Agenda Item 6

Report to:	**Adult Social Care and Community Safety Scrutiny Committee**
Date:	**7 November 2013**
By:	**Director of Adult Social Care and Health**
Title of report:	**Evaluation of Extra Care Housing**
Purpose of report:	**To present the evaluation of Extra Care Housing to Scrutiny Committee for comment**

RECOMMENDATION

The Committee is recommended to consider and comment on the findings of the Extra Care Evaluation in East Sussex and to comment on the next steps planned.

1. Financial Appraisal

1.1. There are no direct financial implications from this report.

2. Background and Supporting Information

2.1. In February 2012 Cranbrook, the Extra Care Scheme in Eastbourne opened, completing the Phase 1 development of Extra Care by East Sussex County Council. This was seen as an appropriate time to evaluate the impact of Extra Care in the County (Appendix 1).

2.2. There are already a number of very positive reports about the general impact of Extra Care schemes nationally or in other localities, but there is no known study about the specific impact from an ASC perspective. This independent evaluation was commissioned to test two very specific Hypotheses which are extremely relevant to Adult Social Care:

a: Extra Care is a preventative service model which enables people to remain in the community and not enter residential / nursing care

b: Extra Care is a more cost effective model than residential / nursing care or clients own home.

2.3. The Methodology focused on establishing care and support needs using ASC assessment tools, support plans and housing assessments of the clients and feedback from both the scheme managers and the care provider managers. The consultant then made a judgement about where people in extra care housing would otherwise be placed if they were not living in extra care. The sample size was 199 out of 217 clients in total. ESCC Care Management then verified the alternative placements with a sample of those living in the schemes. There was a very high correlation between these 4 processes in the hypothetical alternative placements identified.

2.4. In the evaluation, the care and support needs were used to draw up and cost alternative care arrangements assuming the current placement in Extra Care would not be available, to establish a ‘traditional’ care scenario which could be compared with the placement in Extra Care.

Conclusion and Reasons for Recommendation

3.1. Both Hypotheses were overwhelmingly upheld. Extra Care is clearly a preventative model: If Extra Care was not available for ASC clients, 63% would be likely to need some form of residential, Elderly Mentally Infirm (EMI) or nursing care alternative. It is likely that 36% of clients would be able to live in the community, sometimes sheltered housing or their own home. However, they would still require support and care input. On average, Extra Care is also more cost effective than other traditional ways of delivering care and support. Generally the costs of care and support are half in Extra Care than they would be in alternative placements.

3.2. Clients have a superior experience compared to more traditional forms of care provision. They enjoy privacy, higher degrees of freedom of choice, a high flexibility of their care provision, the safety and enabling design of their home a nutritious, a high degree of social interaction and a good diet. Tenants generally report increased levels of wellbeing once they moved into Extra Care. One client, speaking for the majority of clients, expressed that she felt “Peace and Joy” since moving into Extra Care.

3.3. Main savings are from preventing clients needing residential and nursing care, but other, significant savings stem from gaining independence through an enabling environment and increased support through family, friends and neighbours.

3.4. Complex and integrated care, as well as joint working can be more easily delivered in Extra Care, as it presents fewer logistical barriers for agencies involved.

3.5. Key to the success of the model seems to be maintaining its integrity with its enabling design and an optimum mix of care needs. Whilst highest savings can be shown in the upper level of medium care needs, some clients with low care needs are also crucial to enable the concept of a supportive and balanced community to work.

3.6. The social aspect is incredibly important in Extra Care. Clients and Care Providers emphasise the importance of the meals provision for healthy nutrition, as well as the restaurant and meal times acting as a focal point in the day which also facilitates social interaction and social activities.

3.7. The evaluation will be shared intensively both locally and nationally, and used to inform work with relevant partners to develop a better grounded view on housing for older people in East Sussex as well as contributing to the national debate.

3.8. To provide a more rounded picture, additional information gathered routinely outside of the Evaluation of Extra Care about residents’ satisfaction and general impact of Extra Care on residents is also appended (Appendix 2).

3.8. After having proved the effectiveness of the extra care model further work is now planned to evaluate the current priorities and review ASC position to the development of future Extra Care schemes in the future.

3.9. Given the financial constraints in ESCC as well as the reducing subsidy for building homes, ASC is also investigating alternative approaches to enable further expansion with no reliance on capital funding, like utilisation of S106 planning conditions and alternative funding models.

KEITH HINKLEY
Director of Adult Social Care and Health

Contact Officer: Wolfgang Weis Tel: 01273 336829

Local member(s)*:* All
Background Documents: None

East Sussex County Council

Extra Care Housing in East Sussex Evaluation Report

Cranbrook
Eastbourne (2012)

Margaret House
Uckfield (2010)

Downlands Court
Peacehaven (2009)

Newington Court
Ticehurst (2007)

Marlborough House
Hastings (2003)

Report for East Sussex County Council Adult Social Care
June 2013

By Georgiana Robertson
Independent Consultant Social Care and Housing

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Extra Care Housing in East Sussex Evaluation Report

June 2013

Introduction

The reason for undertaking this evaluation of Extra Care Housing in East Sussex was to test two hypotheses set out by the Strategy and Commissioning Division of East Sussex County Council (ESCC) Adult Social Care, namely:

1. Extra Care is a preventative service model which enables people to remain in the community and not enter residential or nursing care.
2. Extra Care is a more cost effective model compared to residential/ nursing care or care provided in a person's own home.

This report is based on a snapshot taken between November 2012 and January 2013 of those people living in the five Extra Care schemes in East Sussex. It was a desktop exercise using Adult Social Care tools of assessment; social care assessments, reviews and support plans supplied for each person, authenticated by scheme visits and staff discussions and supplemented by housing needs assessments and housing support plans. This information has been further verified by a sample moderation exercise by ESCC Practice Managers. It can therefore be demonstrated that four separate processes have authenticated the evidence presented in this report.

The work has been interesting and rewarding. It reveals Extra Care schemes in East Sussex as places of quality providing a positive lifestyle for their residents, valued assets for the landlords, good work places for care staff and a sustainable care and housing delivery model that more people should be made aware of. I am happy to conclude both the above hypotheses are upheld.

The report is presented in sections. The main themes are summarised in an Executive Summary and Key Findings at the start of the report. Fuller evaluation is provided in the main body of the text with appendices containing numerical analysis of schemes individually and across the five schemes.

- ❖ For ease of reading the recommendation and action points throughout the report are denoted by this symbol.

More emphasis has been paid to people living in rented properties than shared equity flats in this report because it was commissioned by ESCC and these individuals represent the majority of their clients.

My thanks to all who have assisted with the work along the way.

Georgiana Robertson
Consultant, Social Care and Housing
June 2013

Executive Summary

Whilst all different in size, provenance and ethos, each Extra Care scheme should be recognised as a real success story. Almost without exception, people living there have enjoyed an excellent quality of life and retained their independence, which they cite as their most prized possession, an independence which is all too often eroded in later years by a combination of poor health, poor environment, loneliness or anxiety.

Extra Care encourages a significant amount of informal care to continue to be provided by relatives, thereby reducing the total amount of formal care required. Many people living in the schemes were couples where one partner cares for another. On average 23% of the population of all 5 schemes were, or had been couples, and in those cases where one partner had died, the remaining partner frequently continued to make a contribution to community life within the scheme. Families of those living in Extra Care remained regularly involved with their relative; for example at Downlands Court where almost 70% of current residents are actively supported by sons, daughters, daughters in law and grandchildren offering informal care.

All schemes catered for people with differing levels of care needs. This was an attractive feature for many living there and their families, and again promoted the ethos of independence and helping one another informally. In each scheme people could be grouped according to high, medium and low care needs.

The schemes deliver what they set out to achieve in terms of care profiles. Across the rented properties, which constituted 86% of total provision, 33% of people have high care needs, 27% medium care needs, 25% low care needs, and 16% nil care/voids.

Noticeably, in the latest scheme, Cranbrook, the number of hours of care required to qualify as the high needs band, over 15 hours per week was considerably more than in the earlier schemes, originally 10 hours plus, now 12 hours per week. A like for like comparison would show many clients categorised as having medium levels needs in Cranbrook (10 -14 hours per week) would have been categorised as high needs in earlier schemes, a reflection of how over time, the extra care concept has evolved in East Sussex.

The schemes are occupied by people who are appropriate to be there on the basis of care, support or housing support needs. On first assessment 85% of those living in the rented Extra Care flats are appropriately placed. On further scrutiny and review of these, the figure rises to 94% of people. Full details were not available across all shared equity properties, but where they were, they too were appropriate. These figures demonstrate a markedly high congruence between strategic purpose and operational delivery.

Extra Care is a real alternative to the option of residential care and nursing care. The hypothesis that Extra Care is a preventative service model which enables people to remain in the community and not enter residential or nursing care is upheld. Analysis of hypothetical alternative placements for the current population in the schemes show that 63% would otherwise be in residential or nursing care, with 36% hypothetically requiring domiciliary care in their own home or sheltered housing. This figure of 63% is more than the combined proportion of people in both high and medium care needs bands and is based on people in the rented flats.

It should be pointed out that a low level of need does not automatically equate with hypothetical alternative placements being low domiciliary care packages at home. The reasons for this are varied, for example couples where the spouse provides care, the enabling environment, the availability of housing support through the scheme manager or reduction of anxiety engendered by a secure environment. Suffice to say it is important to look behind the figures and percentages to reach a deeper understanding of this context.

Care Provider Managers acknowledge the advantages of the Extra Care delivery model in achieving quality and keeping overheads to a minimum because the domiciliary care service is delivered on the same site. For example, where two members of staff are required to deliver 'double up' care for part of someone's care package, this can easily be accommodated in the overall patterns of care delivery and staff deployment. Of the current population in the Extra Care schemes, those requiring 'double ups' ranges from 3% in Newington Court to 26% in Cranbrook. Care Provider Managers cite the advantages of care delivery within the Extra Care setting as the practicality and physical ease of care delivery; service users can be encouraged and prompted to do more for themselves in the accessible environments; consistency and reliability of care are easier to achieve and monitor; key worker systems can be supplemented as staff and residents get to know each other; staff time management, absences, and logistics are easier to manage and formal and informal customer feedback is more forthcoming.

There are many indicators to prove the second hypothesis that Extra Care is a more cost effective model than residential/ nursing/care in own home for ESCC. These include:

- the cost effective care delivery model
- the high levels of informal care available to supplement formal care
- people paying their own housing, utilities, council tax and food costs in Extra Care so that ESCC pay care costs only (depending on financial assessments)
- such a high percentage of people are appropriately placed **and** would still require a care and support package if they were not living in Extra Care
- care and support packages could be higher as they would be delivered in less accessible accommodation on a more dispersed basis
- the strong preventative aspect of Extra Care as so many people would otherwise require a higher level of care in residential or nursing care

All of these indicators suggest that Extra Care is a cost effective model.

Detailed financial work has been undertaken by ESCC and is contained in a confidential Financial Analysis Report (June 2013). The headline message of their analysis is that the comparative costs of re-provision for the alternative placements represents a significant increase over the existing costs of Extra Care Housing. Whilst methodology and full details of this report are confidential to ESCC, in headline figures using actual unit costs, the value for money case is clearly made. The greatest savings in avoided costs are attributable to Cranbrook, as the most recent and largest Extra Care scheme, suggesting that this is the model to replicate in future Extra Care schemes.

Staff calibre was high amongst Scheme Managers and Care Provider Managers who were knowledgeable, with a strong commitment to assisting older people living at their schemes to maximise the benefit of living there. They presented as constructive

in all meetings. Feedback and learning between themselves and the Care Commissioners appeared to be strong and was valued, thereby forming a good basis for any future developments.

The appendices provide data about each scheme plus analysis across all the schemes to be set alongside the contextual information within the main body of the report. It must be stressed that quantative and contextual data need to be viewed together to tell the whole story.

The following table provides summary details of the five existing Extra Care housing schemes in East Sussex:

Scheme Name / Location	**Number of Flats**	**Year completed**	**Registered Provider**	**Care and Support Provider**
Marlborough House Hastings	40 (all rented)	2003	Hyde Housing	Allied Healthcare
Newington Court Ticehurst, Rother	35 (all rented)	2007	Amicus Horizon	Care at Home Services
Downlands Court Peacehaven, Lewes	41 (30 rented, 11 shared equity)	2009	Saxon Weald	Housing 21
Margaret House Uckfield, Wealden	39 (29 rented, 10 shared equity)	2010	Saxon Weald	Housing 21
Cranbrook Langney, Eastbourne	62 (52 rented, 10 shared equity)	2012	Saxon Weald	Housing 21

Key themes from this study of Extra Care

Extra Care works in many ways and on many levels:

- Extra Care is an alternative to residential and nursing care
- Extra Care offers value for money and a sustainable care delivery model for social care, housing and health
- Independence is valued by individuals, Local Authorities and the Government - these schemes deliver on this
- Help from families and neighbours and the housing support provided by the scheme manager combined with the good design of the accessible, physical environment have reduced care packages
- Families retain positive involvement
- Couples can continue to enjoy a quality lifestyle
- Client mix is a positive attractive feature and overall user satisfaction is high
- Staff are of high professional calibre, consistently know their clients well, are motivated and are open to new ideas in all schemes

Key findings across all the schemes

Number of flats,
In total there are 217 flats, of which 86% or 186 are rented, 14% or 31 are shared equity.
Two schemes are 100% rented, three schemes have shared equity flats. Newington Court and Marlborough House are all rented; Margaret House and Downlands Court have 25% shared equity properties; Cranbrook has 16% shared equity flats (an equivalent number to the other schemes, but a lower percentage due to its size).

One bed and two bed flats
58% of the total properties are one bed. Newington Court and Marlborough House have 90% one bed properties compared to Margaret House and Downlands Court having almost equal numbers of one and two beds. Cranbrook has only 30% one bed and 70% two bed flats.

Age
Across the schemes (whose ages were known) 65% were over the age of 76 years and of these 35% were over the age of 85 years. Where people were younger, noticeably in Cranbrook, where 49% people were under 75 years, the Extra Care schemes were appropriate for them.

Couples
13% of the current population were couples. On average it was 23% when a scheme first opened, but reduced markedly as the years passed. In all schemes there were twice as many women to men. Many widows/widowers/ ex-partners continue to contribute to the schemes and also to benefit from the support that living there offers them.

Care profile and usage
82% of all people living in the schemes had care needs, of these, 74% were in rented properties and 9% were in shared equity properties. In the rented properties 86% of the people received care and in the shared equity properties 61% people received

care. There were 4% void properties so no care was being provided. 13% of the total occupied properties had no care, (10% rented and 32% shared equity properties). In these cases usually people had informal care from spouses or relatives, additionally the accessible environment and meal service often meant they had regained personal independence, such as being able to shower by themselves. In summary, the environment in these cases provided the necessary assistance, not staff care.

Overall 32% of the current population who rented had high care needs, 27% medium and 26% low care needs with 11% not receiving a care package and 4% of flats were void at the time of this report. These percentages varied from scheme to scheme. It should be noted that the number of care hours constituting high, medium and low dependency levels has increased during the time Extra Care has developed in East Sussex. This has resulted in some variations between schemes. This report uses the definitions of high, medium and low care bands relevant to each scheme and has not tried to normalize them.

Dementia and 'Double Ups'

The number of people with a formal diagnosis of dementia was 14.0% on average across the schemes (rented flats only), rising to 18.3% if informal diagnosis was added in. Usually people with quite advanced dementia were able to live in the schemes as their condition progressed. Throughout the investigation for this report positive attitudes were encountered from those staff I met, often accompanied by stories of helpful neighbours.

In terms of 'double up care', i.e. two staff required to help one person, an average of 15.6% of people across the schemes currently require this. The range was considerable, from 3% of the current population in Newington Court to 26% in Cranbrook. These are snapshot figures as previously the Newington Court figure had been 9%. ('Double up' care is a useful proxy measure for cost effectiveness as it can be difficult logistically to arrange in some community settings, especially rural areas).

Care Alternatives

Hypothetical alternatives of where a person would be living if they were not in Extra Care revealed 64% would need some form of residential care or Elderly Mentally Infirm (EMI) or nursing care alternative, with the remaining 36% requiring domiciliary care at home or in sheltered accommodation. There are considerable variations between the different schemes with Cranbrook and Margaret House (rented flats) having 75% of the current population requiring residential or EMI or nursing home care, Newington Court 66%, Downlands Court 52% (rented flats) and Marlborough House 45%. In all schemes, the combination of an accessible environment, a meal service, the presence of spouses/relatives/ neighbours and the reassurance of care on-site, and help on hand by the scheme manager, if required, lessened anxiety. These were all potent contributors in helping people to maintain or regain their independence.

Appropriate Placement

The following question was considered: Is living in an Extra Care scheme appropriate as a placement or not? In all cases the answer is overwhelmingly 'Yes'; the schemes are fully occupied by people who are appropriate to be there. On first assessment 85% of those living in the rented Extra Care flats are appropriately placed. On further scrutiny and review, the figure rises to 94% of people in the rented properties. Full details were not available across all shared equity properties, but where they were, people in these properties were appropriately placed.

Financial Analysis

Full details of the financial analysis are contained in a separate ESCC Financial Report (June 2013) which is confidential to ESCC. Suffice to say, following detailed financial analysis and scrutiny ESCC has concluded that Extra Care schemes offer value for money in both gross and net overall costs. The latter takes account of client contributions, compared to the costs which would have been incurred in alternative placements. Cranbrook offers the greatest amount of avoided costs/ savings compared to alternative placements and represents a model to replicate in future schemes.

Revenue : On average, the cost of a placement in extra care is half that of the alternative placements.

Capital : Return on capital investment by ESCC (based on capital contribution in the 5 schemes and gross savings) is 1.5 years in the best case scenario and 3.3 years in the worst case scenario.

Appendices

The appendices contain detailed data about the schemes as follows:

Appendices 1 – 6	headline data from all schemes *(attached to the main report)*
Appendices 7 – 9	more detailed scheme specific data *(available to relevant stakeholders within each scheme)*
Appendix 10	confidential anonymised case studies for each scheme *(available to relevant stakeholders within each scheme)*

In Summary

86% of the 217 total Extra Care housing apartments in East Sussex, or 186, are rented properties, the remaining 14% or 31 flats are shared equity. The void rate is low, overall 4% at the time of this snapshot, 4% in the rented sector and 6% in the shared equity sector. The majority of residents use care, 82% of the total or 86% of those in rented flats, overwhelmingly from the on-site care provider. The accessible physical environment, housing support, the enabling ethos of the schemes and availability of informal care from relatives and partners mean that those 18% not using care, (as well as those using less than they might otherwise have done), are nevertheless appropriately placed. 94% of the people living in the rented flats are appropriate to be living there. On average, across the schemes, 10.6% have come from hospital into Extra Care and 14.0% have a formal diagnosis of dementia, rising to 18.3% across all schemes if informal diagnosis is added in. ‘Double up’ care is currently required by an average of 15.6% of people across the schemes.

Hypothetically, if they were not living in Extra Care, 63% of the rented population would be in residential or nursing home care. Value for money is shown in many ways within the schemes. For ESCC, Extra Care schemes are a cost effective way of ensuring quality delivery of care and support and avoiding the additional costs incurred by alternative placements. The ESCC Financial Report has detailed analysis of the financial considerations for ESCC.

Main Report

Findings

Across the 5 schemes there are 217 flats, the majority rented, 186 or 86%, with the remaining 31 or 14% shared equity (Appendix 1). Two schemes, Newington Court and Marlborough House are 100% rented, Margaret House and Downlands Court have 25% of flats as shared equity and 75% rented and at Cranbrook 16% of the flats are shared equity. The split between one and two bed properties is reflected in the age of the property with a higher proportion of one-bed flats compared to two-bed flats in the older schemes. 90% of the flats at Newington Court and Marlborough House are one bed flats. Margaret House and Downlands Court have almost equal numbers of one and two bed flats within their schemes, whilst at Cranbrook almost 70% of the flats are two beds. Across all schemes the proportions even out so that in total there are 125 or 58% one bed properties and 92 or 42% two bed properties (Appendix 5). At the time of the study there were a total of 9 vacancies or 4%, almost all brought about through death of the occupant or, in rare cases, moving onto a more intensive care setting such as a nursing home.

Three schemes, (Margaret House, Downlands Court and Cranbrook), where Saxon Weald Housing are the landlord, have some shared equity flats. Where details of these people were available to this study, their profile was well suited to Extra Care in terms of age, number of couples and range of care needs, lending reassurance that the landlord was marketing the scheme correctly to appropriate people and that commercial imperatives to sell to the first bidder were not completely dominant.

One scheme, Newington Court, has original tenants who have lived there from the outset and occupy 7 flats (this scheme developed when a sheltered housing scheme was incorporated into a new build extra care scheme). All schemes have tenants who have moved from other sheltered housing schemes that were closing, reflecting the genus of Extra Care housing as both an accommodation **and** a care alternative.

- The vital word here is *and*. People who move into these schemes should have a genuine housing need *and* a care need. If they have only one type of need, such as needing *only* care, or *only* accessible accommodation or a need for housing support, but have no or negligible care needs, it is more appropriate to consider other personalised care or accommodation options because this makes best use of the overall asset. However, if there is a shortage of other accessible accommodation this must be addressed strategically by key Housing and Social Care partners to ensure scarce resources are used appropriately.

Age Range

The age range within all the schemes is highly appropriate. Typically almost 40% of tenants are over the age of 85 years, the exception being at Cranbrook where the proportions are inverted and almost 75% are aged below 85 years (see Appendix 2). Across the schemes 30% of people are in the 75 – 85 years age bracket. None of the schemes reported any problems arising from the mix of ages living in the scheme, except in the case of one younger individual who felt isolated. This is currently being addressed by altering the care and support package to include socialising outside of the scheme. In many instances the schemes cited the varying

age and care profiles as positive features within the scheme, giving examples of how people positively looked out for others of different ages and differing care needs. There is a 2:1 ratio of women to men at all ages.

Couples

Extra Care housing schemes have a unique selling point for couples, as a setting in which couples, where one partner is more dependent than the other, can remain together and receive the care and support needed. Extra Care schemes offer respite for the carer partner and provides both parties with the reassurance of personal security and help on hand in those 'what if…' moments. All schemes had couples living there, on average this was 13% of the overall population across all schemes. Sometimes they occupied two bed flats, sometimes a one bed flat. All schemes had commenced with an average 23% of their population being couples, (range 15% - 27%), but in those schemes that had been open for longer, the proportion of couples had at least halved (Appendix 4). Therefore all schemes had widows, widowers, and partners still living at the scheme. In most cases, quite apart from their tenancy rights to continue to live there, this was appropriate as they qualified on care needs alone or, if not, on the less articulated and less formal basis of age profile and 'giving back' to the scheme.

- ❖ It is important that landlords highlight to prospective tenants both verbally and formally in writing what their succession rights are and what they are not. It is equally important that care staff and families also have a firm grasp of these facts so all are clear on this emotive issue.

There are numerous examples of people who have been bereaved gaining a lot of support from the scheme and also giving back to it. One example is of a man aged 79 years who moved in to support his older cousin (since deceased). He has no care needs, but he now supports another gentleman he has met in the scheme, and runs the cinema group and produces the scheme's newsletter. Neither gentleman requires a formal care and support package as a result. If these facts were simply interpreted in stark terms as two people not requiring care, or an unnecessary use of a scarce resource, it would under-represent this positive outcome (Appendix 4).

Complement of one and two bed flats.

Inevitably there are more two bed flats in the later schemes; approximately seven one-bed to each two-bed in Newington Court and Marlborough House compared to half and half in Margaret House and Downlands Court and a remarkable twice as many two beds as one beds in Cranbrook. Whilst it may be predominantly a question for Registered Providers considering commercial aspects of the proportion of one to two bed flats that they build, from the number of couples within a scheme, approximately 20% (max 27% at Downlands Court and Cranbrook when they first moved in), it is not pressing that more two bed flats are developed.

If a scheme was to be built especially to attract downsizers and to free up family housing from either private or public housing markets, it is likely there would be greater focus on developing two bed flats.

- ❖ It is important for commissioners to know the market a scheme is aimed at.

- Understanding the strategic fit of an Extra Care scheme in relation to local accessible housing and alternatives to residential care provision is important for commissioners.

By far the greatest feature of Extra Care is the attractive combination of easy accessibility, generous space, storage, meals, care and support on site as required and a sense of security and community. It is this that offers 'a place to live' as a positive choice and not as a 'no other alternative but some form of residential care' option. Families seem to like the schemes and make use of the guest flats rather than seek to have their relatives in two bed flats.

- There is an important challenge to publicise and market the schemes to people in the development phase. This includes to staff as well as potential residents and their families. One staff member had referred to the Extra Care scheme in her notes as 'Easy Care Housing'.

Dependency levels; Different levels of care needs

All schemes adhere to the ethos of having a mixed community of people with differing care needs, typically divided into those requiring differing amounts of help (low, medium and high levels) with their personal care. This should be an intrinsic feature of Extra Care housing schemes and fosters a spirit of self and mutual help as well as enabling couples to live a fulfilled life in the schemes.

What is defined by each of the dependency levels varies across the schemes. Over the years ESCC has changed the criteria relating to the different care bands so it is important that everyone associated with a scheme understands what the criteria is.

The early schemes, Newington Court and Marlborough House, were developed on the basis of 10% nil care, 30% low, 30% medium, and 30% high care needs, where 10 hours plus per week constituted high needs.
The later schemes, Margaret House and Downlands Court were developed on the basis of 20% low, 40% medium and 40% high care needs where 12 hours of care per week constituted high care needs.
Cranbrook, the latest scheme, was more varied with 30% low, 40% medium and 30% high care needs, where high needs equated to 15 hours care per week, medium 10 - 14 hours per week (i.e. high needs in the other schemes) and low needs being differentiated into 10% very low at 2.5 – 5 hours per week and 20% being moderately low at 5 – 9 hours per week (or moderate needs in the other schemes). Cranbrook specifically also had as part of its admission criteria that 15% of flats, or 9 in total, would be offered to older people with an additional formal diagnosis of either mental health needs or learning disability. Of these it was further agreed that no more of 5 of these flats would be offered to people with a learning disability.

All schemes provide specific housing support to tenants that is delivered through the scheme manager.

The process of working out who has low, medium and high needs may appear straightforward, but in practice it is not so. A concrete example can be drawn from one scheme where a person requires many hours of input from the care provider to help manage her medication at specific times of day, i.e. high needs in terms of hours, but was regarded by the care provider in some ways as having low needs as she required no personal care such as getting up, going to bed, toileting, eating etc.

The plan is to reduce this level of hours so as not to 'disable/ induce dependency' for her. The attitude of the care staff is refreshing as they regarded this person as very able, but burdened by having to manage a complex medication regime. Nevertheless care contracts have to be based on agreed and measureable criteria. For the purposes of this report the person was deemed high needs having 28 hours per week.

The Care Provider cited this person as summing up what Extra Care living is about; delivering time specific medication regimes to single people in the community is a logistical nightmare, but relatively easy within an Extra Care setting. As someone who was very vulnerable in the community and taken advantage of, since moving to Extra Care in July 2011, this lady has become more confident and independent. She is no longer dependent on her brother doing her shopping, but does it herself, has involvement in her own finances, is eating far better and has graduated from pureed onto solid foods, so her medication is working better as her body is absorbing more nutrients. She no longer attends 2 hours per week of day care, but instead participates in social activities within the scheme. This compares to her isolation, loneliness and refusal to join in things when living alone. She says she has felt "peace and joy" ever since moving to Extra Care and is very happy. Each scheme can cite similar examples to celebrate.

The mix of high, medium, low care needs as currently apportioned across the schemes is shown in Appendix 3 for all rented flats. For some shared equity flats no information was supplied; for others who did use the care services, partial details were available. It was not the case that people in shared equity flats had no care input. Many people in shared equity flats also used care services. Once again it is encouraging that the landlords have marketed and sold predominately to people who fit the overall profile of others in Extra Care housing. Some people have fluctuating conditions, sometimes requiring high levels of care and at other times being able to manage on less. This flexibility of care delivery is a positive aspect of Extra Care and should be retained in all future care commissioning.

At Downlands Court a particular feature of the care profile is the high number of very dependent people (47% with high care needs in the rented flats, Appendix 3). Analysis of the figures show they actually have the expected number of people in both the high and the low care bands and have a lower than expected number in the medium care band (5 – 12hours per week). They report that it can feel like 'all or nothing'. The contrast particularly comes as many in the high band have very high levels of care. Further analysis of the17 high dependency people shows:

- 14 are in rented flats, 3 are in shared equity flats
- 8 people require double up calls
- 9 people receive 20 plus hours of care, ranging between 21 and 36 hours per week, with an average of 29 hours; 8 of these are in rented flats

Care staff question whether in practice they have too many people in the low care band reflecting they also have another 10 flats with no care delivered at all. This has to be seen however in the context of the contrast with the high care band and not wanting the Extra Care setting to appear to be a nursing home in all but name. Of the flats where no care is delivered there are explanations behind the statistics; 2 are vacant, but future occupants are likely to have care needs, 2 house widowers who contribute to the scheme and whose wives used to require care and 2 house current couples where the spouse does all the care rather than receive formal care. Most of these are shared equity flats, i.e. 6 of the 10, and include someone aged 88 years on

the original Steering Group for the scheme development whose husband died before they could move in together.

It should be pointed out that low levels of need do not automatically equate to hypothetical alternative placements being domiciliary care packages at home. The reasons for this are varied, e.g. being a couple where the spouse provides care, the availability of housing support through the scheme manager, the enabling environment, or reduction of anxiety engendered by a secure environment; suffice to say it is important to look behind the figures.

- There must be clarity and agreement between Commissioners and care providers about what the dependency level definitions formally mean; these will need to be revisited from time to time.
- Commissioners should seek to ensure that there is flexibility in care delivery. This is intrinsic to the model as it enables fluctuation in the care and health needs of people and their carers to be met appropriately.
- When commissioning care for the future it is important that Commissioners are clear about what they are looking for, e.g. as per Cranbrook criteria, but recognize that in reality it is a more fluid picture. One way of gauging this is to look at some of the people at the margins of the dependency level bands and see where improvements or deteriorations have occurred.
- The proportion of hours in the high, medium and low care bands per scheme should be reviewed across the schemes. Commissioners need to feel confident schemes are achieving the right balance of care, but equally for providers, the criteria change from time to time. If many people have very high levels of care in a scheme, care providers may perceive that the care needs in a scheme are high overall.

Hypothetical Alternatives

For this report I was asked to consider, 'Where would people be living if they were not living in Extra Care and what would the hypothetical alternative placement be for them?' Information was supplied to me by ESCC from their records and my findings were verified with the Care Provider Manager and Scheme Manager jointly at meetings at each scheme. ESCC Practice Managers completed a verification exercise and made their own recommendations of hypothetical alternatives for a sample group of residents at each scheme. Hence four separate processes have authenticated the evidence presented here.

There were 6 hypothetical alternatives;

- Support at home through domiciliary care in a person's own home, termed ***dom*** at home
- Support in sheltered accommodation, termed ***sheltered***
- Some people considered might at present manage at home with care, but it was unlikely to be sustainable beyond 6 months and these were termed '***very short term dom'***. It was considered likely that if this was not sustained, these people would require some form of residential placement as an alternative
- Moving into a residential care home placement, termed ***resid***
- Moving into a care setting especially for people termed elderly mentally infirm, termed ***EMI***. Further work has been done to establish EMI residential or EMI nursing care
- Moving into a nursing home placement, termed ***nursing***

The findings are set out in more detail in Appendix 6 and summarised in Appendix 1. Analysis of the hypothetical alternatives shows that Extra Care is a real alternative to residential care.

For 36% of current Extra Care residents (in the rented flats) across all schemes the hypothetical alternative placements would be a support at home alternative, either domiciliary care in their own home or in sheltered accommodation. For the remaining 63% of current Extra Care residents (in the rented flats), their hypothetical alternative would be some form of residential care, namely either a residential care home, or an EMI placement or a nursing home placement.

It is significant how many people would be in residential, EMI or Nursing home care as a hypothetical alternative to their current living arrangements. This is higher still if all those deemed as 'very short term domiciliary' are added into the collective residential number. The reasoning behind this is that if their short- term domiciliary package was not sustained, (deemed unlikely to be beyond 6 months.), it was considered that these people would require some form of residential placement as an alternative. Notably, for many of those deemed hypothetically either residential or EMI or nursing home care, the Care Provider Manager commented '…but it would not suit her or she would hate it'. This is a powerfully positive message about the benefits of Extra Care, repeated in all the schemes.

It is worth noting that some people had done so well since moving in to Extra Care that they would now manage in their own home with domiciliary care. An example was an 81 year old lady who moved from sheltered accommodation to one of the schemes and now has only 1 hour per week domestic assistance but no personal care. Eight months after she moved the care manager wrote:

"Since moving to this scheme, Mrs. X has found that her need for social care has really decreased; being in a better, more modern and accessible environment has had a positive impact on Mrs. X's health, and the easy access and social activities mean that Mrs. X's needs to have a sociable time with other people, and to be able to get out and about independently, are being met simply by the new environment. Mrs. X continues to have quite complex health needs which are a combination of COPD (Chronic Obstructive Pulmonary Disease) and diabetes; she remains prone to chest infections (although again this has really improved since the move)".

A few people had not needed much, if any, care when they first moved in, notably the original tenants at Newington Court, some of whom were living in the sheltered scheme which formed part of the new extra care scheme. However, by the time of this study they would have needed a care package if they had been living in the community and not in Extra Care. By contrast, in Downlands Court, nearly half the current population would hypothetically otherwise be in residential, EMI or nursing home care; 53% of the 36 flats (where information was known) or 52% of the 29 rented flats (where the information was known). This figure is somewhat above the percentage of people in the high care band and reflects the effectiveness of the Extra Care environment for medium and low care needs people. Obviously where people are, or have been couples, they would not have been able to remain living as couples in residential care settings.

Two significant themes emerged when reading ESCC Social Care assessments, support plans and reviews and considering alternative placements; accessibility and independence.

1) **Accessibility**
Many people in the Extra Care schemes found they were more able in this environment and did not require as much equipment or assistance because the environment is accessible. Frequently in their previous accommodation they were rendered disabled, unable to manage either external or internal steps or the small dimensions of the rooms in their accommodation. In other words they felt their home environment trapped them. This had a disproportionate, negative impact on their wellbeing, confidence, self-perception and dependency on others. It also significantly increased their loneliness and reduced their quality of life.

2) **Independence**
Independence is what we all want, the 'golden nugget' everyone prized. I was struck by the persistence of this throughout all the assessments I read. This is why people clung onto their home environments, even when far from ideal, why some declined assistance when in the schemes, although some also did not want to pay for it. Even with equipment, such as commodes, support bars, wheelchairs or major adaptations, on the whole people were nowhere near as mobile and fit as they were when they moved to an accessible environment and regained their skills of independent daily living.

- The message that Extra Care settings permit people to remain independent for longer should be publicised more widely to people, families and referring agencies.

Appropriate Placement or not?

Another key issue addressed in this report is 'Are people appropriately placed in Extra Care?' The answer (based on the 189 people who were assessed) is overwhelmingly 'Yes' for 95% of these individuals.

Where there are some unknowns or questions about appropriateness these mainly arise from shared equity clients where full details are not known, widowed spouses, people who have made good progress whilst in the scheme, or some of those who have moved from previous accommodation that was closing, i.e. decants, for whom the accommodation is suitable but who do not require the care. In a handful of cases there is another reason, e.g. frequent movers or very disruptive tenants. As ever, the qualitative information behind the quantative information tells a fuller story as some of the case examples already cited show. (See Appendix 1 for summary and Appendix 6 for more detail).

On first assessment, two schemes appeared to have a higher number of inappropriate people living there (Marlborough House and Cranbrook) but there was not a correlation between either the length of time the scheme had been operational nor between the eligibility criteria for the scheme and the number of inappropriately placed people. Cranbrook has a higher number of younger people with high support and low care needs, a higher number of people with no care needs, and a higher number of people on first consideration deemed to be inappropriate. The most likely reason for all of these is the high number of people who moved from other accommodation, so called 'decants', which might reflect the lack of alternative local accessible accommodation. However, on review, no scheme had a significant number of inappropriate placements, especially amongst those tenants in rented flats.

The review of appropriateness revealed a proactive attitude amongst staff in all schemes. Staff commented on residents' overall level of need and their use of facilities within the scheme. Where current residents neither needed, nor used, the full range of facilities, they deemed such people inappropriately placed and considered other people might benefit more. This is helpful and a positive, but firm, position, worthy of further peer exploration, because many people would have still needed similar or more costly alternatives if not living in an Extra Care setting.

Taking account of the above, some of the appropriate/not appropriate categorisations have been revised. Where this has occurred it is made transparent in all the spreadsheets. These revisions and the revised figures are based primarily on the fact that either the person was an ex-carer and their spouse/partner had died, or they are over 80 years old now, and/or they made a positive contribution to the scheme. Admittedly it is more an art than a science, but reasons have been stated, clearly linked to specific people, thus making the reasons for these revisions as transparent as possible.

In the final analysis one of the main reasons why people may not be the most appropriate for Extra Care is not simply that they require little personal care, (or sometimes will not accept any care), but that they neither use nor contribute to the Extra Care community. In some instances they may actively disturb it on a long term basis (i.e. not just occasionally). It is these people who impact on a scheme. It would be a mistake to assume all of these people are simply so independent they do not require care; it is more a case of requiring a different care package, and a different accessible environment, but not in an Extra Care setting.

Several key issues which emerged include:

- One of the biggest challenges that this study points to is the availability of accessible accommodation. A key strategic question is: what alternative suitable resources for people who require accessible accommodation are available?

- Is enough recognition being paid to the preventative and maintenance of wellbeing aspects offered by Extra Care schemes?

- The implications are that Extra Care is a valuable resource, so who is referred and accepted into schemes needs to be actively managed; equally some people improve markedly in Extra Care and because of this success, they no longer need it.

- Are people encouraged to consider moving on from extra care housing if this was seen as an appropriate option due to independence being regained to a level whereby they could live in sheltered housing or a similar housing resource?

Personalisation and Management

Having one provider of domiciliary care on site at each scheme simplifies the management of the scheme for the care commissioners, simplifies the care delivery patterns for the provider agencies and appears to offer a high quality service to the schemes' residents. Given the choice, most people in both rented and shared equity flats use the on-site care provider. A few people who originally moved in using a care

agency of their choice have since changed to the on-site care provider as they see the staff in the building are familiar with them and benefit from their presence within the scheme. This leaves a very small minority of people in the shared equity flats that have a different care agency of their choice.

One example illustrates many of these issues. A man who had Direct Payments, used his money to continue to purchase care from the agency, which he used before he moved into extra care, because he wanted a specific care worker to continue to provide his care. It appeared to be an attachment to the worker rather than the agency which was key to this decision. Whilst this was entirely his choice, some obvious quality issues have ensued. One example was when the client was left in the dark for hours without any lights switched on because of the time of the domiciliary workers call, or delays or a change in the weather. Unless the client complained about these things nothing will change. In the community, clients often feel vulnerable or reluctant to cause a fuss. In Extra Care settings with the benefits of 'more pairs of eyes' and the on-site care team's ability to be proactive about situations, there is an opportunity for regular coordination and improvement. In this particular case it might even be that the worker would wish to transfer to the on-site care team.

- Whilst there are benefits from using other care agencies, coordination of care can sometimes be lost. In commissioning care for future clients, care managers and commissioners must not overlook the detail of how different service agencies work together on a day-to-day basis.
- Personalisation could mean being in charge and getting the service you want as a user, not necessarily stipulating who delivers it. On that basis, Extra Care is well placed to provide personalised care services.

In terms of management and service delivery, the Care Provider Manager based at Downlands Court particularly welcomed the attention to higher quality afforded by delivering domiciliary care in a compact setting such as Extra Care, compared to delivering care to people living in their own homes in the wider community. She commented on the benefits of getting to know clients better, being able to supervise staff more closely and that friends and neighbours could bring things to the attention of staff in a positive way on behalf of another resident, when they themselves might be reluctant to make a fuss. From her experience of managing a large domiciliary care staff team in the community, where she knew clients could be isolated and didn't know others in the same situation, she was convinced that clients did not deteriorate as fast in Extra Care compared to typical patterns in the wider community. She spoke glowingly of how even the chef kept an active eye on everyone and noted if eating patterns changed. An example of this was when the chef served food for a resident on a dark plate so she could distinguish the 'eating area' more easily. Written like this it sounds slightly like a 'Big Brother' environment, but in reality this was not the case at all. The reverse exists in fact; time spent with residents in the scheme revealed their skills, talents and abilities including being a good Samaritan to each other.

Another staff member similarly commented on the benefits of interagency working afforded by the Extra Care model compared to domiciliary care delivery in the wider community, where co-ordination can be more difficult to achieve. She spoke of working closely with GP's, nurses, day centre and activities coordinator staff which, with the best will in the world, she considered was not as seamless nor as widespread in the community. Obviously whilst this can be beneficial, it is equally as important to retain the positive aspects of people living in their own homes and avoid the negative aspects that can be regarded as an 'institutionalised feel'.

- A model whereby a prerequisite of moving into the scheme is that people need and use a basic level of service from the on-site care providers seems to be the route to follow, with additional services above this level being open as to who provides these. Experience to date suggests that residents will choose the on–site provider in the majority of cases.
- Something for the future would be proactive information sessions and planning for people, and their families, who might wish to move in or out of Extra Care. These could be hosted within the schemes and open to other people from the local community. They would serve as a forum for people to share their experiences of Extra Care and elsewhere as well as informally spreading the word of what Extra Care is about, whilst being able to see it in person. They could easily be run by local Third Sector groups.
- Delivery of domiciliary care within Extra Care settings could extend outside the setting of the scheme into the nearby local community; a so-called virtual extended Extra Care.

Family Involvement

All schemes reported a significantly high level of active family involvement, not just of sons, daughters and daughters-in-law, but of grandchildren as well, all helping with shopping, collection of medicines and taking relatives on outings and socialising. Some also assisted with domestic and laundry tasks. An example of the prevalence of this can be seen in Margaret House where 69% of the rented flats had family members regularly assisting with shopping and similar tasks and a further 3% of these also assisted regularly with domestic and laundry tasks.

All the Care Provider Managers spoke of expecting families, where they exist, to support relatives to be independent, not dependent, within their living environments. They also spoke of the bonus for residents of having an on-site team. Equally this was not an excuse for families to withdraw. On-site care does not mean an ad-hoc service, nor a 5 star hotel service, e.g. for those occasions when someone has dropped their TV remote. Care Providers were clear it is planned care, agreed for a purpose. In all cases people can, if they choose and could afford it, pay for additional services, and some do.

Obviously not everyone has relatives living locally or even in this country. Where they do however, this family support is positive for all involved and overall reduces the need for formal care. The design of the Extra Care schemes was positively welcoming to families. The self- contained nature of the accommodation lent itself to family visits. Several times during this study the attractive, modern, hotel style communal aspects of the schemes with their café facilities were cited as inviting places for relatives of all ages. The guest flats were also cited as an attractive feature used by visiting distant relatives, but no data was collected for this report, nor was any financial sum attributed to the avoided costs of care through family involvement.

Commissioning Care

It is important to be clear that care in an Extra Care setting is domiciliary care, delivered into people's own homes. People have the right to choose or refuse care. Extra Care is also something of a new hybrid service model which combines housing

with care and offers great opportunities for the positive delivery of care. It is important that all partners understand these key aspects of care delivery to the full.

ESCC have done a lot of work in recent schemes with new and potential residents to explain that there is a minimum level of service they must buy. If potential residents consider they do not require this service, or are unwilling to pay for it, then they are sign-posted elsewhere. This strategy is well worth continuing.

ESCC are working well with partner housing authorities, landlords and care providers regarding tenure *and* client mix within schemes; Cranbrook, the most recent, being a particular success to point to. Again this strategy is well worth continuing. The Care Provider Manager and the Scheme Manager mentioned the mutual learning and benefits this mixed tenure *and* mixed client care grouping had brought.
There are possible questions for ESCC Commissioners to consider, in discussion with their partner agencies. Some of these are listed below but what is certain is that Extra Care schemes should be used to their full potential. In recent national debates about the need to cater positively for the increasing proportion of older people in our society, Extra Care is a good example of a service model which does this.

Key Questions

- Given how many residential and nursing home placements are avoided by placement in an Extra Care setting and the congruent health gain, is there scope for joint commissioning with Clinical Commissioning Groups (CCGs)?

- Are care providers exceeding their service specification by the above and over- performing, rather than the more common concern of underperforming?

- Are there benefits in care providers and landlords working together as a consortium or partnership, or of the care across some schemes being jointly commissioned rather than scheme-by-scheme?

- Where do the current and future Extra Care schemes sit when it comes to considering other services which ESCC commission or grant support such as domiciliary care, meals in the community, day time support, particularly if these operate in the same neighbourhood and geographical area?

- Can Extra Care schemes play a role in reducing duplication and overlap of related services in a geographical area?

- Is there an outreach/community hub/ community focus to both care provider and landlord functions that could be factored in in future care commissioning specifications?

- Would joint training and information sessions between commissioning, care management, care provider, landlord and health staff be beneficial? Would some aspects of these be open to residents, their families, local commercial retailers and others? Dementia Aware Communities would definitely welcome such initiatives.

Financial Implications

Extra Care is preventative, promotes wellbeing, avoids referral to residential care and can generate significant health gain. The study has shown that if Extra Care were not

available 63% in total of the current occupants in rented properties would be in some form of Residential or EMI or Nursing care. See below for details.

Of the 179 occupied rented flats across all schemes, the current occupants would need the following range of placements:

- 38% of the occupants would require residential care ; this figure would rise to 44% if those whose hypothetical alternative placement was deemed 'very short term domiciliary care' were included i.e. people considered able at present to manage at home with care, but for whom the situation was unlikely to be sustainable beyond 6 months and if not sustained, these people would require some form of residential alternative
- 4% would require EMI care specifically for people with dementia, most of whom would need EMI residential care rather than EMI nursing home care
- 15% would require nursing care

It can appear; because of client contributions that residential care is a cheaper alternative to the local authority. Residential and nursing home care costs more than domiciliary care in gross terms, but these costs can be offset by higher client contributions, reducing the net costs to the local authority. This is counterintuitive to the promotion of service user independence as well as the opposite of using the least intrusive level of service. Nevertheless, it is relevant to Extra Care schemes because domiciliary care is delivered in these schemes, but residential and nursing care is avoided.

The financial analysis is based on 75% of the current Extra Care population (the number of people in Extra Care whose care and support is funded by ESCC, the remaining 25% are likely to be self funders). This examines actual current costs to ESCC of care and support in Extra Care and compares these to actual and published rate costs of alternative placements, net and gross, taking into account the differential rates of client contribution as well as factoring in Housing Support costs. Suffice to say ESCC has conducted a very detailed analysis and scrutiny of all the financial aspects. The conclusion is that on both counts of actual unit costs and published rate unit costs for alternative placements, Extra Care schemes offer value for money in both gross overall and net figures.

In general terms, care and support in Extra Care costs half the cost of the alternative placements (gross costs).From the capital perspective, whilst ESCC has only provided a small proportion of the required capital to build the individual schemes, this capital would be repaid in 1.5 years in the best case scenario and 3.3 years in the worst case scenario.

Of all the Extra Care schemes, Cranbrook, the newest and largest scheme, offers the greatest amount of avoided costs/relative savings compared to alternative placements.
It is felt that Cranbrook represents a model to replicate in future schemes.

What constitutes a financial saving?

When considering Extra Care there are unquestionable benefits in terms of quality of life for people moving into schemes. For the Local Authority there are financial aspects with many different perspectives to consider in any business case for Extra Care.

The following two areas are covered by the financial analysis undertaken by ESCC for this evaluation.

Actual savings: money that was spent on a care package or residential care placement that is no longer spent but saved. This applies to some people in each of the schemes who have moved out of residential care or hospital into Extra Care. On average 11% of people in the schemes moved from hospital into Extra Care, thus avoiding potential admission to residential care.

Avoided costs: money that would have been spent had the cost not been avoided i.e. the client can remain in Extra Care with a care package and not move into residential or nursing care. This applies to as many as 63% of the current Extra Care population who, (hypothetically speaking), would be in residential or EMI or nursing care were they not in Extra Care.

If the numbers of people who would hypothetically otherwise be in residential, EMI or nursing home care is taken as a financial saving or avoided cost to ESCC, it can be seen that Extra Care offers a sound financial case as a model for care delivery. Inevitably some people may hold the view that people live longer in Extra Care settings than in other settings, or, described crudely, the attrition rate is lower. However, this is not an argument by which to defend the indefensible or to suggest that people should continue living in unsuitable accommodation or in inappropriate settings.

The following are additional financial benefits outside the scope of this evaluation and the supporting ESCC financial analysis.

Effective delivery The numbers of people who require 'double up' care is another indicator of a cost effective care delivery model. Double up care in peoples' own homes in the wider community is often logistically hard to organise and subject to greater disruption and frequently it cannot be physically delivered with ease in some smaller domestic environments. It may trigger residential care unnecessarily and often carries a price premium. In terms of the current population in the Extra Care schemes the percentage of people requiring double ups ranges from 3% in Newington Court to 26% in Cranbrook.

Family input Where carers have remained actively involved, as couples or as family members, they continue to offer a lot of support to their relative. This reduces the extent of the care package required and constitutes an avoided cost. There are clear examples in each scheme of how couples support each other on remarkably low formal care packages. At present 13% of the current total population are couples, but this figure is higher, 27%, in the newer schemes. All schemes have also cited the benefits of proactive support offered by relatives on daily/weekly regular and ongoing basis. For example at Margaret House where almost 70% of people have regular family input a few of these also provide domestic and laundry assistance to their relatives.

Savings to the public purse These include savings made in health, local authority housing, Adult Social Care, and state benefits. These might be actual savings or avoided costs as above. Although these are often not costed they include the following: avoided crises, disruption and trauma for people, savings in time, improved continuity and consistency of care delivery, reduced hospital stays and repeat admissions for people, reduced falls, reduced intensive interventions, reduced levels of medication, improved dialogue and oversight.

Housing gain This includes freeing up of family sized homes as people downsize.

Self -funders, those who pay for their care, are cautious about how much they pay for their care and have sometimes cut back on assistance when they would benefit from more. There were some, albeit rare, examples of clients who have run up debts because they have refused to pay.

General observations

When reading through assessments for over 200 people, there are some general observations that come through strongly. Like all generalisations they are open to contradiction, but they are enduring themes and should humanise and inform our approach when professionally undertaking our work.

- The amount that people will endure, and what they put up with as their lifestyle becomes more limited as they age and their environment is no longer accessible
- How reliant a person is on their spouse. Basically with two people, so much more can be managed than when someone is single in old age
- The same applies to reliance on family particularly if they are local
- Reliance can also mean vulnerability
- Financial abuse by family members is uncomfortably common, so all professionals need to be alert to this
- Needs fluctuate and medical conditions take up a lot of time, both logistically getting to appointments and in managing one's own welfare
- Loneliness and social poverty negatively impact on people's wellbeing, which typically improve again with regular social stimulation. This issue has been highlighted by Duncan Selbie, Head of Public Health England, (PHE), a new government body, which came into force April 2013. He is quoted as saying that being isolated shortens life and increases disability. It is the equivalent of smoking 15 cigarettes a day. However, such things do not occur on death certificates, or as he has said, 'What ails you isn't necessarily what kills you.' (The Guardian 13.3.2013)
- The frequency of diabetes was noticeable; awareness and information about how to actively manage the condition is relevant in so many cases

Notes for Schemes

These are relevant general issues:

- The provision of meals is vital as the restaurant gives a scheme its heart, and in turn this leads to socialisation and many ensuing benefits
- Without a meals service the schemes are often de-facto large sheltered schemes where people do not socialise very much
- Opportunities for socialisation assist in generating a supportive neighbourly environment; without this more demands may be made on care providers
- A good programme of social activities is crucial and it is advantageous to use the restaurant as a spring-board for ensuring this occurs
- Housing support is a vital building block in the totality of care and support

- There is a need to involve the local community in information sessions, exercise and social activities in order to make best use of extensive communal areas and spread by word of mouth about the schemes
- Without the above i.e. meals, social and community interaction, the schemes are underused, have a reduced value for money and do not realise their potential. There is no sense of maximising the potential of the scheme
- Regular open events/open days/respite stays help with attracting appropriate people to apply for future vacancies
- Visiting family members of all ages, especially children, are attractive for the whole scheme, so intergenerational events that encourage them to visit schemes are important and have a positive benefit e.g. Easter Egg hunts
- Peer learning amongst staff and residents in the different schemes is valuable e.g. Peer Champions who may cover such issues as how we set up our film club, the role of the social activities coordinator, how someone's drinking was reduced, how staff coped with end of life care for people who die at home
- Pet positive policies have many benefits
- Schemes with mixed ages and mixed care needs contributing to a mixed community work well
- Those GPs who value the scheme for the benefits they offer both to residents and their families, as well as to the health agenda, should be used to positively promote the schemes
- GPs especially will appreciate how peoples' health needs fluctuate. Early interventions, as well as time specific medical prompts and interventions can prevent deterioration. Extra Care schemes are an excellent setting in which to tackle this as people's fluctuating needs can be met through flexible care delivery
- Use schemes to the full for all the opportunities they offer; they are too valuable an asset to tolerate drift or underuse of their full potential
- Statistics and figures alone do not represent the full human story; quantative information must be interpreted with qualitative information
- The schemes do not look, or smell, or have the feel typically associated with homes for older people. These are key aspects in marketing schemes to a wide range of older people, including owner occupiers for the shared equity flats
- The sense of security offered to people by the schemes is more than just physical security; schemes offer both emotional and psychological security because people look out for each other within the building

Conclusion: Why would you not do Extra Care?

Extra Care Housing really does help people, and their families (where they exist) to remain more independent. The combination of accessible accommodation, care and support provision, housing support provided by the Scheme Manager, meals, social opportunities, an ethos of independence, self-help and neighbourliness are all tangible factors that help to maintain people's independence in Extra Care housing. Unlike the residential or nursing home care model, the varied client mix and varied care needs profile in Extra Care is valued and mutually supportive. The whole set up of the schemes also make it much easier for families to be actively and positively involved. Enabling couples to stay together provides great security for them.

- These features should be more actively marketed as the 'Image of Extra Care'.

The Extra Care schemes work positively in many ways and on many levels. Financial details analysed by ESCC prove the financial effectiveness of the Extra Care model of care and support delivery. Extra Care emerges as a powerfully preventative service model which enables people to remain in the community and not enter residential or nursing home care. The schemes present a cost effective model by which the delivery of domiciliary care is sustained. A key advantage is that Extra Care enables people to benefit from the whole system approach and effective partnership working, thus preventing people being passed between different parts of the housing, care and health systems.

In summary, Extra Care has many powerful success indicators; satisfied customers, a high quality service, avoidance of residential and nursing care, cost effectiveness, reliable staff, meeting the agenda of Local Authorities, communal facilities that ensure sustainability and offer opportunities for future growth, greater outreach and local community neighbourhood role. A danger would be to miss the opportunity of using the potential of the Extra Care schemes to the full. The sustainable benefits of the Extra Care schemes demonstrate the case for more investment in this service model.

The overall conclusion is why would Commissioners not extend Extra Care?

Georgiana Robertson
Consultant, Social Care and Housing
June 2013

CONTENTS OF APPENDICES

All Extra Care Schemes ***

***** Where references are made in appendices to 'Actual' and 'Theoretical' the following applies:

Actual: based on original care profile/dependency levels when scheme opened
Theoretical: based on new care profile/dependency levels when revised

Appendix 1

Appendix 1 SUMMARY TOTALS Extra Care Schemes January 2013

	Flats	Voids and Not Known	No. of assessments etc looked at	No. Flats using Care	No. Occupied /Nil Care	% Flats using Care	% Occupied / Nil Care	Assessments: Revised Appropriate Placement*	Assessments: Revised non Appropriate Placement	Assessments: % Revised Appropriate Placement*	Assessments: % Non Appropriate Placement	No. Alternative = Domicilary Care	No. Alternative = Residential Care	% Alternative = Domicilary Care	% Alternative = Residential Care (incl. short-term Domicilary Care
All	217	28	189	179	29	83%	13%	180	9	95%	5%	68	121	36%	64%
Shared Equity	31	21	10	19	10	61%	32%								
Rented	186	7	179	160	19	86%	10%	169	10	94%	6%	65	113	36%	63%

NIL CARE does not automatically translate as not appropriate for Extra Care
REVISED APPROPRIATE PLACEMENT* - revision based on age over 80yrs, ex-partner/ carer who has died in the scheme, contributes/ gives back to the scheme.
NB Some categorised as non- appropriate might need additional care eg mental health or resources other than Extra Care setting, rather than being more independent.
Please refer to Appendices 5 and 6 for more details; full details not available for shared equity flats.

Appendix 2

Appendix 2 OVERALL AGE PROFILE Extra Care Schemes November 2012 - January 2013						
Age profile	**Newington**	**Marlborough**	**Margaret**	**Downlands**	**Cranbrook**	**Total**
65 yrs. and under	4	3	2	2	11	**22**
	13%	8%	6%	6%	20%	**12%**
66 - 75 yrs.	3	13	9	6	16	**47**
	10%	33%	29%	18%	29%	**25%**
76 - 85 yrs.	12	10	7	11	14	**54**
	39%	26%	23%	33%	25%	**29%**
Up to and including 85 yrs.	61%	67%	58%	58%	75%	**65%**
86 yrs. +	12	13	13	14	14	**66**
86 yrs. +	39%	33%	42%	42%	25%	**35%**
Total whose ages known	31	39 (two people in one flat)	31 (of whom 29 rented)	33 (of whom 29 rented)	55 (of whom 52 rented)	**189**
Voids in scheme	3	2	2	2	0	**9**
Total capacity	35	40	39	41	62	**217**

NB. Margaret House, Downlands Court and Cranbrook – rented predominately; some ages known of people in shared equity flats as care given there.

Appendix 3

Appendix 3 OVERALL CARE PROFILE Extra Care Schemes November 2012 -January 2013						
Care Profile	**Newington**	**Marlborough**	**Margaret**	**Downlands**	**Cranbrook**	**Totals**
	11	10	10	14	14	
High	31%	25%	34%	47%	27%	33%
	8	11	9	6	16	
Medium	23%	28%	31%	20%	31%	27%
	6	6	9	6	22	
Low	17%	15%	31%	20%	42%	25%
	7	11	0	3	0	
Nil	20%	28%		10%	0	12%
	3	2	1	1	0	
Voids	9%	5%	3%	3%	0	4%
Total	35	40	29	30	52	186

NB. Margaret House, Downlands Court and Cranbrook – rented only

Appendix 3a

Appendix 3a OVERALL CARE PROFILE (ACTUAL) Extra Care Schemes November 2012 -January 2013											
Scheme	**NEWINGTON**		**MARLBOROUGH**		**MARGARET**		**DOWNLANDS**		**CRANBROOK**		**TOTALS (based on ***Actual)**
Care Profile	**H =10+ hrs; M=5-10hrs; L=below 5hrs ***		**H =10+ hrs; M=5-10hrs; L=below 5hrs***		**H =12+ hrs; M=5-12hrs; L=below 5hrs***		**H =12+ hrs; M=5-12hrs; L=below 5hrs***		**H=15+ hrs; M= 10-14 hrs; L= v. low 2-5 hrs. and low 6-9 hrs***		
Care Hours	**Originally** **H= 30%; M=30%; L=30%**	**Now** **H=40%; M=40%; L=20%**	**Originally** **H= 30%; M=30%; L=30%**	**Now** **H=40%; M=40%; L=20%**	**H= 40%; M=40%; L=20%;**		**H= 40%; M=40%; L=20%;**		**H=30% M=40%; L=30%; of which 10% v low; 20% low**		
	Actual	**Theoretical**	**Actual**	**Theoretical**	**Actual**	**Theoretical**	**Actual**	**Theoretical**	**Actual**	**Theoretical**	
High	11	14	10	16	10	12	14	12	14	16	59 Actual
	31%	40%	25%	40%	34%	40%	47%	40%	27%	31%	32%
Medium	8	14	11	16	9	11	6	12	16	21	50 Actual
	23%	40%	28%	40%	31%	38%	20%	40%	31%	40%	27%
Low	6	7	6	8	9	6	6	6	22	15	49 Actual
	17%	20%	15%	20%	31%	21%	20%	20%	42%	30%	26%
Nil	7		11		0		3		0		21 Actual
	20%		28%		0		10%		0		11%
Voids	3		2		1		1		0		7 Actual
	9%		5%		3%		3%		0		4%
Total	35		40		29		30		52		186 Actual

NB. Margaret House, Downlands Court and Cranbrook – rented only

*** L = Low**
M = Medium
H = High

****Originally = when scheme first opened**

***** Actual:** based on original care profile/dependency levels
Theoretical: based on new care profile/dependency levels

Appendix 4

Appendix 4 COUPLES	Extra Care Schemes					January 2013			
Scheme Name	**Total Flats**	**No. of Couples (in scheme now)**	**% of Total Population**	**Previous Total (when scheme opened)**	**% of Total Population (when scheme opened)**	**Outcomes for non-remaining couples**			
						Resultant Widows	**Resultant Widowers**	**Both Died**	**Other**
Newington Court	35	2	6%	8	23%	3	2	1	
Marlborough House	40	1	3%	7	18%	3	1		2 (a daughter and a cousin)
Margaret House	39	3	8%	6	15%	2		1	
Downlands Court	41	6	15%	11	27%	3	2		
Cranbrook	62	16	26%	17	27%	1			
TOTAL	**217**	**28**	**13%**	**49**	**23%**	**12**	**5**	**2**	**2**

NB. Margaret House, Downlands Court and Cranbrook – rented only

Appendix 4a

Appendix 4a DOUBLE UPS; DEMENTIA; MOVED FROM HOSPITAL; Extra Care Schemes November 2012 - January 2013						
DOUBLE UPS (all flats: rented & shared equity - 217)	**Newington**	**Marlborough**	**Margaret**	**Downlands**	**Cranbrook**	**Total**
Now	1	3	6	8	16	**34**
	3%	**8%**	**15%**	**20%**	**26%**	**15.6%**
Was	3	3	3	9	15	**33**
	9%	**8%**	**8%**	**22%**	**24%**	**15.2%**
DEMENTIA (rented flats only - 186)	**Newington**	**Marlborough**	**Margaret**	**Downlands**	**Cranbrook**	**Total**
Formal Diagnosis Now	4	1	4	8	9	**26**
	11%	**3%**	**14%**	**26%**	**17%**	**14.0%**
Informal Diagnosis Now	2	0	1	1	4	**8**
	6%	**0**	**3%**	**3%**	**8%**	**4.3%**
MOVED FROM HOSPITAL (rented flats only - 186)	3	1	5	4	7	**20**
	9%	**3%**	**17%**	**13%**	**13%**	**12.9%**

Appendix 5

Appendix 5 FLAT TYPE, TENURE AND CARE USAGE Extra Care Schemes January 2013

Scheme Name	Total Flats	One bed	Two bed	Shared Equity	Rented	Total Void	Shared Equity void	Rented void	Total Use Care	Total Rented Use Care	Total Shared Equity Use care	Nil care /full	Nil care, rented / full	Nil care Shared Equity full	Nil Care / Void	ESCC ASC funded	ESCC Self funded
Newington Court	35	31	4	0	35	3	0	3	25	25	0	7	7	0	3	25	4
Marlborough Court	40	35	5	0	40	2	0	2	29	29	0	9	9	0	2	23	6
Margaret House	39	19	20	10	29	2	1	1	35	28	7	2	0	2	2	29	5
Downlands Court	41	21	20	11	30	2	1	1	31	26	5	8	3	5	2	22	6
Cranbrook	62	19	43	10	52	0	0	0	59	52	7	3	0	3	0	56	2
TOTAL	217	125	92	31	186	9	2	7	179	160	19	29	19	10	9	155	23
TOTAL % of 217 flats		**58%**	**42%**	**14%**	**86%**	**4%**	**1%**	**3%**	**82%**	**74%**	**9%**	**13% ***	**9%**	**5%**	**4%**	**71% a**	**11% a**
T0TAL % of either rented or shared equity							**6% of Shared Equity**	**4% of rented**		**86% of rented**	**61% of Shared Equity**		**10% of rented**	**32% of Shared Equity**			

NB All % rounded to nearest whole figures. **a** ASC/ Self funders info supplied by ESCC may not be complete.

* Those who don't use care might still be appropriately placed see Appendices 6 and 9 detailing REVISED APPROPRIATE revision based on age over 80yrs, ex-partner/carer who has died in scheme, contributes/gives back to scheme.

Appendix 6

Appendix 6 APPROPRIATE AND ALTERNATIVE PLACEMENTS Extra Care Schemes January 2013

Scheme Name	Flats	Void	Shared Equity (Not Known)	Appropriate	Not Appropriate	Revised not Appropriate	Revised Appropriate	Domicilary Care at home	Sheltered Housing	Total Domicilary Care	Very short term Domicilary Care	Residential Care	EMI	Nursing Care	Total Residential Care	% Total Residential Care *	Total Residential with very short term Domicilary Care	% New Total Residential Care *	% New Total Domicilary Care minus very short term Domicilary Care	Notes
Newington Court	35	3	0	28	4	2	30	9	2	11	3	13	1	4	18	56%	21	66%	34%	All rented, 32 occupied
Marlborough Court	40	2	0	31	7	1	37	6	15	21	2	12	1	2	15	39%	17	45%	55%	All rented, 38 occupied
Margaret House All	39	1 (rented void only)	10 (includes 1 shared equity void)	No. info supplied on Shared Equity people																No info supplied on 10 S/E flats
Margaret Rented	29	1		24	4	2	26	6	1	7	1	10	2	8	20	71%	21	75%	25%	% calculated on 28; ie all 29 minus 1 rented void. (NB previous occupant was approp, moved to nursing)
Downlands Court All	41	2	3	32	4	2	34	13	3	16	0	11	2	6	19	53%	19	53%	44%	% calculated on 36: ie all flats minus 2 voids and 3 n/k S/E. NB all 5 known S/E approp
Downlands Rented	30	1		25	4	2	27	11	3	14	0	8	2	5	15	52%	15	52%	48%	% calculated on 29; ie all 30 minus 1 rented void
Cranbrook All	62	0	6	49	7	1	55	1	12	13	6	27	2	8	37	66%	43	77%	23%	% calculated on known alternatives, ie Total 56 flats, discount 6 n/k S/E
Cranbrook Rented	52	0		45	7	1	51	1	12	32	6	25	1	7	33	63%	39	75%	62%	% calculated on all rented as all known ie 52
TOTAL All (Rented and Shared Equity)	217	8	19	164 of 190* known	26	8	182	35	33	68	12	73	8	28	109	57%	121	64%	36%	
TOTAL of RENTED across all schemes	186	7		153 of 179* known	26	10	169	33	33	85	12	68	7	26	101	56%	113	63%	47%	
% of RENTED across all schemes (*known)				85%	15%	6%	94%				7%	38%	4%	15%	56%		63%			

*** denotes total minus voids, minus n/k.**

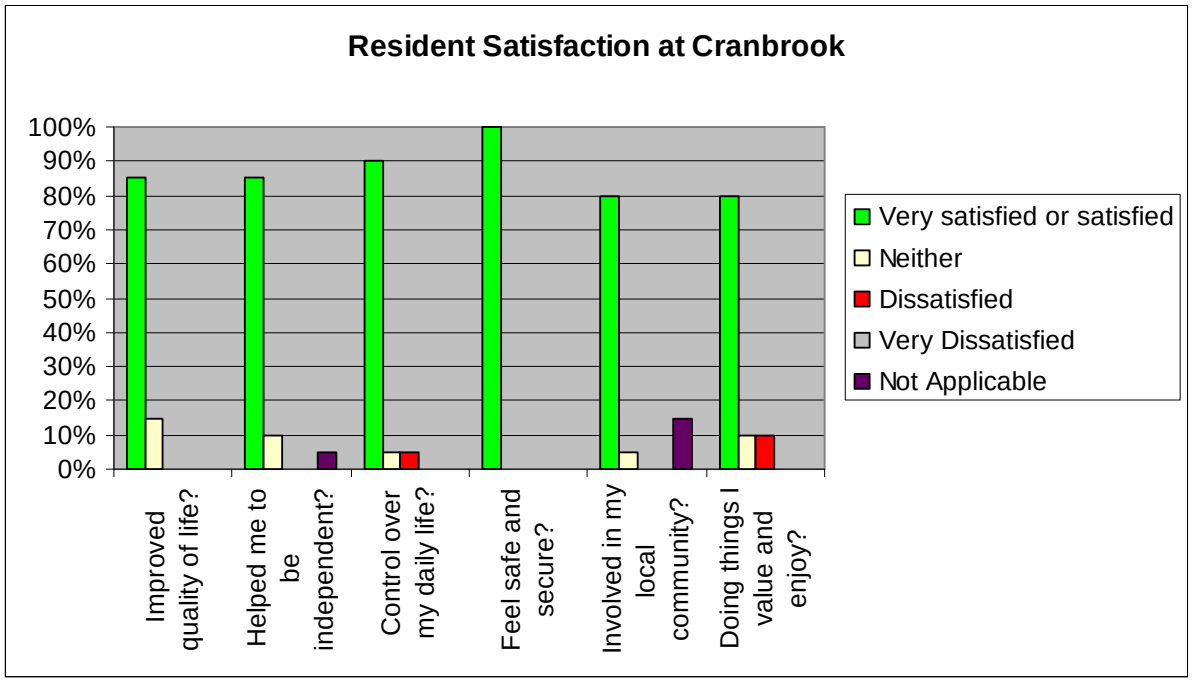
REVISED APPROPRIATE revision based on age over 80yrs, ex-partner/carer who has died in scheme, contributes/gives back to scheme.
NB Some categorised as not appropriate might need additional care eg mental health or resources other than Extra Care setting rather than being more independent.

Appendix 2: Client satisfaction and change impact data before / after related to Cranbrook Extra Care

The information for this overview has been taken from our internal Key Background Information Template (KBIT), which is used as a basis for tracking changes in the resident's care packages over time.

We also asked each interviewee, how satisfied they were overall with how Cranbrook is meeting a list of defined needs. The results were as follows and are similar to previous schemes:

Graph 1



Other highlights from our background information template include:

More people (85%) receive some informal care (family, friends, neighbours) now, compared to (64%) before moving in. This reliefs the pressure on care services and increases social interaction.

Before moving in, 60% of clients took part in community events. This figure rose to 75%.

Social interaction generally has increased for 90% of clients.

Falls in the previous 6 months reduced from 90 before moving into Extra Care Environment to 12.

GP call outs in the previous six months have been reducing from 54 before moving into Extra Care to 13.

Admission to unplanned care (nursing, EMI ect) in the previous six months fell from 307 to 21 days.

Days spend in hospital in the last six months fell from 165 to 143.

Lewes, 7, November 2013-10-22
Wolfgang Weis, Head of Strategic Commissioning (Supported Housing)
Phone: 01273 336829