Care should also be focussed on outcomes – providing those services which support people in achieving what they need and want. While recognising that care providers have to manage staff time effectively and efficiently, and that Personal Budgets may lead to a number of providers in a scheme, in FCH, we expect people who use care services to experience them as sensitive, supportive, flexible and purposeful. We also expect care management to happen as seamlessly as possible around the resident, with organisations working together to provide them with the help they need over time.

FCH can be a very satisfying place for staff to work, in assisting people to enjoy a very good quality of life and to help them through difficult times. The success of a scheme is likely to depend substantially on the quality of the staff who work there. Where the Council is commissioning services, we will expect high standards of staff training. We will also assist as far as possible by linking staff working in FCH with appropriate support from the Council and NHS to develop that training and their career pathways.



# Health and wellbeing – connecting with the NHS

FCH has many benefits for the health and wellbeing of people living there, including:

- ◆ A safe and supportive community
- ◆ Purpose designed communal and individual accommodation
- ◆ Easily adaptable accommodation
- ◆ Assistive technology
- ◆ Facilities which could include a restaurant, hobbies room, library or gym equipment
- ◆ Care and support available ‘round the clock’
- ◆ Opportunities for co-ordinated approaches to health improvement and provision of health services

FCH residents have the same entitlement to NHS services as anyone in their own home. Inevitably, given the age and conditions of some people living in any scheme, there may be quite heavy demands on NHS services. But the accommodation, facilities, staff and resident group do allow for very positive co-ordinated approaches to be taken to the health and wellbeing of people living there. This co-ordination and partnership should begin as early as possible in planning schemes. The following table shows the range of ways in which special relationships and involvement of healthcare services can be built in to FCH – there are examples of some of these approaches already in Staffordshire and others elsewhere in the country.

Type of involvement	Benefits	Costs – who pays?	Scope for development
Proximity of services – GP practice on same site	Good access to GPs, practice nurses, pharmacies; can be made to be proactive in health promotion and checks, risk monitoring and care planning	Each organisation, though can use LIFT, regeneration, Flexicare housing fund	Extensive in developing new schemes subject to need and funding;
NHS friendly premises - designing in treatment rooms	Encourages good involvement of District Nurses etc in care and treatment of residents. Attractive to potential residents	Charge to NHS for use or gratis	Extensive subject to costs





etc			
Planned partnership with existing NHS community services	Proactive approaches to health and wellbeing, close involvement of NHS staff	NHS pays for NHS involvement – need to evaluate cost savings	Approach accepted in principle by local NHS. Will need active implementation
‘Wellbeing nurse’ on site	Known and consistent person or people to provide the health benefits, guaranteed prioritising of these	Variable – could be NHS or built in to service costs	Critical mass required – a feature of ‘villages’
Intermediate care	Allows for assessment and recovery in a ‘home like’ setting, so reducing risk of institutionalisation in a care home. A half way house between intermediate care in a care home and at home	NHS has lead for intermediate care but usually joint funded. better value than a care home or community hospital, but capacity, voids, whether and when specialist staffing needed on site an issue	Business case needs further development
Dementia care	Growing numbers in need, preserving independence longer, very good for couples, potential alternative to care homes.	NHS support through community teams unless meeting nursing care criteria (see below)	Staff competence will need to increase and some specialist units will be required
Nursing care/continuing healthcare	Alternative to care homes for some people – either in providing continuity through deteriorating conditions or a specialist facility	Requires infrastructure to be in place in which nursing care can be part of the service – which would be NHS funded	Feasible only within a ‘village’ size scheme or specially designated unit
End of Life care	Sustaining people in their own home during terminal stages with the support of known staff and fellow residents. Additional care and support could be purchased for night times.	NHS funded once meeting palliative care eligibility	Staff awareness and confidence would need to be developed.

To facilitate positive partnerships in Staffordshire, the following framework for partnership involvement by the NHS is part of this strategy. It may develop further as integration between Social Care and Health and the local NHS increases.

In developing schemes, Staffordshire Social Care and Health and the local NHS will reach a formal agreement for each scheme identifying their roles, responsibilities and boundaries with the on site scheme services, considering the inclusion of the following:



- ◆ Planning of service developments – involvement of an NHS commissioner or provider manager in the planning group, with links to PBC/local GP practice/s. They will consider the range of potential health involvements in this scheme – co-location of services (e.g. GP practices, Health/integrated teams), specialist units e.g. dementia, intermediate care, respite/rehabilitation. Agreement on what ‘Flexicare’ involves for the particular unit, including how nursing care or support will be provided.
- ◆ NHS provider involvement in allocations policy and the panel for rental properties; balance of ‘levels’ of need, inclusion of health criteria in assessment documents and judgements, possible focus on particular conditions.
- ◆ Nominated NHS provider lead for connection with the core care and support provider and with the lead social care worker
- ◆ Health prevention input – individual and group health advice and checks, falls/exercise classes etc
- ◆ Room availability for clinical assessments and interventions. Co-ordinated District Nursing approach to care in the unit
- ◆ Support to ‘expert patient’ individuals and groups
- ◆ Co-ordination and oversight of care programmes e.g. at hospital discharge or to prevent hospital admissions and for people with long term conditions
- ◆ Traffic lighting people approaching end of life and EoL team co-ordination and oversight of care programmes
- ◆ Using telemedicine and tying in with other assistive technology
- ◆ Community Mental Health team support for people with dementia and other conditions and co-working with care and support staff
- ◆ Assisting in developing specs for requirements of staff working for the core care and support provider/s
- ◆ Training for care and support providers
- ◆ Potentially in larger schemes, where there is agreement that the schemes will provide for people assessed as eligible for nursing care funding, working with on site nursing staff on care programmes and out of hours emergency support
- ◆ Core care and support providers will be required to make use of locally agreed health and social care documents and systems such as personal care plans, care pathways, long term condition and end of life protocols and triggers.



# Funding Flexicare housing

The development of Flexicare in Staffordshire will be divided between capital and revenue costs. The main sources of expenditure that will need to be considered for a proposed scheme are given in the table opposite.

Set out below is some of the capital and revenue possibilities, which indicate where the resources may come from:

Capital Costs	Revenue Costs
Build or Purchase Costs	Care Costs
Land Costs	Housing Costs
Architects Fees	Support Costs

## Capital Resources

Experience to date suggests the following development costs associated with FCH:

- ◆ New build scheme (60 units) - £10m - £12m
- ◆ Refurbished sheltered housing scheme - £500k - £1.4m

There are four principle types of capital resources available to meet these costs:

### Land

For social housing schemes such as Flexicare developments it is usual for consideration to be given to land/buildings owned by the public sector to be provided at discounted value or transferred to a development partner where a business case can evidence that the scheme offers a strategic benefit to the County Council often in respect of nomination rights to the Flexicare units provided

### Core capital

This could be from public or private finance. The majority of Flexicare developments rely on varying mixes of:

- ◆ Homes & Communities Agency Grant – mostly available to Registered Social Landlords, but now possible for private developers as well. District Councils will play a key part in securing grant funding through local development plans and the ‘local investment plan’ process with the HCA.
- ◆ 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 Flexicare schemes



built in recent years have depended on combination of these three types of finance. It is possible to have all three sources funding in one scheme.

## Sales

Flexicare schemes built entirely for sale are by definition funded by the proceeds of sales. It is also increasingly seen as desirable to offer some Flexicare for sale in social housing:

- ◆ for demographic reasons;
- ◆ to create a balanced community;
- ◆ to meet demand.
- ◆ to meet the needs of asset rich, cash poor older owners;
- ◆ to offer a choice; and

It may also be necessary to sell a proportion of dwellings to achieve financial viability. The impact of selling some properties would be:

- ◆ the receipt from properties sold reduces the amount of borrowing required;
- ◆ the extent to which the market value of dwellings sold exceeds costs the 'profit' element can be used to subsidise the provision of dwellings for rent. Some social housing developers view this as a means of funding or part funding extensive communal facilities; and
- ◆ sales may be outright or on shared ownership terms - shared ownership allows sales to be tailored to the financial circumstances of individuals, for example, owner-occupiers moving from a poor condition property may choose this option over renting and the sale of their property is reinvested in the new property.

## Miscellaneous Capital

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 facilities or equipment.
- ◆ Developer's own resources.
- ◆ Section 106 agreements whereby private developers make available part of the site for social housing or contribute an equivalent resource.
- ◆ Business activity – in very large developments some services may produce a modest surplus.
- ◆ Primary Care Trusts – may fund health related facilities



## Development Options for Flexicare schemes

Future developments will involve a mix schemes commissioned directly by the County Council and partners, and others led by developers.

There are a number of ways of developing of Flexicare schemes open to Commissioners:

### **Partnership with Registered Social Landlords (RSL)**

An RSL is a housing association or a not for profit company registered by the Homes and Communities Agency to provide social housing. RSLs run as a business but do not trade for profit. To meet capital costs of a build they can raise private finance, access grants, or use receipts from sale of units. RSLs will also look to other methods of financing, including capital contributions from partners, i.e. the local authority and PCT. The most common contribution from local authorities is land at nil or discounted value.

### **Partnership with an RSL and the independent sector**

Partnerships between RSLs and the independent sector are becoming more common in mixed tenure Flexicare developments. It is possible that there may also be a growth in three way partnerships, particularly across capital and revenue costs. By working with a development company who is also a care provider, a long term contract could be established that provides an income stream for the developer which would enable them to contribute capital at the outset.

### **Capital programme funded through Private Finance Initiative (PFI)**

PFI would involve the Council entering into a long-term (25-30 years) service contract with an independent sector provider. The Council defines the standards of Flexicare and the outcomes it wishes to achieve. It may retain certain powers of control, e.g. retaining nomination rights over property to let or allocation and sale policies. To ensure value for money, potential developers compete for the build contract and raise the necessary funds. The Council pays for the service on an annual basis over the course of the contract. Tenants remain secure tenants with all their usual rights.

Evidence in Staffordshire suggests that as commissioners have developed interest in the market place that this may not be necessary as the market is now developing FCH models independently

### **Section 106**

Flexicare can be incorporated as part of Local Authorities Section 106 requirements from private developers of any large new housing development, if it recognised as strategic priority within the local district or borough.



These agreements require the developer to make available a proportion of a site or dwellings for affordable housing as a condition of planning. Agreements reached may either be in the form of a scheme built by the developer and then handed over to a provider to run, a handover of land at subsidised or nil cost to a specialist provider, the local authority to build a scheme, or a monetary contribution which can be put towards future developments.

## Revenue Funding

The key to ensuring the viability of a flexicare scheme is making sure there are identifiable revenue streams available to meet the costs of providing the housing related support (around £50k p.a.) and care services (around £300k p.a.). In general, ongoing revenue funding is required for:

### Care costs

In the social housing sector, it is usual for Adult Social Care to meet the costs of the provision of domiciliary care for service users who qualify for assistance through means testing. Self-funding (leasehold) tenants would be responsible for the costs of their care until their capital assets reached the level at which they would be eligible for financial assistance. Increasingly a number of authorities are requiring tenants residing within Flexicare schemes to use their attendance allowance as a contribution to their care costs.

### Housing Costs (including rent and service charges, meals and maintenance and repairs)

Housing Benefit will cover the rent for those who are eligible and some additional services. If not, residents themselves will be responsible for rent, accommodation service charges, and support charges. Supporting People may cover some of the housing support service costs, e.g. alarm service or scheme manager. Attendance allowance and disability premiums will also help cover the cost of domestic assistance for those eligible. The responsibility of maintaining the properties will usually fall to the landlord who will cover such costs, normally through the accommodation service charge.

Attendance Allowance a non-contributory, non-income related and non-taxable benefit for older people who are so severely disabled, physically or mentally, that they need someone with them to help with personal care. 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. It is expected that a significant proportion of residents in FCH are eligible for this allowance.



## The Cost Effectiveness of Flexicare

The cost effectiveness of Flexicare in relation to residential care is a complex calculation because of the implications of financial resources available to individuals, differences in calculating unit costs and the impact of whether carers would be able to continue to offer care.

Flexicare provides a service that fits between traditional care in the community and traditional residential care. Flexicare enables individuals to maintain a good quality of life in the community, rather than going into residential care. The care costs for traditional residential care are all paid for by the local authority, including non-care costs such as premises, provisions etc. Flexicare gives the opportunity to access other sources of funding, such as benefits and allowances to cover non-care costs. Maintaining customers in the community, rather than in residential care reduces the dependency and its associated cost. The table opposite illustrates other sources of funding:

Charges to customers (under Fairer Charging) are disproportionately less than charges for residential care (under Charging for Residential Accommodation Guide) because fairer charging is calculated on lower (i.e. subsidised) costs and lower assessed income levels due to disregarded income.

It is also evident that those older people living in Flexicare with a low income are left with more personal allowance after meeting housing and care costs. This is evidenced by a Joseph Rowntree study carried out in 2002, which compared the financial circumstances of people who were similar in terms of their care needs but some of whom lived in residential care and some in very sheltered housing (equivalent to FCH). It found that disposable income, (after accommodation, living, care and support costs had been paid for) was higher for the very sheltered housing tenants and that for social services it can be a very favourable cost option due to economies of scale and the role of housing benefit.

Cost effectiveness can be greatly improved by careful financial modelling at the onset of development, which can ensure that a scheme consists of the right number of units, mix of tenures, and facilities to make it economically viable.

Overall, the cost to the local authority of Flexicare is lower than the cost of residential care as funding can be found from other sources. A recent study within SC&H looking at the cost implications identified that for each placement in Flexicare (for an individual qualifying

Type of running cost	Potential source of funding
Accommodation (e.g. rent and housing management)	Housing Benefit Personal Income (pension, pension credits, savings, etc)
Housing support	Supporting People Personal Income
Personal expenses (e.g. utility bills)	Personal income Benefits and allowances
Personal care	Local authority funding/individual budgets and direct payments Client contributions Self funded care Attendance allowance



through Fair Access to Care criteria) there was a cost avoidance saving of £5,000 per year based on assessed need at the time of entry into the scheme.

National studies being undertaken by the DoH suggest significant savings for the NHS arising from reduced unplanned acute admissions and community health requirements, therefore the development of FCH will contribute to QIPP priorities. It is anticipated that further savings could be realised through the development of a re-ablement model of service delivery rather than that of domiciliary care.

It is recommended that further cost benefit analysis is undertaken exploring and evidencing the above.

### **Impact of the Recession on Flexicare**

It is possible that the new purchasing and rental arrangements occasioned by the recession and resulting from the inability of older people to sell their own homes will embed as permanent features of a new financial landscape within the FCH sector.

Provision for people on low incomes is almost exclusively delivered by the public and not for profit sectors and is targeted at people supported by benefits, who will take up social and affordable Flexicare Housing options. What is clear is that the needs of those who may have housing equity but who cannot realise it or whose assets are insufficient to buy in to private developments, will become more complex and more difficult to meet under existing arrangements and solutions will be needed to deal with this. Shared ownership will be one solution, but it is clear that good quality independent financial advice will become increasingly important for potential residents.

Those supported by benefits are also likely to be affected by potential changes to Housing Benefit, Attendance Allowance and the funding of personal care. Monitoring these changes and their impact will be key to the successful implementation of this strategy.

Savings in the public sector will inevitably affect the development of new FCH. Grant funding from the Homes and Communities Agency has already been cut, and will be more difficult to access in the future. This is likely to mean an increase in the proportion of leasehold accommodation developed at the expense of socially rented units. It also presents an opportunity to review the amount of costly communal space that is included within schemes. In future all facilities will need to be fully justified in terms of both build costs, and on going service charges.





# How are we going to get there?– the ‘logic chain’.

## Impact 2020 – outcomes - measures – actions - lead

The ‘logic chain’ below sets out a route map for implementing this strategy. On the right hand are the sets of ‘impacts’ that we aim to achieve by 2020, and then, reading the columns right to left, shows the outcomes to be worked towards to achieve that impact, the measures that will identify how we are doing in getting there and the actions that will need to be taken to get there.

A SMART implementation plan will be produced to accompany this strategy, including further detail on the actions listed below.

### Choice and Control

ACTIONS	MEASURES	OUTCOMES	IMPACT 2020
<p>Strategic leadership with Joint Commissioning Unit.</p> <p>Develop Flexicare development plan with partners.</p> <p>Marketing of Staffordshire with potential developers.</p> <p>Annual review of needs analysis against development plan</p>	<p>▶ Waiting lists for Flexicare housing schemes which are in place.</p> <p>Feedback from social care assessor and District strategic housing staff on unmet needs.</p>	<p>▶ Enough FCH in place to meet demand for purchase and rent.</p> <p>A range of tenure and funding options in place.</p>	<p>▶ FCH will be available for everyone who chooses it in Staffordshire.</p>



ACTIONS	MEASURES	OUTCOMES	IMPACT 2020
<p>Design to lifetime homes and sustainable homes standards. Specs requiring cost transparency.</p> <p>Review FCH charging strategy.</p> <p>Explore resident-led service commissioning and management.</p> <p>Develop Flexicare Quality Mark</p>	<p>▶ Scheme designs meeting national lifetime homes and sustainable homes standards. Transparent cost information available for each scheme.</p> <p>Feedback from schemes on number and duration of void lettings and unsold properties.</p> <p>Flexicare Quality Mark ratings</p>	<p>▶ Transparent cost structures for all elements of FCH.</p> <p>VFM approaches from people who live in Flexicare housing, providers and commissioners.</p> <p>No hard to let properties in FCH.</p> <p>Future proofing in design as far as possible.</p>	<p>▶ Flexicare housing will be seen as a positive, quality, affordable, value for money option.</p>
<p>Establish task group to consider how to achieve at a collective level and define requirements for contracts</p>	<p>▶ Number of residents with DPs/IBs</p> <p>Management arrangements that are influenced by people who live there</p>	<p>▶ Increased use of Direct Payments and Individual Budgets in FCH</p> <p>People in FCH will be empowered to shape and manage services in their schemes.</p>	<p>▶ People who live in FCH will have choice and control</p>



ACTIONS	MEASURES	OUTCOMES	IMPACT 2020
<p>Develop a format for a standard agreement between a flexicare scheme and local health and social care services.</p> <p>Adapt routine monitoring to include the information sought people leaving Flexicare.</p> <p>Report at least annually to the Housing and Care Partnership Board and the Joint Commissioning Executive (or their successor arrangements) on the effectiveness of Flexicare in usually providing a 'home for life'.</p> <p>Specs for care and support to include the expectation that staff should be able to provide for people with mild to moderate dementia</p>	<p>▶ Agreement in place with local community health and social care teams.</p> <p>Routine information on why people leave Flexicare, including, if possible, how long people live for who leave for hospital, hospice or a care home.</p> <p>Also information on the numbers and reasons for people who leave the scheme because their condition or behaviour is seen not to be manageable within the service.</p> <p>Numbers and reasons for home adaptations in Flexicare housing</p>	<p>▶ People in FCH do not move on to care homes</p> <p>People who live in FCH end their lives there</p> <p>People who develop dementia will be able to stay in FCH as long as possible</p> <p>Reduction in demand for home adaptations in FCH</p>	<p>▶ FCH will usually provide a home for life</p>



ACTIONS	MEASURES	OUTCOMES	IMPACT 2020
<p>Design a core contract arrangement to enable 24/7 unplanned care and support availability</p> <p>Design a contracting process which will enable people to access Direct Payments and Individual Budgets</p> <p>Develop a format for a standard agreement between a flexicare scheme and local health and social care services.</p>	<p>▶ Use and experience of 24/7 core contract</p> <p>Numbers and reasons for people leaving Flexicare.</p> <p>Hospital, hospice and care home admissions from FCH</p> <p>Feedback from people who live there</p> <p>Organisational feedback</p>	<p>▶ Care and support arrangements which 'flex' according to need.</p> <p>NHS services available according to need</p> <p>Increased use of Direct Payments and Individual Budgets in FCH</p>	<p>▶ Flexicare will provide care and support for people as their needs change</p>
<p>Review contract monitoring for FCH schemes</p>	<p>▶ Complaints concerning all involved agencies</p> <p>Safeguarding referrals and outcomes</p> <p>Satisfaction surveys of people who live there and informal carers</p> <p>Contract monitoring</p> <p>Levels of staff training</p>	<p>▶ Appropriate quality of life and high quality services</p>	<p>▶ People who live in FCH will feel safe and secure and treated with dignity and respect</p>



ACTIONS	MEASURES	OUTCOMES	IMPACT 2020
Ensure Staffordshire FCH programme manager is aware of tenure and funding initiatives and works with developers and providers to keep up to speed with the opportunities	<p>▶ Range of tenure options adopted.</p> <p>Publicity available with all schemes about tenure options</p> <p>Feedback from people who choose not to take up FCH</p>	<p>▶ A range of tenure options will be available for people in FCH.</p>	<p>▶ FCH will be financially accessible to people who could benefit from what it offers</p>

### Family and Carer Benefits

ACTIONS	MEASURES	OUTCOMES	IMPACT 2020
Encourage awareness and promotion of FCH by carers organisations	<p>▶ Customer survey</p> <p>Views of carer organisations</p>	<p>▶ Welcoming environments</p> <p>Inclusive care packages</p>	<p>▶ Family carers will feel valued and supported to continue their caring role with people they do not live with but who live in FCH</p>
Encourage awareness and promotion of FCH by carers organisations	<p>▶ Numbers of units with two occupants</p> <p>Numbers and reasons for ending of dual occupancy</p> <p>Number of respite breaks outside the scheme</p> <p>Customer survey</p>	<p>▶ FCH available for family units at risk of separation</p> <p>Reduced carer separations/ breakdowns</p> <p>Reduced use of out of home respite</p>	<p>▶ People will stay together as a family unit who might otherwise not be able to</p>



## Health and Wellbeing Benefits

ACTIONS	MEASURES	OUTCOMES	IMPACT 2020
<p>Ensure SC&amp;H is routinely contacted as a key consultee in all planning applications.</p> <p>Target and review an agreed proportion of all new developments for people with a disability.</p> <p>Consider planning requirements and implications to enable under 55s to access.</p> <p>Design of FCH to include Assistive Technology, progressive privacy, hub and spoke where appropriate.</p> <p>Build in NHS involvement for planning and development, referrals, allocations and working with the schemes.</p> <p>Review business case format to include NHS outcomes and benefits as well.</p> <p>Service spec for flexicare to include re enablement and access to nursing care.</p>	<p>▶ Health prevention advice and support in place</p> <p>Agreement in place with local community health and social care teams</p> <p>Customer surveys</p> <p>For people where there has been continuity – GP and District Nursing feedback</p> <p>GP call outs</p> <p>Falls requiring a response</p> <p>Hospital admissions</p> <p>Hospital length of stay</p> <p>Referrals, applications and allocations/purchases which include customers under 55 years.</p>	<p>▶ Fewer health crises.</p> <p>Reduced hospital admissions</p> <p>Reduced hospital length of stay</p> <p>Reduced depression</p> <p>Increased statements of happiness</p> <p>Suitable provision for older people and for younger adults with a disability</p>	<p>▶ FCH will improve the health and wellbeing of older people and of younger adults who choose to live there</p>



## Organisational Benefits

ACTIONS	MEASURES	OUTCOMES	IMPACT 2020
<p>Clear policy for admissions and 'banding' balance for each unit</p> <p>Multi-agency allocations panel for each FCH unit or District.</p>	<p>▶ Achievement of 'banding' for admissions.</p> <p>Numbers of people admitted whose needs were seen as equivalent to residential or nursing care</p> <p>Numbers of people resident assessed whose needs are seen as equivalent to residential or nursing care</p> <p>Hours of domiciliary care received</p>	<p>▶ Reduced call on health and social care services.</p> <p>Reduced demand for social care funding.</p> <p>Increased use of FCH for people who would otherwise need residential care.</p> <p>Increased use of FCH for people who would otherwise need nursing care.</p> <p>Increased use of FCH for younger adults with a disability.</p>	<p>▶ FCH will lead to reduced need for health and social care services</p>



## Community Benefits

ACTIONS	MEASURES	OUTCOMES	IMPACT 2020
<p>Produce a marketing strategy and tools for informing the public and professionals.</p> <p>Highlight the impacts and benefits of Flexicare and review services that are in place.</p>	<p>▶ Referral levels.</p> <p>Purchase and application levels.</p> <p>Ethnic origin of residents</p> <p>Void/unsold levels</p> <p>Use of services by non resident population.</p> <p>Customer feedback</p>	<p>▶ Public and professional awareness and positive view of the Flexicare concept.</p> <p>Community use of FCH facilities.</p> <p>Seen as accessible by all sections of the community</p>	<p>▶ Flexicare schemes will be well known and seen as a positive part of their local communities.</p>
<p>Ensure positive engagement of local community organisations and residents in planning and developing FCH</p>	<p>▶ Non-resident use of the FCH facilities.</p> <p>People from FCH using local facilities</p> <p>Feedback from people who live in FCH</p> <p>Feedback from local community organisations</p>	<p>▶ FCH will be an integrated part of its local communities, providing opportunities and benefits for people living there, staff and other people living locally</p>	<p>▶ FCH will assist community regeneration and development</p>
<p>Promotion of opportunities and benefits of working in Flexicare settings</p>	<p>▶ FTE posts employed in providing services to FCH developments</p>	<p>▶ Posts working in FCH settings, either directly employed or through contracts, Individual Budgets etc</p>	<p>▶ FCH will provide local employment opportunities</p>





## Staffing Benefits

ACTIONS	MEASURES	OUTCOMES	IMPACT 2020
<p>Define competency expectations for staff working in Flexicare</p> <p>Tie in with competency frameworks in health and in social care, particularly the developing Integrated Support Workers</p>	<p>▶ Numbers of staff achieving levels of qualification</p> <p>Staff surveys and exit interviews</p>	<p>▶ Staff working in Flexicare will be trained to do the job well</p> <p>Staff working in Flexicare will achieve job satisfaction</p> <p>Staff working in Flexicare will bring experience from similar roles</p> <p>Staff working in Flexicare will see opportunities for career development by working there</p>	<p>▶ FCH will be part of a career pathway for health and social care staff</p>

## Implementation, monitoring and review

The leadership for implementing this strategy rests with the Joint Commissioning Unit, responsible to the Joint Commissioning Executive and the partner organisations. Day to day implementation will be overseen by a delivery management board, chaired by the County Commissioner, Prevention and Independence. The membership of this will need to be kept under review to ensure that there is appropriate membership from partners and that it continues to be informed by user experience and the local and national knowledge base. The JCU will report annually to the Joint Commissioning Executive (or any successor body) on the progress there has been in implementing the Strategy, any revisions to the Strategy and the aims for the year ahead.



# Conclusion and Recommendations

This strategy aims to provide the direction and information to help transform the opportunities for housing and care in Staffordshire. The development of high quality, effective FCH on such a large scale will require good and purposeful working relationships between many organisations in Staffordshire. The financial environment now makes the challenge even more pressing. Development opportunities and funding streams will need to be used to the full, but with careful scrutiny of cost implications for residents and organisations. Performing well, FCH will act as a preventive service which will both prolong independent living and reduce the need for more expensive forms of health and social care. The best of both worlds should remain the target.

Most of the recommendations and actions to implement this strategy are built in to the 'logic chain' above. Some other sections of the text make clear the intentions of this strategy - particularly the statements of 'What Staffordshire expects...' and the section on delivering FCH and Flexicare. The following need to be read alongside these.

1. The JCU Flexicare Programme Manager should continue to map information about existing services, needs and opportunities at local levels, District by District, to assist in the development of FCH.
2. The JCU Flexicare Programme Manager should develop a quality mark for FCH schemes, building on 'What Staffordshire Expects' and making use of existing Supporting People, Social Care and Health, and NHS monitoring systems, and more specific, focussed evaluations where these will assist future development.
3. Care and Support services should be tendered for together to avoid the tensions that have arisen in the past between different and formally unconnected providers.
4. The Director of the JCU and the County Commissioner, Prevention and Independence, should ensure that the potential benefits of Staffordshire's moves to more integrated services and a more integrated workforce are realised in FCH, through effective service relationships and staff competency development.
5. This strategy should be implemented in tandem with the 'Prevention and Independence Strategy', once that is completed.
6. Progress against this strategy should be reviewed annually through a report to the Joint Commissioning Executive or any successor body, with clear aims and targets for the year ahead.
7. The strategy should be posted on the Staffordshire website, with other FCH material of public interest.



# Appendix 1 – Delivering priorities and meeting current Performance Indicators

The following are drawn from **Housing, Health and Care, Davis, Porteus and Skidmore, Chartered Institute of Housing / Department of Health Housing LIN, 2009**, endorsed by the Association of Directors of Adult Social Services and the NHS Alliance. The document provides more detail on ways FCH and other housing based solutions assist in meeting these and evidence sources for effectiveness.

National Indicator 119 – self reported measure of people’s health and wellbeing. NHS Vital Sign – self reported measure of people’s overall health

National Indicator 120 and NHS Vital Sign – all age all cause mortality rate

National Indicator 124 and NHS Vital Sign – people with a long term condition supported to be independent and in control of their condition

National Indicator 125 and NHS Vital Sign – achieving independence for older people through rehabilitation /intermediate care

National Indicator 129 and NHS Vital Sign – access to appropriate care enabling people to choose to die at home

National Indicator 136 and NHS Vital Sign – people supported to live independently through social care services

National Indicator 137 and NHS Vital Sign – healthy life expectancy at age 65

National Indicator 139 – the extent to which older people receive the support they need to live independently at home

National Indicator 141 – percentage of vulnerable people achieving independent living

National Indicator 142 – percentage of vulnerable people who are supported to maintain independent living

National Indicator 145 and NHS Vital Sign – adults with learning disabilities in settled accommodation

National Indicator 149 and NHS Vital Sign – adults in contact with secondary mental health services in settled accommodation

Also a planned PI for 2011 for ‘Emergency bed days for multiple acute admissions’.



# Appendix 2: Some key strategic documents

## National Strategies

### **Lifetime Homes, Lifetime Neighbourhoods – a national strategy for an ageing population (2008)**

This strategy aims to increase the housing options available to older people. It recognises that most housing and communities are not designed to meet people's changing needs as they grow older and that older people's housing options are often too limited to care homes or sheltered housing. One challenge the strategy identifies is getting the right range of good quality specialist housing (in particular Flexicare housing) to expand choice and meet projected future demand. Another is ensuring that there are improvements to the quality of all forms of specialised housing. The strategy outlines a new positive vision for specialised housing as somewhere that older people want to live in later life.

It said: "Extra Care Housing describes a type of specialised housing that provides independence and choice to adults with varying care needs and enables them to remain in their own home. Extra Care Housing should be able to provide most residents, if they so desire, with a home for the remainder of their life, regardless of changes in their care needs."

### **Our Health, Our Care, Our Say (Department of Health 2006)**

In this seminal document the goals for Health and Social Care are:

- ◆ Better preventative services with earlier intervention to minimise crisis.
- ◆ More choice and influence for individuals in their own care.
- ◆ More progress is needed on tackling inequalities and improving access to community services.
- ◆ More support for people with long term, complex needs to enable them to manage their conditions themselves within their local community, with the right help from health and social care.



## **Putting People First – a shared vision and commitment to the transformation of Adult Social Care (Department of Health 2007) and Transforming Adult Social Care (Department of Health 2008)**

The Concordat commits particularly to prevention; early intervention and re-enablement; personalisation; information, advice and advocacy, with the timetabled introduction of personal budgets for all publicly funded social care support. TASC lays out the programme for implementing these aims and expectations on Local Authorities.

## **Living Well With Dementia – A National Dementia Strategy (Department of Health 2009)**

This strategy has three key steps to improve the quality of life for people with dementia and their carers. These are:

- ◆ To ensure better knowledge of dementia and reduce the stigma.
- ◆ To ensure early diagnosis, support and treatment for people with dementia and their family/carers.
- ◆ To develop services to meet changing needs better.

Objective 10 in the Strategy states that:

‘Considering the potential for housing support, housing-related services and telecare to support people with dementia and their carers. The needs of people with dementia and their carers should be included in the development of housing options, assistive technology and telecare. As evidence emerges, commissioners should consider the provision of options to prolong independent living and delay reliance on more intensive services’.

The Strategy also states that ‘Staff working within housing and housing–related services (have) to develop skills needed to provide best quality care and support for people with dementia in the roles and settings where they work.’

## **Under Pressure – Tackling the financial challenge for councils of an ageing population (Audit Commission 2010)**

Reinforces the impact which the demographic shifts are having on services and showcases the evidence for planned and preventive approaches. It states that improved health and wellbeing reduces demand for services, with:

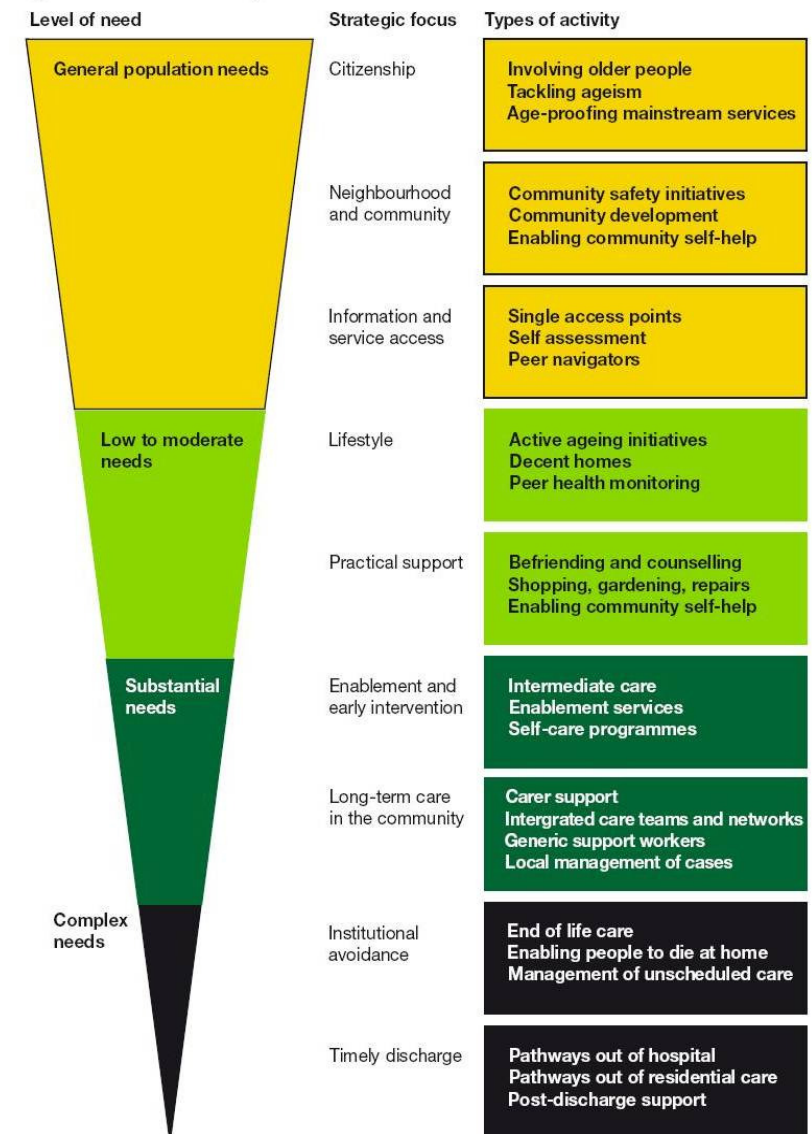
- ◆ Councils and partners should co-operate to tackle the main causes of social care need:
  - ◆ Poor housing and environment
  - ◆ Health and mobility problems
  - ◆ Breakdown of informal support and
  - ◆ Social isolation



- ◆ Most medium term financial planning fails to use demographics, information about the impact of preventive work, or data about older people's preferences
- ◆ Older people are an untapped source of information about what works and the value of support to independent living
- ◆ Early intervention can improve wellbeing and save money. One county saves £1 million a year on residential care costs by providing telecare services
- ◆ Cheaper alternatives are often the service most valued by older people, their families and communities
- ◆ Small investments in services such as housing and leisure can reduce or delay care costs and improve wellbeing
- ◆ Older people are more likely to volunteer to support local communities. Carers over 60 provide care worth twice public spending on care services for older people.

It also says: 'Research from the UK and other countries highlights the common features that can deliver more for less by focusing on prevention, early intervention and minimum use of institutional solutions' demonstrated in the 'inverted triangle of action', (see below):

Figure 5: The 'inverted triangle' of action



Source: Audit Commission 2009, Association of Directors of Adult Social Services/Local Government Association 2003



## Regional strategies

**The West Midlands Regional Housing Strategy: Delivering a Housing Vision for the West Midlands in the 21<sup>st</sup> century: Pathways of Choice** (West Midlands Regional Assembly 2005) raises some broad issues relating to older people and housing need. Specific references highlight the need to:

- ◆ Ensure the way older people live is the result of choice rather than lack of choice. This requires increased provision of good quality accommodation for sale and rent that meets the needs of older people.
- ◆ Provide housing solutions which are intimately linked to access to care and support at home.
- ◆ Encourage public, Registered Social Landlord's and private providers (including private house builders) to provide sheltered and Extra Care accommodation and other types of housing suitable for older people. To make such schemes financially viable, LHA's will need to identify suitable sites within their Local Development Frameworks

**The West Midlands Supporting People Strategy** (West Midlands Regional Housing Board 2005) feeds directly into the Regional Housing Strategy and aims to tackle the issues that undermine the life opportunities of individuals and communities. Some of the key strategic priorities for Staffordshire identified in this document included the need for more floating support, the provision of Extra Care accommodation, the installation of telecare (to include community alarm services) and upgrading existing accommodation. The strategy clearly identifies a trend towards new models of provision using floating support, Extra Care and more independent forms of accommodation.

Some of the key points outlined in **The West Midlands Health and Well Being Strategy** (West Midlands Regional Assembly 2008) when referring to housing, care, support and independence include:

- ◆ The proportion of older people in the West Midlands has steadily increased and is projected to continue to increase. The implications of this are the need for more supported housing, homes suitable for an ageing population, homes suitable for independent living, as well as the development of adaptable housing and homes that are suitable for people throughout their life.
- ◆ Bringing together health and social service providers with housing providers to develop patterns of service delivery which support older people is essential, given the expected increase in the elderly population in the West Midlands. There should be strategically planned and commissioned services intended to enable the maximum degree of independence, choice and self care for older people.



Access to all areas of the home and facilities is a basic requirement for independent living. An adequate supply of appropriate housing in suitable, safe, well-designed locations is needed along with schemes to assist older people to move to more suitable housing.

## County wide strategic priorities

**The Staffordshire Sustainable Community Strategy 2008 - 2023** states:

‘All Staffordshire’s people will benefit from equality of opportunity and access to the resources they need to improve their health, well being and quality of life. Our citizens will be encouraged to lead healthier, more active lives and make healthier choices...our County’s older people will be empowered to live independently and have greater choice of and access to the services they need and want...’

**Staffordshire County Council’s Social Care and Health’s Directorate Improvement Plan 2010/11 – 2014/15** aims for the following outcomes:

Improving health and emotional well-being – ‘People are able to lead as healthy and active lives as possible’

Improved quality of life – ‘People enjoy the best possible quality of life’

Making a positive contribution – ‘People are able to take part in community life’

Increased choice and control – ‘People are able to make decisions about their own care and are given choice’

Freedom from discrimination or harassment – ‘People in Staffordshire have fair access to services and are treated equally’

Economic well-being – ‘People have enough money to meet their living and support needs’

Maintaining personal dignity and respect – ‘People are treated as individuals and are kept safe from all forms of abuse’

And among its priorities is ‘Modernised Services – the transformation from traditional in-house building-based services to the development of a broad range of opportunities for people to access without needing direct recourse to the Health and Social Care system. This will include a range of local activities and services in their local community which will help to sustain local facilities for everyone, and support the prevention agenda by working to reduce health inequalities and promote healthier lifestyles.’





**The Staffordshire Joint Commissioning Strategy for Older People 2008 - 2012** details the priorities for older people as:

- ◆ Ensuring older people have access to a range of flexible and re-enabling packages of support to prevent inappropriate admission to hospital.
- ◆ Enhancing provision of Supporting People “floating support” and the range of housing tenure options for older people, including increased Flexicare housing.
- ◆ Continuing the strategic reduction of care homes provided by the County Council.
- ◆ Continuing the work in progress to develop Flexicare services in each district.

**The Staffordshire Joint Commissioning Strategy for Services for People with a Learning Disability 2008 - 2012** identifies the need for major programmes of development of supported housing and states:

‘Staffordshire sees choice of housing tenure as well as of support arrangements as a key plank of its strategy for housing with support and is keen to encourage a wide spectrum of housing opportunities for people with learning disabilities, including home ownership.’

**The Staffordshire Joint Commissioning Strategy for Services for People with Physical and Sensory Disabilities 2008 – 2012** includes the following Commissioning Intentions among its Strategic Objectives:

- 1b Develop supported living opportunities for people with a physical and sensory disability across Staffordshire in line with the Supporting People 5 Year Strategic Plan, working with statutory, voluntary, independent sector providers, District and Borough Councils and housing providers
- 1c Increase the number of people with physical and sensory disabilities accessing direct payments and personal budgets across the County
- 1d Develop a housing brokerage scheme for people with physical and sensory disabilities to help them to assess their needs and access appropriate housing in a variety of tenures



**Staffordshire's 5 year Supporting People Strategy (2005-2010)** set the strategic direction for commissioning activities which will contribute to enabling:

- ◆ **Independent living** – accommodation and support is available to enable choice and independence to meet the changing needs of individuals. To reduce dependency on services and enable people to develop skills to live independently.
- ◆ **Social inclusion** – encourage people to access employment, training and education to facilitate social inclusion. To work with traditionally excluded groups to facilitate inclusion into the community.
- ◆ **Community safety** – improve the safety and stability of the local area by supporting services that reduce the negative effect on communities of criminal and anti-social behaviour.
- ◆ **Sustainability** – appropriate assessment when entering services to ensure needs of service users are properly met. Ensure a co-ordinated approach to support planning in all services to ensure independent living is sustainable in the future.
- ◆ **Reduced health inequalities** – increasing life chances through quality services that meet need.

### **Strategic Review of Sheltered Housing to Older People with Support Needs (SCC Supporting People Team) 2006**

This review set new priorities for these schemes as part of the wider range of services, including:

- ◆ To recognise that sheltered housing can be effective at:
  - ◆ delivering low intensity housing related support
  - ◆ preventing problems for independent living
  - ◆ delivering wider uncoded benefits for health and social care
- ◆ To better promote choice and control, developing services that are flexible and tenure neutral and allowing older people the choice to remain in their existing home. Development priorities will be:
  - ◆ the proposed floating support service for older people
  - ◆ increased provision in Staffordshire Moorlands
  - ◆ home improvement agencies and handyperson schemes
  - ◆ new development commitments for very sheltered housing
- ◆ To achieve a consistent level of service and define minimum quality standards.



- ◆ To deliver improved value for money, limit the level of price differentiation and deter the use of top-up charging.
- ◆ To ensure a sufficient supply of sheltered housing services that is well positioned to meet future patterns of demand.
- ◆ To develop the performance monitoring framework, particularly to better recognise support outcomes.
- ◆ To target support at those with identified housing related support needs.
- ◆ Try to ensure sheltered housing services are effectively aligned with wider services.
- ◆ Help tackle social exclusion amongst older people

## Local NHS Strategic Priorities

**NHS North Staffordshire's Strategic Plan 2009/10 to 2013/14** with its vision for 'A healthy future for all in North Staffordshire' includes two Goals to:

- ◆ Improve prevention, early detection and early management for those at increased risk, and
- ◆ Improve health outcomes for people with long term conditions

Among its aims for Services, are that services should be:

- ◆ Delivered as locally as possible and be timely and convenient to access
- ◆ Holistic, integrated and delivered in partnership
- ◆ Increasingly proactive in supporting health
- ◆ Delivered in primary/community rather than acute care wherever appropriate

And its Priority Health Outcomes include to:

- ◆ Reduce health inequalities
- ◆ Increase life expectancy
- ◆ Reduce hospital admission for Ambulatory Care Sensitive conditions (ie medical problems which are potentially preventable)
- ◆ Improve end of life care



**South Staffordshire PCT's Strategic Plan 2008 – 2013** (refresh 9<sup>th</sup> February 2010) with its Vision 'To prevent ill health and promote long life and wellbeing' includes the Strategic Goals to:

- ◆ Increase life expectancy and reduce health inequalities
- ◆ Improve care for people with long term conditions
- ◆ Improve mental health and learning disability services
- ◆ Improve end of life care

And the PCT is undertaking a series of relevant Strategic Initiatives, focussing on improving intermediate care, dementia care, case management for long term conditions, and 24 hour end of life care.



## District and Borough Councils' Priorities and Flexicare Housing provision.

### Cannock Chase District Council

Strategy / Plan	Issues and priorities in relation to Flexicare housing
Housing Strategy (2007-2010)	Cannock Chase District Council's Housing Strategy (2007-2010) affirms that the authority will work closely with Staffordshire County Council and other partners to ensure that a new Extra Care scheme is developed in the area. The Council accept that there is an increased need for Extra Care housing, especially as demand for the School Court Extra care scheme is extremely high.
Local Development Framework	The Core Strategy Development Plan Document (April 2009) identifies issues of concern to local communities including Healthier Communities, Housing and Older People. In order to provide services and housing provision for older people the council are considering a number of policy options to achieve a balance of both independent living options and extra care developments (with care and support).
A Strategic Housing Market Assessment for the C3 Housing Market Area of the West Midlands	Sub regional research indicates that there is an unmet need for all dwelling types in Cannock apart from 2 bedroom houses. The highest shortfall is in the 3 bedroom category. Given that the population is ageing some of the provision for new housing will need to be appropriate for older and more vulnerable people, as well as flexible to adapt to changing population needs. In this regard the application of Lifetime Homes' standards is likely to be appropriate. The provision of extra care developments will also be an important element in meeting this need.

### East Staffordshire Borough Council

Strategy / Plan	Issues and priorities in relation to Flexicare housing
Housing Strategy (2009-2014)	East Staffordshire Borough Council completed a new Housing Strategy (2009-2014) in March 2009. The document highlights that 'some older people will need extra care housing – their own home in a complex where they receive care.' The figure quoted in the Strategy as the estimated number of older people needing extra care housing is 462. The Council support extra care developments in appropriately located areas. Working in partnership with Trent and Dove Housing and Staffordshire County Council a new extra care scheme on Anglesey Road, Burton will be developed. This new scheme will replace Horace Pritchard House and Anglesey Court.
Local Development	The Core Strategy Issues and Options (July 2007) document identifies key issues that need to be addressed in



Framework	<p>the future development of the Borough. This includes ensuring that there is a wider choice of housing for key stages of people's lives and improved equality of access to services e.g. health, leisure, recreational facilities etc.</p> <p>Burton on Trent is recognised as having a significant role in revitalising the sub regional area. This presents the challenge of broadening its economic base by maintaining investment and employment levels, supported by a high level of housing growth that will meet local requirements. This will include offering choices to a wide range of people including the elderly.</p> <p>Policy decisions for rural areas need to ensure that housing, access to and delivery of services (including healthcare) all have increasing importance to the old, those who have limited access to transport, those who have specific healthcare needs and those that become isolated by the areas that they live.</p> <p>The council's proposals' in regard to new housing includes ensuring that a wide range of accommodation is provided that meets the needs and aspirations of households. A study of these needs was undertaken to identify levels of affordable housing in addition to supported and sheltered accommodation for older people.</p>
Strategic Housing Market Assessment (West Midlands North Housing Market Area)	<p>The BME population is relatively larger in East Staffordshire than other areas (with the exception of Stoke-on-Trent). Although overall numbers and proportions for older members of BME groups remain low, the increasing proportions of older BME members will mean that increasingly culture -sensitive attention needs to be paid to their specific needs and aspirations.</p>

### Lichfield District Council

Strategy / Plan	Issues and priorities in relation to Flexicare housing
Housing Strategy (2006-2009)	<p>Assessing and prioritising the need for support and adaptations required to keep people in their own homes, re-assessing the existing sheltered stock and looking to developing more 'extra care' accommodation for the frail elderly is referred to under one of the delivery options in Lichfield District Council's Housing Strategy (2006 – 2009).</p>
Local Development Framework	<p>The Council recognise the need to respond to the changes in demographics in particular the rise in the older population. The Core Strategy Issues and Options document affirms that the Core Strategy needs to take into account impacts arising from an ageing population e.g. care and support services and older persons' accommodation.</p>



A Strategic Housing Market Assessment for the C1 Housing Market Area of the West Midlands	In terms of housing needs of older people the Strategic Housing Market Assessment concluded that over 20% of the population of Lichfield District is over 60 and the shifting demographic patterns across the age ranges of 60-79 and over 80's have major implications for meeting the differing and evolving housing and support needs of older people living alone.
Rural Housing Needs Survey	The report mentions about the need to provide appropriate accommodation to enable older people living in rural areas to move on and allow larger properties to be released for families in the area.

### Newcastle under Lyme Borough Council

Strategy / Plan	Issues and priorities in relation to Flexicare housing
Housing Position Statement 2008-2010	In terms of increasing older people's housing choice, the Borough Council is committed to enabling the development of Flexicare in line with the Independent Living Strategy. The Council is actively seeking to support partnerships where either existing sheltered housing schemes can be improved and possibly extended to form new extra care schemes or support the development of new extra care schemes on suitable land. The Council will also actively discuss with the County Council if any decommissioned Care Home sites are suitable for extra care developments.
Local Development Framework	The Core Strategy asserts that future Development Plan Documents (including site allocations) will make provision for a housing mix to meet needs identified through locally based assessments, in line with national and regional policy, and taking into account the requirements of specific groups, in particular families with children, older and disabled people.
Strategic Housing Market Assessment (West Midlands North Housing Market Area)	<p>The assessment recognised that Newcastle-under-Lyme has a high proportion of single pensioner households, particularly in social housing. It is therefore important that sufficient resources are allocated to appropriate care and support services for older people living alone.</p> <p>Reference is also made for potential implications for future accommodation in particularly:</p> <ul style="list-style-type: none"> <li>• Increased requirements for support to enable older people to stay at home.</li> <li>• Increased need for specialised accommodation for older people.</li> </ul>



## South Staffordshire District Council

Strategy / Plan	Issues and priorities in relation to Flexicare housing
<p>A Strategic Housing Market Assessment for the C3 Housing Market Area of the West Midlands</p>	<p>The Strategic Housing Market Assessment for the C3 Market Housing Area (West Midlands) 2008 refers to the age structure in South Staffordshire as having the widest variance against the C3 average, with 48% of the population in the Local Authority District older than 44 years compared to 41% in the C3 as a whole. The study also refers to many 70+ households who do not require care and do not want to move from their current homes.</p> <p>Local housing needs and demand studies have shown in South Staffordshire that demand for supported housing from existing households is primarily for sheltered housing in the social housing sector and independent accommodation with external support. Suggestions have been put forward that resources should focus on the provision of home based support services and adaptations for older people living at home in both social rented and owner occupied housing, in addition to providing more older persons accommodation in general. These reports note that although a high proportion of older people may have their own resources to meet their accommodation and care needs, and provision should not be exclusively in the social rented housing sector, others will need financial support to enable them to access housing support services.</p> <p>Referring to the Housing Market Assessment there is a need for 599 units of extra care accommodation in South Staffordshire over the next three years. This need has been identified mainly from the number of elderly relatives moving into the area and the rise in the number of older people in particular those aged over 80. Stakeholders taking part in consultation exercises did feel that purpose built 'villages' for older people would be better to provide support than mixed communities.</p>
<p>Local Strategic Partnership Housing Strategy 2009-2012</p>	<p>The Council are committed to work closely with the County Council to develop Staffordshire's Flexicare Strategy to ensure that efforts and resources are directed to where they are needed most. Two extra care developments are currently being progressed in Penkridge and Essington.</p> <p>Throughout the lifespan of the housing strategy opportunities for extra care schemes in each of the District's five localities will be sought. Additionally, there is a commitment from South Staffordshire to use some of their capital resources to increase the supply of extra care housing.</p>
<p>Local Development Framework, Core Strategy , Development Plan Document and Preferred Spatial</p>	<p>The key issues and challenges that will drive change in the District, the spatial issues that arise and which the Core Strategy will seek to address are summarised under the Sustainable Community Strategy themes, which include for Housing meeting the provision of extra care accommodation.</p> <p>Following discussions with infrastructure and delivery agencies, including social care and health agencies, the District Council recognise the need for improvements to existing facilities and the provision of additional extra care housing. The development of extra care housing is seen as a particular priority for each of the main</p>





<p>Strategy (Consultation document 2009)</p>	<p>service villages in all areas i.e. locality areas 1 to 5, Northern, North Western, North Eastern, Central and Southern. The aims for each area are as follows:</p> <p><b>Locality Area 1 (Northern Area)</b> The village of Penkridge will have developed its key role as the main service village and improvements to social care and health facilities, including the provision of extra care housing, will have been delivered with partners.</p> <p><b>Locality Area 3 (North Eastern Area)</b> The villages of Essington and Featherstone will have experienced modest growth to meet local needs and to support existing facilities and services. Proposals to provide extra care housing within these communities will have been delivered with partners.</p> <p><b>Locality Area 4 (Central Area)</b> The villages of Codsall, Bilbrook and Perton will have developed their key roles as the main service villages and improvements to social care and health facilities including the provision of extra care housing will have been delivered with partners.</p> <p>With respect to primary care, current service provision is generally satisfactory but there is potential to develop larger single site health centres and to co-locate and integrate facilities with other social care and health services in a number of villages. The preferred strategy will support these aims and objectives and the need to identify sites for new facilities will be examined in the Site Allocations DPD (Development Plan Document).</p>
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### Stafford Borough Council

Strategy / Plan	Issues and priorities in relation to Flexicare housing
<p>Local Development Framework</p>	<p>Included in 'Delivering the Plan for Stafford Borough, Draft Core Policies (February 2010) there are two Draft Core Policies which relate to extra care housing developments i.e. Lifetime Homes and Specialist Housing.</p> <p>The council have affirmed that they will expect all new housing developments to adopt lifetime homes standards, unless it can be demonstrated that it is not technically feasible or will render the development viable. Due to Stafford Borough's demographic profile and the forecasts of a growing elderly population, the addition of lifetime homes will play an important part in meeting the Borough's needs.</p> <p>Referring to the Draft Core Policy on Specialist Housing the Council say that they will, through the allocation of sites and/or granting planning permission, meet the anticipated need to provide 703 net additional extra care beds units in Stafford Borough by 2025 over and above the current provision as at 2008 by:</p> <ul style="list-style-type: none"> <li>Resisting development that would lead to a reduction in the number of extra care premises unless it can</li> </ul>



	<p>be demonstrated that a replacement facility was being built or that such a use was unviable.</p> <ul style="list-style-type: none"> <li>• Ensuring that any new developments are situated in a sustainable location, are self contained and are accessible by public and private transport.</li> <li>• Allowing for the extension of existing nursing homes and conversion of existing buildings taking into account some stipulations such as the development being compatible with the character of the local area.</li> <li>• Seeking to secure the provision of new extra care facilities through liaising with its partners, Staffordshire County Council and South Staffordshire Primary Care Trust (PCT) on new major development schemes.</li> </ul> <p>Meeting the need of 703 extra care Units there would need to be an increase in the levels of provision of 20.2 units per 1000 aged 65 plus from the current level of 1.3. The majority of the need will need to be addressed by owner occupied units with a smaller number from the social and private rented sectors. There is concern that this type of housing will not be delivered with the first few years of the Plan period as the majority of new developments taking place over that period will be residential development made up of existing consents, windfall sites and identified Strategic Housing Land Availability Assessment (SHLAA) sites. None of the existing consents are for extra care Housing and few sites suitable for development are likely to come forward.</p>
Housing Strategy (2008-2013): Homes for our Community	This strategy highlights the provision of extra care accommodation as being a development priority for the next 5 years. Stafford's Housing Needs Study suggests a requirement of 1.632 units of sheltered accommodation for older people including considerable re-provision of current schemes to make them fit for purpose.
Strategic Housing Market Assessment (West Midlands North Housing Market Area)	This study highlighted that Stafford will experience a substantial increase in the number of people post retirement age. In 2006 people over the age of 65% comprised of 16.8% of the population, by 2025 this is projected to increase by 49.4%. The largest increases will be seen in the 80-84 and 85 plus age group, which will experience increases of 75% and 96.7% respectively in the same period. These demographic changes will have a substantial impact on extra care housing provision as well as health services.

### Staffordshire Moorlands District Council

Strategy / Plan	Issues and priorities in relation to Flexicare housing
Housing Strategy – Strategic Framework (Sept 2009)	The development of extra care housing in Moorlands is a “green priority” for the Staffordshire SP Partnership and is a strategic priority for Staffordshire Moorlands District Council. As part of the joint venture with Harvest Housing, the district’s first extra care housing scheme for older people is being developed in Leek, with Biddulph and Cheadle earmarked for potential future site developments.
Staffordshire Moorlands	The local authority has engaged with the Harvest housing Group to develop a joint venture that will deliver around 600 affordable housing units including 80 as extra care housing for older people.



Sustainable Community Strategy 2007 – 2020	
Strategic Housing Market Assessment (West Midlands North Housing Market Area)	<p>Staffordshire Moorlands has high proportions of people aged 35-49 and 50-64, which although suggests a stable population could (in the case of the older segment) mean that in ten to twenty years more pressures will be put on services for older people. Reference is made specifically to the increased need for specialised accommodation for older people with the shift towards an ageing population. A projected figure to support this need has been identified as 582 extra care housing places by 2025.</p> <p>In terms of older people Staffordshire Moorlands has the highest percentage of their total population over 60 as well as higher levels of single pensioner households. This will present challenges for providing growing numbers of older people with equity in their own homes with housing choice. Reference is also made for potential implications for future accommodation in particularly:</p> <ul style="list-style-type: none"> <li>• Increased requirements for support to enable older people to stay at home.</li> <li>• Increased need for specialised accommodation for older people.</li> </ul>
Local Development Framework	<p>The Core Strategy Development Plan Submission Document (May 2009) includes a section on the Spatial Strategy for Staffordshire Moorlands. Reference is made to the strategy seeking to address the needs of a changing population by increasing the provision of suitable accommodation and services for older people. As well as ensuring there is a suitable range of housing provided to meet these needs, specific housing needs will be addressed through support for the development of extra care housing.</p> <p>Biddulph has been earmarked as one area for increasing the range of available and affordable house types especially for first time buyers, families and older people, including extra care housing. The Anzio Camp, Blackshaw Moor is one of the sites identified as potential development for extra care housing. It is proposed that any development on this site shall be of a scale required only to meet local needs which cannot otherwise be met in a settlement.</p> <p>Housing for special groups will also be needed to meet the future increase in elderly persons across the District and the needs of those with a learning or physical disability. This may be in the form of sheltered housing, extra care homes or supported housing. Further guidance on these types of housing will be set out in an accompanying Housing Delivery SPD.</p>



## Tamworth Borough Council

Strategy / Plan	Issues and priorities in relation to Flexicare housing
Housing Strategy 2007-2010	<p>Tamworth's Housing Strategy 2007-2010 (Amended April 08) refers to the area as having no extra care provision. Recognising this Tamworth Borough Council have supported the development of remodelling two existing sheltered housing schemes, MacGregor Tithe and Thomas Hardy Court, into extra care schemes. Although extra care accommodation is seen as a high priority for the district the Council does expect provision will be achieved through remodelling rather than new build.</p> <p>In order to address the current and future growth in older and frail older households across all tenures and their related care and support needs Tamworth Borough Council are currently developing a Housing &amp; Health Strategy, currently planned for March 2011.</p>
Local Development Framework	<p>Tamworth Core Strategy Development Plan Document 2006-2026 asserts that appropriate housing will be built to meet the needs of an ageing population requiring specialist needs and support or care (spatial objective S010). This includes the requirement for homes that are suitable to the needs of older people, persons with disabilities and those with special needs contribute to the provision of affordable housing.</p>
A Strategic Housing Market Assessment for the C1 Housing Market Area of the West Midlands	<p>Although Tamworth has a smaller percentage of older residents compared to regional and national average it does have the second highest proportion of people aged 60-64 (28.9%). Taking this into account consideration needs to be given to design services to engage with this 'younger' older population age group to move them into their older life and keep them fit and healthy.</p>



# Appendix 3: Some research evidence relevant to this strategy

## 1. Personal Social Services Research Unit, University of Kent

PSSRU is leading the research on the FCH units across the country which have received Department of Health funding. Most of their work is available on line at [www.pssru.ac.uk/projects/FCHi/htm](http://www.pssru.ac.uk/projects/FCHi/htm). In November 2009 they ran a workshop at which they presented their findings to date:

### 1.1 *Social Well-Being in FCH* – L Callaghan. (A study of 15 schemes.)

- ◆ FCH can provide an environment supportive of social well-being
- ◆ Communal facilities and activities were valued and were important for friendship development
- ◆ Resident involvement in running the schemes' social lives was beneficial but staff support is crucial both early on and over time
- ◆ Local community links were valued; location is important in facilitating these links
- ◆ Smaller schemes and villages have different challenges to overcome to promote social well-being

She found..

- ◆ Residents valued independence, security and social interaction offered by FCH
- ◆ 2/3 rated Quality of Life as 'good' or 'very good'
- ◆ 90% had made friends since moving
- ◆ 80% felt positively about social life
- ◆ 70% took part in an activity at least once a week
- ◆ 75% were fully occupied in activities of their choice
- ◆ Some residents were socially isolated
  - ◆ More likely to be in receipt of care,
  - ◆ Rated health as worse
  - ◆ Mobility problems a barrier
- ◆ Some schemes were addressing social isolation



(Lisa Callaghan has also produced a **Directory for promoting social wellbeing in FCH and other settings** (Housing LIN website, 2010) which gives ideas for good practice)

### 1.2 *Changes in the Characteristics, Turnover and Destinations of those who have left extra care* – R Darton

- ◆ For those in FCH receiving care, main need for help is with IADLs (Index of activities of daily living) and mobility
- ◆ Very few with severe cognitive impairment....
- ◆ Average level of dependency lower in FCH (*compared with care homes*)
- ◆ Relatively little change in dependency in first 6 months...
- ◆ Two thirds of deaths occurred in schemes....
- ◆ Majority of moves were to hospitals and care homes but some for personal reasons

Expanded in the PSSRU Newsletter No 3 January 2009 – ‘ These results suggest that extra care housing is not operating as a direct alternative to care homes, but providing for a rather different population, who are making a planned move rather than reacting to a crisis. While extra care supports residents with problems of cognitive functioning, most appear to prefer residents to move in when they can become familiar with their new accommodation before the development of more severe cognitive impairment....residents of extra care were less likely to show changes (in level of physical and cognitive functioning) during the first six months after moving in, than the residents of care homes. This suggests that entry to extra care may help residents to maintain their level of functioning for longer and thus delay the need for more costly care and support.’

### 1.3 *‘The Rowanberries study’: Costs and outcomes of an extra-care housing scheme in Bradford* by Theresia Bäumker, Ann

Netten and Robin Darton PSSRU/Joseph Rowntree Foundation 2008.

#### *Key points*

- ◆ Overall, costs rose as a result of moving into the extra-care housing scheme. However, the residents also experienced better social care outcomes and quality of life.
- ◆ On average, it cost £380 per person per week before moving into Rowanberries, compared with £470 after moving. This cost was based on comprehensive estimates for each of the broad cost components (health care, social care, accommodation and living expenses).



- ◆ This increase in cost was primarily associated with higher costs of accommodation, social care and support in the extra-care scheme. But health care costs were lower.
- ◆ Informal care costs fell, from an estimated £80 per person per week before the move to £25 per week afterwards.
- ◆ Approximately £360 of the cost per resident per week after moving into the extra-care scheme was the responsibility of the public sector, taking into account benefits that the residents received.
- ◆ The improvement in social care outcomes for residents, when comparing their perceptions before moving and six months afterwards, reflected an improvement in reported levels of met need.
- ◆ On the same basis, residents also reported improved quality of life. However, perceived functional abilities of residents had not improved during this period.
- ◆ There was no change in self-perceived health and psychological wellbeing, when comparing residents' reports six months after moving with their views shortly after they moved in.
- ◆ Reductions in residents reporting unmet need appeared to reflect the impact of the increased level, and cost, of resources. The decrease in health care and informal care costs did not seem to adversely affect outcomes.
- ◆ The researchers conclude that some methodological challenges need to be met before a comprehensive evaluation of the cost-effectiveness of extra-care housing can be conducted.

### *Health care*

Overall, health service costs fell from £121 per person per week before the move to Rowanberries, to £53 per person per week afterwards. The greatest single difference was in relation to nurse consultations at home: an average reduction of £37 per week after the move. While the number of residents who were visited by a nurse had more than doubled, the average number of visits per resident had decreased from approximately 22 to 11 visits in a six-month period. There was evidence of a change in the pattern of accessing health care resources (such as a nurse and/or general practitioner): more residents accessed the services, but less frequently, after moving to Rowanberries. By comparison, the proportion of residents accessing hospital services such as accident and emergency, outpatient appointments and inpatient stays, was slightly lower in all instances after the move to Rowanberries.



## 2. Publications of the Department of Health Housing LIN (Learning and Improvement Network)

The LIN continues to add to the large stock of immensely valuable Guidance Notes, Factsheets, Case Studies and Briefings and several are referenced in this Strategy and its Appendices. These are accessible through [www.dhcarenetworks.org.uk/housing](http://www.dhcarenetworks.org.uk/housing) under 'At a glance'. The Housing LIN produced an invaluable **Extra care Housing Toolkit** (DH Care Services Improvement Partnership, 2008) which has plenty of very practical tools, such as checklists and model products.

## 3. Evaluation of Reeve Court Extra care Village (Sue Garwood, 2008)

Sue Garwood, an independent Extra care specialist, was commissioned to undertake an evaluation of this Extra care village in St Helen's. The following is from the publically available extract of her report, published in July 2008. Italics are mine. (The Executive Summary can be accessed on line at the DH Care Networks site)

'Reeve Court was opened in October 2004 and *comprises 206 dwellings*, 103 for rent and 103 for various ownership tenures. Arena Housing Group owns the land and its subsidiary, Arena Options, manages the landlord function for the group. The Extra care Charitable Trust (The Trust) manages the village and all on-site services apart from the housing element. The village provides a wide range of facilities and services, including 24 hour care commissioned by St Helen's Council for about a third of the residents.....

St Helen's *block contract* for care is divided into bands: Band 1 for those needing the least care and support, and *band 5 needing the most, including nursing care*. Residents move between bands if their care needs change significantly. Since the scheme opened, *50 residents have remained in the same band while 21 have needed more care, and 27 less*.

A chi square calculation suggests that the number of people needing reduced levels of care is unlikely to be attributable purely to chance, and that living at Reeve Court appears to improve residents' independence more than might be expected from traditional home care in the wider community. A sense of improved well-being and satisfaction with having moved to Reeve Court was supported by interviews with "support" residents, *some of whom had moved from residential care to the village.....*'

The summary of findings lists several connected reasons why people benefit from the service, including:

'A range of services in addition to care provided by staff from the Trust and Arena, who are generally perceived as friendly and approachable:

*The well-being service is led by a trained nurse to promote good health and prevent ill-health. For example there is evidence of well-being checks detecting conditions early.*

*The "Enriched Opportunities Programme" gives extra support to particularly vulnerable tenants, including those with dementia and learning disabilities, to help fulfil their potential.*





...A net comparison if the whole group were on full benefits shows a saving to the council for the band 4/residential care group but extra expenditure for the band5/nursing home group. Overall, the arrangement appears to provide good value for money to St Helen's for the block as a whole, especially when the additional services such as night care and other value-added elements of living at Reeve Court are taken into account. However, some crude calculations of unit costs within bands suggest that the services and costs within each band are not properly aligned, so that income for services to the lower two bands subsidise the services in the upper bands. This is particularly relevant to self-funders at the lower end of bands 1 and 2 who are unlikely to require planned care at night, and are likely to consider that the charge is expensive for the amount of care they receive. This is likely to become much more relevant with the introduction of individual budgets.

### Range and Level of Needs Within the Support Group

People at moderate, substantial or critical risk within FACS criteria may all form part of the "support" group. The group comprises people aged 55 and over with a wide range of needs, including physical frailties and disabilities, learning disabilities and mental health issues.

At point of entry, the last group does not normally include people with dementia, although couples where one has dementia are not barred, and, once there, people with dementia are supported to remain there as long as possible. *Given the size and layout of the village this exclusion does not seem unreasonable.*

*The village supports people who would otherwise be in residential care. Twenty-one people moved to it from care homes. As has been seen, they generally thrive.*

*For people in band 5, the nursing service can be seen as a much more flexible and responsive alternative to the district nursing service. The PCT is said to recognise that it is a cost-effective service. There are at least two, and probably more, people in band 5 who would otherwise be in a nursing home, where they would be unlikely to derive the many benefits of living independently at Reeve Court. However, band 5 could not be a complete replacement for nursing home care.*

"A home for life" has so far been a reality for many residents. At the time of the study, 19 residents had lived at the village til death, although it is not known how many actually died at home. Only three people in the "support" group had moved to more intensive care....

### Community Mix and Expectations

In addition to the one-third of residents with care needs, anyone over the age of 60 (or 55 with disability) can apply to live at Reeve Court, and the vast majority of the core group are completely independent. People come to the village from a diverse range of socio-economic backgrounds.

*There is a vocal minority within the "core" group who complain about the number and types of disabilities manifest in the "support" group, say they were not expecting such diversity, and are concerned about the impact of such a visible group on attracting "younger", fit applicants who can take over the volunteering. These attitudes appear to create some community tension and appear to be a mix of*



intolerance, unfulfilled expectations and possibly some valid concerns..... These attitudes need to be taken into account should St Helen's ever wish to see a shift in the ratio of "support" to "core" residents in order to house more people with care needs at Reeve Court.

The scale at Reeve Court, combined with the overall layout and design of the village, is probably better suited to people who are not at risk of isolation or disorientation caused by physical frailty or cognitive impairment. ...It seems fair to say, therefore, that although the range of facilities and wheelchair accessibility across the village promote well-being, the scale and distances may detract from some residents' independence and well-being. *As the Trust recognises this makes the village less suited to people with dementia.*

### Well-being Service

This is a service about health promotion and prevention. A trained nurse is employed to undertake individual health and well-being checks. It is not a clinical treatment role. He also runs well-being sessions which include falls prevention, light exercise, healthy eating, Tai Chi, hand waxing and yoga. Well-being ambassadors – volunteers – promote the service, support the well-being nurse and undertake "express" assessments. Every year all residents have a full assessment covering a wide range of health and well-being measures and domains – for example, blood pressure, breathing, diet, mobility, senses, sleep, psychological and spiritual well-being, etc. The nurse provides regular drop-in sessions when people call about a range of health concerns.

Other data provided by the Trust has shown that between April 2005 and March 2007, three cancers were detected in one month and in the pilot study which was a forerunner to the development of the well-being service, 122 previously undiagnosed conditions had been identified....This service undoubtedly complements others to promote health and well-being; assisting in early diagnosis, promoting good health through wellbeing groups, helping to prevent ill-health, and listening to and supporting residents.....

### Reeve Court "support" costs compared to care home costs

There is little doubt that if Reeve Court were not available, at least some of the people in bands 4 and 5 would be in residential or nursing homes. Calculations show that the gross cost to Social Services for bands 4 and 5 in Reeve Court is less than the cost for the same number of people in residential homes (band 4) and nursing homes (band 5), the difference being approximately £64K for band 4 and £11K for band 5. These figures do not take into account that were these people to be in residential or nursing homes, the proceeds from the sale of their property (if they own one) would contribute to Social Services care charges, whereas in Reeve Court capital bound up in the property is not available to Social Services.

Even where people don't have capital assets, the council is guaranteed a minimum income of £98.60 per week towards residential care charges through the benefit system. Comparing the net cost to Social Services, the department pays around £12.5K p.a. less for the 10 residents in band 4 than they would pay in residential care, but £66K p.a. more for the 15 people in band 5 than if they were in nursing homes at the indicative price.



Here again, one needs to look at the whole picture, not just a simple cost comparison. The .. benefits and added value ..in the context of comparisons with social care services in the wider community applies here. ...

What does bear spelling out is that people living in residential or nursing homes do not have a property with several rooms that they can call home. They do not have a tenancy or lease which affords security of tenure and certain rights such as deciding who can cross their threshold. It is possible, but unlikely, that the range of activities and social stimulation in most care homes is comparable to that at Reeve Court. It is possible, but unlikely, that care to people in residential care is delivered in an independence enhancing way. Indeed, the lack of facilities militates against that: would someone in residential care be given the opportunity to make a cup of tea or a sandwich? Unlikely.

Another hugely significant benefit of Reeve Court over residential care is that it houses couples where only one may need “support”. Carers can be supported in their caring role and both the cared for and carer can participate in the wide range of activities and opportunities for involvement as far as they wish to.

Value for money to the council for people in band 5 compared to the nursing home alternative is therefore less compelling than compared to likely domiciliary care costs, but in the context of the extra gains at Reeve Court can be argued to be money well spent.

#### What about value for money to the PCT?

The PCT contributes a weekly amount per person for the 15 people in level 5, to cover the cost of the nursing input. Unlike in a nursing home, this amount is paid in a lump sum to the Trust via Social Services, so one person can receive more intensive care and another less.

By definition, people are only in this band if their health needs are such that they require care led and supervised by a nurse. If the individual was in a nursing home instead, the PCT would contribute £101 per week. If on the other hand the individual was at home and required similar levels of nursing input, it would have to be provided by the district nurse. In terms of time spent travelling to-and-fro, level 5 offers economies of scale.

The PCT interviewee indicated that the PCT had recently looked at their contribution and had reached the conclusion that it did provide value for money to the PCT. What also emerged from interviews with staff and a number of residents who were, or had been, on level 5 was the excellent quality of the service... In the same way as care and general support is delivered in an integrated, seamless way, so too the nursing input. Similarly, the nursing input is flexible and responsive at Reeve Court.

It is claimed that the number of hospital admissions for people in Level 5 is low, and often GPs do not have to come out but can give advice over the phone because they are talking to medically qualified staff. This claim, whilst difficult to quantify, seems likely to be true. So it seems reasonable to conclude that the PCT is getting value for money. As one of the interviewees said, “it’s a win-win situation”



Social well-being in Extra care Housing (Evans and Vallely, Joseph Rowntree Foundation, 2 papers, 2007) summarised in Sue Garwood's Reeve Court report

'Key factors highlighted by their literature review as promoting social well-being included: the availability of inclusive and diverse activities, both social and creative; the provision of a range of facilities as venues for social interaction – particularly a shop, restaurant and garden; imaginative and accessible design that promotes a sense of community; access to social networks beyond the housing scheme; opportunities for service users to be involved in decisions about care delivery and service development; and a person-centred approach to care provision. Factors identified by their research study as playing a part in promoting social well-being in Extra care housing included: friendship and social interaction; the role of family carers; engaging with the wider community; the role of facilities; design, location and layout; and staffing systems and the culture of care.'

**4. Extra care Housing and People with Dementia – summary of findings from a scoping review of the literature.** Rachael Dutton, Housing 21 – Dementia Voice/ The Joseph Rowntree Foundation 2009.

This report reviewed literature concerning Extra care housing and people with dementia. It found little British research but much more from the USA and so there were caveats, but the following were among its findings:

“There is mounting evidence that people with dementia living in FCH generally have a good quality of life although studies consistently show that some tenants with dementia can be at risk of loneliness, social isolation and discrimination.

It is apparent that Extra care can be an effective alternative to residential care, and can delay or prevent moves to nursing care. What is more, many people with dementia have been supported in Extra care through to the end of their lives. However, enabling *all* tenants, with or without dementia, to remain in place through to the end of their lives in Extra care housing is not usually possible.

Common factors found by many studies that influence whether people with dementia are required to move from Extra care to alternative accommodation and care solutions are:

- ◆ ‘challenging behaviours’ and their impact on staff and other tenants;
- ◆ difficulties in providing the necessary levels and flexibility of care in response to increasing care needs;
- ◆ availability of resources, including increasing demand for carers time;
- ◆ the level of community nursing services available to tenants;
- ◆ targets for dependency mixes, and maximum numbers of high-dependency tenants, that can be cared for in schemes;
- ◆ the availability of places in other facilities;



- ◆ the willingness of funders to pay for increasing levels of care for individuals;
- ◆ choices and preferences of tenants and their families.

Extra care is able to offer some people with dementia an alternative, more independent lifestyle than is possible in a care home. Independence is a key concept of FCH and certainly appears to be an achievable goal for those with early to moderate stages of dementia. As dementia and/or other conditions worsen, the need for care and support increases and with that the ability to live independently inevitably diminishes. At this stage, aspects such as choice, self-determination and quality of life will prevail.

It is clear from current evidence that having people with dementia living in Extra care schemes it can be:

- ◆ intensive in terms of staff time
- ◆ possible to effectively manage common behaviours such as incontinence, anger and distress
- ◆ difficult to manage other types of behaviours which are detrimental for other tenants (e.g. disruptive, disconcerting, worrying, annoying)

and requires:

- ◆ flexibility and responsiveness in care and support
- ◆ innovative and insightful approaches
- ◆ staff to have a positive attitude, and good understanding, about dementia and about each individual with dementia
- ◆ a stimulating environment including social activities
- ◆ effective management of symptoms such as incontinence
- ◆ effective management of common behaviours, such as anger, that distress or harm caregivers and neighbours.

There is strong evidence and general agreement that it is not appropriate for people to enter Extra care when they already have advanced dementia.”



## 5. Journal of Care Services Management Volume 3 No.3 – Special edition: Housing and Dementia, 2009 (available in the JCU)

This includes a series of articles, among which are:

Practice papers reporting on:

Effective partnership work between the local Alzheimer's Society and sheltered housing staff to improve awareness of dementia among residents, reintegrate isolated people with dementia and impact on people seeking help earlier and using the resources of the Society. (Moore)

A 'floating support' service for people with dementia in their own homes, supporting them to develop or maintain independence in the community, prevent the loss of their own home or tenancy and avoid unnecessary use of more institutional forms of care, with good early results. (Adeniji)

A study of an innovative and effective broad approach to use of telecare in West Lothian, with users reporting increased sense of security and safety; for people with dementia this was particularly valuable in supporting them to remain in their own, known home. (Bowes and McColgan)

A report on Rowan Court, a specialist FCH facility for people with mild to moderate dementia. In the previous year it had been able to maintain 87% of residents in that setting and has been looking at ways to increase that proportion and extend the service (Burns et al)

There is also a study by Brooker et al (University of Sheffield) on **The mental health needs of people living in FCH** which reports on data from 268 residents in ten Extra care schemes who were judged to be at risk of exclusion because of mental health problems. In the article they cite the 3 year study of people with dementia in Extra care by Vallely et al (**Opening Doors to Independence..**' Housing 21, 2006) which 'showed that residents with dementia and their relatives were very positive about Extra care as an experience' but that 'over half of the people with dementia they followed were admitted to other care settings during the first two years'. The numbers in that study were relatively small. The Brooker study was of non-specialist schemes but found high levels of depression (around 24% in some) and significant levels of dementia (from 5% up to 47%) although they stress the number of sites studied was relatively small so it would be risky to extrapolate. Nevertheless, they conclude 'It shows that even in newly opened, non-specialist dementia schemes, there is a significant number of residents experiencing a high degree of psychiatric morbidity and vulnerability. This suggests that housing providers and community health teams need to take a proactive approach to meeting the needs of this group. Mental health awareness raising, training and education in the long term support of people living with mental health problems could help in many situations. The likelihood of crises situations arising if a proactive approach is not taken appears highly probable with the outcome of people having to leave a lifestyle option that they have chosen for a more restrictive care provision such as admission to hospital or care home.'



A paper by Torrington (University of Sheffield) on '**FCH: Environmental Design**' highlights the crucial significance of design in not just reducing problems but also in enabling aspirations for activity and quality of life for people with dementia. She identifies principles which should be built in from the start but can also be brought in to existing schemes:

- ◆ Spaces should clearly convey their purpose
- ◆ Strategies should be adopted to make people feel a sense of ownership of the facilities provided for them
- ◆ Routes should be designed to support wayfinding using graduated spatial hierarchies from public to private space...
- ◆ Routes should allow for a smooth flowing passage of movement that takes in inside and secure outside areas
- ◆ Adequate arrangement for deliveries and storage of goods should be made to avoid using main circulation routes and prevent the accumulation of clutter
- ◆ A consistent approach to signage and display of notices should be adopted
- ◆ Communal areas should be designed to accommodate specific activities and include adequate storage for related equipment
- ◆ Spaces should be designed that allow casual social contact
- ◆ Personalisation of the entrance area to individual apartments and the opportunity for individual owned external space should be possible
- ◆ Apartments should be large enough to accommodate hobbies and activities
- ◆ Good connections are needed between individual apartments and the outside; views should be meaningful, and it should be easy to access outside areas.

## 6. Design

As well as the paper above by Torrington, the Housing LIN has a Factsheet '**Design principles for Extra care**' (2008) which includes a section on design for dementia and another paper on '**Design of Housing for People with Dementia**'. **The Extra care Housing Toolkit** (Housing LIN 2008) has a checklist for the design of FCH. DH Housing LIN/CABE (Commission for Architecture and the Built Environment) also produced



**Homes for our old age – Independent living by design** (2009), available in the JCU, which states the following:

‘Lessons –

- ◆ Design for home care or support must recognise that each building is someone’s home, not just a place for social care
- ◆ Those delivering the schemes need to be aware of the experiences of the ageing and disabled population – poverty and affluence, discrimination and equality, isolation and inclusion, and the needs and requirements of a diverse society
- ◆ Internal house design and layout needs to be flexible to accommodate changing care or support needs
- ◆ Independence and quality of life require high quality design, management and services
- ◆ Design for social care means future–proofing the buildings we already have so that a resident knows they can remain in their home as their needs change
- ◆ Schemes need to be seen as community assets which allow residents to mix with local people but also enable them to feel their home is secure and private
- ◆ Developers and providers should talk to and involve residents, both before and after development and occupancy’

## **7. Other useful articles from the Journal of Care Services Management (available in the JCU)**

Vol 3 No 1 2008 **Going the extra mile in delivering FCH for people living with dementia** (Helen Joy) gives ideas for effective practice, including design, personalised services, education for staff and relatives, activity, links to the local community and use of assistive technology.

Vol 3 No 2 2009 **Planning for and meeting the needs of an ageing population: Gloucestershire’s Experience** (Stubblings and Foreman) in which the PCT Chief Executive describes a range of approaches including an FCH scheme in which the PCT has been a partner and has a preventative and therapeutic healthcare programme.

Vol 3 No 4 2009 **The design of housing for people with dementia** (Utton) describes principles for design and how they have been applied in practice





## 8. End of Life

**Is it that time already? Extra care housing at the end of life - A policy into practice evaluation** – Easterbrook/Vallely, Housing 21/NHS EoL 2008 (Available online at the Housing 21 website)

This is a helpful and encouraging study of a pilot programme within 3 Housing 21 Extra care schemes to promote good partnership practice in end of life support. It provides sensible and useable advice. It highlights that this time of life is one when the key themes of:

- ◆ Personalisation
- ◆ Dignity
- ◆ Choice

are critical and changes in practice can enable them.

They made a baseline study across several schemes and found 'Responses from the 35 Extra care schemes run by Housing 21 found 65 reported recent deaths amongst tenants. Of these, 16 people (24.5%) had died at home in their flat; 46 (70.1%) died in hospital; two in a nursing home, and one in a hospice.

Analysis confirmed that those who had lived longest in the schemes (and so tended to be amongst the oldest), and whose deaths were expected, were far more likely to die in their flat. Doing so had met the known wishes of 75% of this group.

In contrast, hospital deaths were much more likely to be unexpected, and amongst more recent tenants. Just over half (58.7%) of those who died in hospital had been there for more than a week. These hospital deaths were reported to have met the wishes of only 20% of that group. In addition, and of the 46 tenants who died in hospital, the families of just 18 tenants (39.1%) were believed to have known about the person's wishes regarding where they would prefer to die.'

In their detailed study of the 3 pilot schemes they say:

'Some tenants who took part in the project certainly made plain that they had strong feelings on where they should die. The project also underlined that - with a little effort - staff from across health, housing and social care could appreciate what each could offer in the care and support of a dying Extra care tenant....In many cases, paid carers in Extra care schemes build up a real relationship with the tenants they support. The study shows that armed with appropriate training, they can turn the instinctive warmth, concern and empathy uncovered in this study into an effective plan for each tenant's end of life care – and help deliver it.'

The paper reported the following outcomes:

- ◆ 'Aside from external developments, over the course of the evaluation several significant changes became clear:
  - ◆ It had become more 'normal' for Extra care staff to talk and think about end of life care;



- ◆ Staff knew more about what signs to look for, and how to respond: for example, when during the course of the project a tenant deteriorated suddenly and died over a weekend, they were able to improvise whilst waiting for the district nurse to attend with supplies;
- ◆ Health, housing and social care professionals wanted to talk about and plan how Extra care schemes could support end of life care;
- ◆ Health professionals began voluntarily to offer additional support to scheme staff;
- ◆ Extra care staff knew more about what the local specialist services offered, and how to access these.

Four key issues emerged during the project and its evaluation. These concerned issues to do with:

- ◆ Promoting dignity and choice for older people and family carers
- ◆ Staff support and skills development
- ◆ Extra care and its links to wider health and specialist resources
- ◆ Commissioning and funding.'

It concluded:

‘Despite some initial lack of understanding of Extra care housing amongst service commissioners, health and social care providers and tenants and their families alike, this project demonstrated a very real desire to learn more about what was possible in terms of supporting people at the end of their lives in Extra care housing, and to put examples of best practice into place. What appeared to have been holding professionals and organisations back was essentially an uncertainty about what to do for the best, and a fear of doing something wrong

This relies heavily on knowing what tenants would like to happen; which in turn relies on asking them about and recording their wishes, and then ensuring these are known, respected and adhered to by all involved, whether family or paid professional. At the heart of effective personalisation and partnership working, everyone involved needs to have a shared understanding of their individual role(s) in helping the tenant achieve what the tenant wants at the end of his or her life.

Policy makers and service commissioners should ensure that Extra care housing is seen as part of the continuum of living at home, as part of the community rather than in the context of care homes.



Specific training for Extra care managers and staff should include new arrangements under the Mental Capacity Act 2005; symptoms of terminal stages of life and technical knowledge of what to look for, report and record; information about local services and how to access these; support for bereavement and grief.

- ◆ It is important for tenants and their families to have opportunities to discuss and record their wishes. A 'one size fits all' model is not appropriate and any questions or forms should be optional. Extra care providers should consider how to incorporate the issue of end of life care into existing policies and practices. For example, a simple question could be linked to an existing care or support plan.
- ◆ Tenants need to feel sure that their wishes will be respected as far as possible. This includes respect from families, even if they are opposed to what the tenant has chosen for him or herself.

Extra care housing providers should ensure that specialist support can be accessed for people with dementia or other mental capacity issues, so that the choices of people with dementia can be communicated and recognised.'

'What can help?

- ◆ Making sure that tenants know the scheme will do everything it can to support them to stay in their flat until the end of their life, if this is what they want.
- ◆ Creating early, and regular, opportunities for tenants and their families to ask about what level of care can be supported if circumstances change, and providing information that answers those questions.
- ◆ Recording tenants' wishes, and supporting them to share this with any relatives if they so choose.
- ◆ Having information about what support local specialist services can offer and how to access these; and about arrangements such as Lasting Powers of Attorney, and making advanced decisions.

The evaluation identified what seems to be a general lack of understanding over what Extra care housing is, and is not. This was proving challenging in several respects....Those health and social care professionals whose perception of Extra care is simply as an upmarket residential care home may wrongly assume that the schemes offer the same amount and type of overnight care as is provided in residential care.

Several reports were shared of hospital staff informing families that the tenant now needed nursing care and so could not return to the Extra care scheme, as this did not offer nursing services. This raised two issues: firstly the lack of knowledge about Extra care housing; and secondly, a distinct lack of partnership working across the acute and community health sectors. These conversations did not involve either the scheme manager, or the district nurses or Community Matrons – who between them may have been able to offer and organise sufficient support for the tenant to return home.



Flexibility to change the care provided, and the ability to do so quickly if someone's care needs radically change at the end of their life, are key elements. On occasions when a tenant's situation does deteriorate very swiftly, Extra care teams need either an existing, blanket, permission to increase support immediately (even if subsequently this has to be reviewed and reassessed) or need to receive specific agreement to do so within a matter of hours.

Translating the practical examples in this report of what a personalised approach or service ethos can mean for Extra care tenants, into contracts and specifications for future services, to ensure a match between the approach of landlord and that of care provider.'

## 9. The financial context

Housing LIN Factsheet 30 '**FCH and the Credit Crunch: impact and opportunities**' (2009) describes the changed financial environment for commissioners and developers, the problems this has created but the opportunities there can be for more social rented housing and for innovative approaches to the changed housing market.

Housing LIN Report **Marketing Extra care Housing** (2009) also considers the current context. It points to the need to increase awareness of FCH among 'commissioners, planners, investors, consumers and the public at large', and states that 'localism is central to marketing strategy' given the disparate nature of FCH and the interested parties. It found positive evidence of continuing, if slowed investment, and that the recession encourages a 'mixed economy' of provision, often within developments. Private providers now seem to be following not for profit providers and RSLs in looking at the value of partnerships, and developing schemes which will be characteristically mixed income and mixed tenure communities.

## 10. Extra care and Personal Budgets

Housing LIN Workshop Report **FCH and Personal Budgets** (2010) reports on a seminar at which 4 different approaches to the use of PBs with Extra care were considered along with wider implications. Most models involved a 'core and add-on' approach. The seminar was not conclusive but provides a good summary of options and issues arising at this stage of the development of both FCH and PBs. The Housing LIN concluded that 'all of the scenarios outlined in this report raise as many questions as they do answers'.

## 11 The range of FCH Schemes in existence

The range of FCH schemes in existence is wide. The following is drawn from the **Extra care Housing Toolkit** (Department of Health Care Services Improvement Partnership 2008) as shortened in the Leicestershire FCH Strategy 2010-2015. The Toolkit version provides examples of all such schemes.



Type of Scheme	Description
Purpose Built Extra care scheme without community resources	<ul style="list-style-type: none"> <li>◆ Normally around 40-50 units of accommodation in one location</li> <li>◆ Flats or bungalows</li> <li>◆ Scheme for use by residents only</li> </ul>
Purpose Built Extra care scheme with community resources	<ul style="list-style-type: none"> <li>◆ As above but with attached community facilities, e.g. resource or activity centres, health, recreational and leisure facilities, which are open to local older people</li> </ul>
Virtual Extra care	<ul style="list-style-type: none"> <li>◆ A team of home carers operate between the hours of 10pm to 7am to provide intensive support to vulnerable people otherwise at imminent risk of admission to residential or nursing home care or may be especially vulnerable after hospital discharge</li> </ul>
Core and Cluster Extra care schemes	<ul style="list-style-type: none"> <li>◆ Small local schemes with a core central building e.g. a scheme perhaps spread across four or five villages in close proximity to each other, with eight to ten housing units in each location but with services based at one central building. Shared housing, care management and staffing of all schemes</li> <li>◆ Local housing units are often bungalows</li> <li>◆ Schemes may be virtual, ie the link is via services provided rather than geographical closeness</li> </ul>
Remodelled Extra care	<ul style="list-style-type: none"> <li>◆ Probably at least 30 units of accommodation if they are to achieve economic viability</li> <li>◆ Due to the need for a minimum number of units to make a scheme viable, remodelling tends to be of newer and larger sheltered schemes or homes</li> <li>◆ Schemes may not have all the the facilities of a new build Extra care scheme, eg a buggy store and charge, extensive communal facilities</li> <li>◆ Cost in most instances will determine the appropriateness of ordinary sheltered housing for conversion</li> </ul>
Retirement Village	<ul style="list-style-type: none"> <li>◆ Large development - 100 plus units of accommodation - spread over one large site</li> <li>◆ Often incorporate a range of buildings including flats, houses and bungalows</li> <li>◆ Extensive communal, health and leisure facilities</li> </ul>



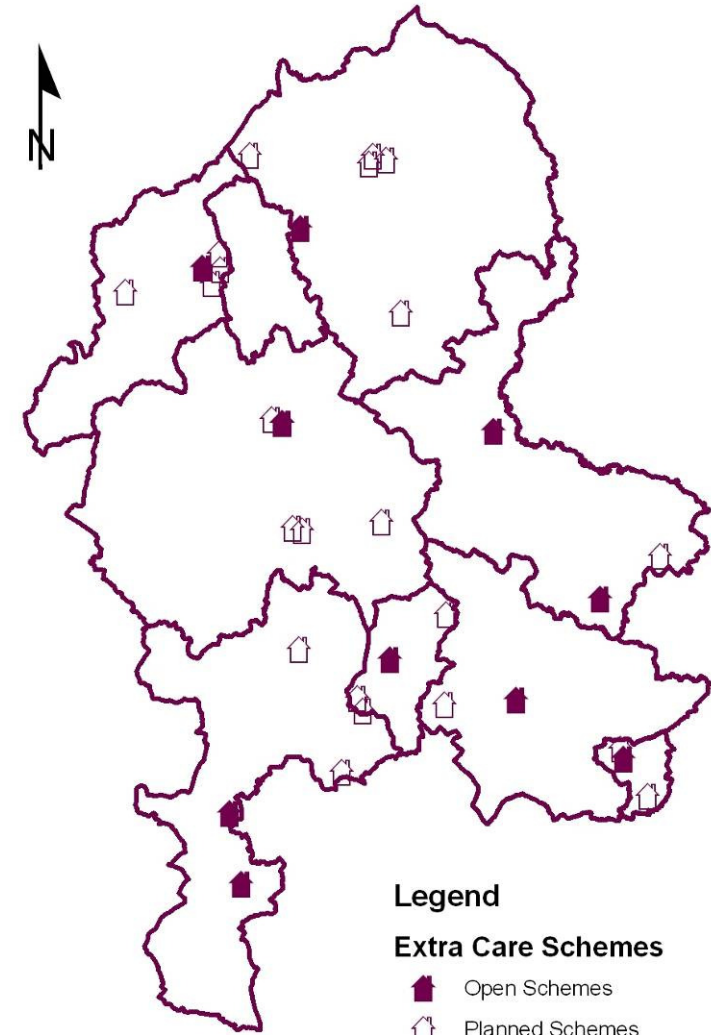
	<ul style="list-style-type: none"> <li>◆ Scheme may incorporate a residential care or nursing home on site</li> </ul>
Extra care schemes for people with specialist needs, e.g. dementia, learning difficulties	<ul style="list-style-type: none"> <li>◆ Smaller than many other schemes - often around 20 – 30 units</li> <li>◆ Scheme specifically developed for individuals with specialist need</li> <li>◆ Scheme incorporates specific care and health facilities, designed to meet the needs of these groups</li> <li>◆ Schemes may incorporate a day resource for individuals both in and outside of the scheme with similar specialist need</li> </ul>
Extra care linked to care home provision	<ul style="list-style-type: none"> <li>◆ Small number of units – often flats - attached to existing care home</li> <li>◆ Units often specifically for couples where one has a very high care need or specialist need and the other who is a carer</li> <li>◆ Ability to access care, support and facilities of existing home</li> </ul>
Extra care as a co-housing scheme	<ul style="list-style-type: none"> <li>◆ A model of shared ownership provision originally developed in the Netherlands and Denmark</li> <li>◆ Independent living within private space but alongside others within a community that promotes active engagement with others, in communal spaces and around common interests</li> </ul> <p>Key features are:</p> <ul style="list-style-type: none"> <li>◆ Private dwellings with common facilities</li> <li>◆ Resident structured routines and management</li> <li>◆ Design for social contact</li> <li>◆ Resident participation in the development process</li> <li>◆ Realistic social objectives</li> </ul>



# Appendix 4: Existing and proposed Flexicare housing schemes in Staffordshire

## Existing Flexicare Schemes – May 2010

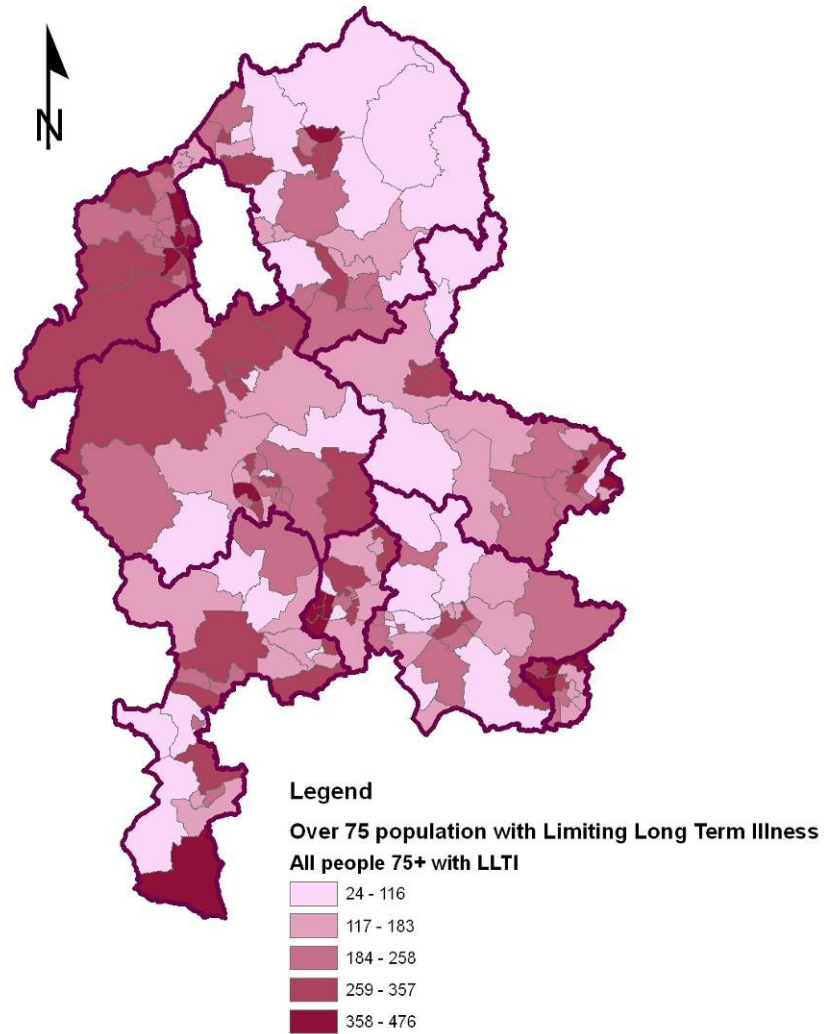
Scheme Name	District	No of Units
School Court	Cannock Chase	41
Highwood Court	East Staffordshire	38
Barton Mews	East Staffordshire	29
Beacon Park	Lichfield	135
Mill Rise	Newcastle	60
Brunel Court	South Staffordshire	35
Corsers Court	South Staffordshire	62
Jubilee Court	Stafford	43
Summerfield Court I	Stafford	42
Bagnall Heights	Staffordshire Moorlands	51
MacGregor Tithe	Tamworth	68



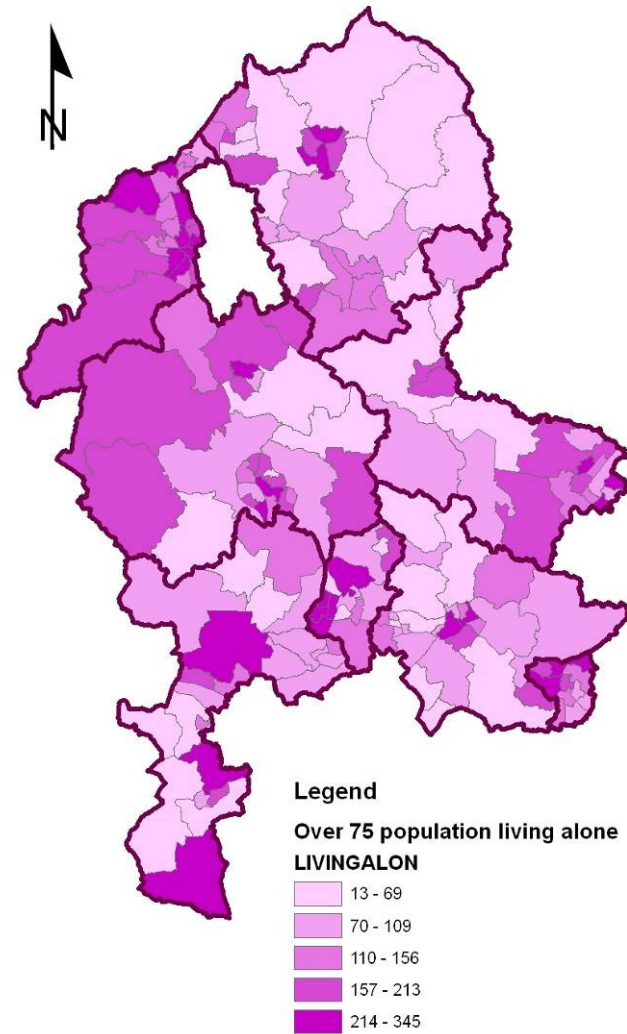
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## Distribution maps of over 75 population



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# Appendix 5 - Strategic Review of FCH. Executive Summary

## Introduction

The scope of the review was to consider six Flexicare housing schemes in operation at the time of the review. These were developed by Staffordshire County Council in partnership with housing associations and care providers. One scheme was funded through a Department of Health (DOH) capital grant, the remainder were funded by the Housing Associations, Housing Subsidy from the then Housing Corporation, and contributions of land and capital from Staffordshire County Council.

The schemes included in the review are:

Scheme	Landlord	Units	Care Provider	Support Provider
Beacon Park	Homezone Living	135	Extra care Charitable Trust	Extra care Charitable Trust
Brunel Court	Midland Heart Housing Association	35	Extra care Charitable Trust	Extra care Charitable Trust
Corsers Court	Housing Plus Ltd	62	Housing 21	Housing Plus Ltd
Highwood Court	Trent and Dove Housing Ltd	38	Housing 21	Trent and Dove Housing Ltd
School Court	Midland Heart Housing Association	41	Extra care Charitable Trust	Extra care Charitable Trust
Summerfield Court	Housing 21	42	Housing 21	Housing 21

The majority of the properties are apartments in a main block and are social rented. In the more recent schemes the developments have included bungalows and mixed tenure options. All of the schemes are aimed at older people.

The care provided in the schemes is through a block contract with a single provider in all cases. Housing support is also provided through a block contract arrangement. In some cases this is through the care provider, however in others it is through the landlord.



The scope of the review was to consider:

- ◆ Purpose of Flexicare Housing (FCH)
- ◆ Effectiveness
- ◆ Value for Money
- ◆ Quality
- ◆ Outcomes achieved
- ◆ Services users views
- ◆ Options for the future

A detailed review report is available at [www.staffordshire.gov.uk/health/care/olderpeople/extracare/review/](http://www.staffordshire.gov.uk/health/care/olderpeople/extracare/review/)

## Conclusions

The strategic review concluded that for Staffordshire:

- ◆ Flexicare housing offers a real alternative (to current residential and domiciliary care options) for older people with care and support needs. However the model needs to be fit for the future and adapt to meet changing needs, aspirations and expectations. In particular, Flexicare housing should be developed to support a wider group of people than older people.
- ◆ Flexicare housing buildings have been developed to a high standard, but it is recognised that the majority of provision is social rented. More tenure options need to be developed to reflect the fact that in Staffordshire 77% of people over the age of 55 are owner occupiers and will have equity to invest in their future housing and care needs.
- ◆ Service users express reasonably high levels of satisfaction with the current service model. However there were concerns expressed about whether Flexicare housing is normally a home for life as people who have developed more complex conditions have not been able to be supported within schemes.
- ◆ The current charging policy for Flexicare is unpopular and confusing for service users and families, in particular the “spot charge” for the two care bands is seen as unfair to those people receiving low packages of care.
- ◆ The support costs within schemes vary considerably and show no positive correlation between staffing ratio’s and costs applied.
- ◆ The current models of commissioning do not support personalisation.



- ◆ Commissioners and operational teams value the Flexicare housing schemes where they have been able to shape and influence the service model and have a direct influence on allocations within the scheme.
- ◆ There is little evidence of outcomes being achieved in Flexicare housing; however this is predominantly due to the care contracts not being outcome focused.
- ◆ Development to date has been opportunistic and for the future a strategy for Flexicare housing in Staffordshire should be developed to identify areas where development should be prioritised and options for pump prime investment should be capitalised on.
- ◆ There is little evidence of involvement of the NHS in the commissioning and development of Flexicare housing.
- ◆ There is low public awareness of Flexicare housing developments and what they can offer people.
- ◆ Front line staff are sometimes unclear as to the role of Flexicare housing and the context in which people should be referred.
- ◆ Although all the schemes reviewed knew the differences between tasks delivered as housing related support, and those of care, it was sometimes unclear who was delivering which elements, and that these were being done in the appropriate proportions in relation to the contracts in place.
- ◆ Allocations policies and processes were found to be inconsistent, and in some cases there were no formal arrangements in place which lead to difficulties ensuring appropriate nominations were made and that there was an appropriate care mix within schemes.

## Recommendations

- ◆ Care and support contracts within Flexicare Housing schemes should be subjected to market testing and contracts in a scheme should run concurrently with the same end dates.
- ◆ Joint working protocols should be drawn up in instances where there is more than one organisation providing the care and support.
- ◆ Flexicare Housing must enable people to have a home for life (if that is their preferred choice). This will require consideration being given to building design at the point of commissioning. Care and support services will provide a flexible solution which will be capable of adapting to meet people's changing needs (both short and long term).
- ◆ The care and support service within schemes will be redesigned and a model specification will be developed to outline the principles and outcomes.



- ◆ *FlexiCare* services will be commissioned in a way that ensures a seamless service is provided regardless of whether they are delivered by the same provider at a scheme.
- ◆ *FlexiCare* contracts will be designed in such a way that enable people to access direct payments and individualised budgets. This will be achieved through the use of block contracts solely for “core care and support” hours (ensuring 24 hour staff and night time response).
- ◆ *Flexi Care* services will be outcome focused and an agreed set of outcomes will be developed in partnership with service users and carers.
- ◆ Joint commissioning of *FlexiCare* will be explored with the NHS and systematic ways of involving the local NHS in the development and running of Flexicare schemes should be established with them.
- ◆ A strategy for Flexicare Housing will be developed and will pay particular regard on how to ensure meaningful engagement with service users and carers, and all stakeholders and partners for current and future developments.
- ◆ A fundamental review of the Flexicare Housing charging policy should be undertaken.
- ◆ Flexicare Housing will be developed as a resource for a wider group of people than it currently is. In particular for younger adults with disabilities, people with dementia and people with mental health conditions.
- ◆ A framework for Flexicare allocations/nomination policies and processes will be developed to ensure appropriate and timely nominations in line with both providers void turn around times and Social Care and Health assessment timescales.
- ◆ Flexicare housing schemes will be developed as a resource which benefits the wider community and this should be a specific requirement of the developer and care provider.
- ◆ A Best Practice Club for Flexicare providers and commissioners should be established in Staffordshire.
- ◆ A Staffordshire Flexicare/Flexi care marketing strategy should be developed to ensure all stakeholders including staff, service users and the general public are aware of what this resource offers.
- ◆ Appropriate training for front line staff including social workers, care assessors etc., on the Flexicare/Flexi care model. (Flexicare master class?).



# Appendix 6 Equality Impact Assessment

To be completed

