Review of housing and care needs of Older People in Rushmoor and Hart

Report from Contact Consulting

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1 Executive Summary

The Older Population of Rushmoor and Hart

Both Rushmoor and Hart have substantial populations of older people with significant numbers in the oldest age categories. The age profile among retired people is broadly constant between the two local authority areas. In the short to medium term there will be a substantial number of older women living alone into advanced old age. Both Rushmoor and Hart are experiencing growth in all cohorts of their older populations

The age profile of both Rushmoor and Hart lead to conclusions about the likely prevalence of a variety of conditions that are indicators of potential need for accessible, adapted or specially designed accommodation, and a range of supporting services. Almost three thousand older people in Rushmoor and more than two and a half thousand in Hart are likely to be experiencing difficulties with mobility.

Around a thousand older people in both Rushmoor and Hart are likely to have difficulty with at least one personal care task. (Rushmoor 1,015 & Hart 990). Difficulties with domestic tasks is even more prevalent with around eighteen hundred older people in Rushmoor and seventeen hundred and fifty in Hart likely to be facing such problems.

Just under eight hundred people in Rushmoor and almost seven hundred in Hart will have some measure of moderate to severe cognitive impairment.

Black and Minority Ethnic elders over 75 years of age are in no more than single figures in any BME community in either authority.

Tenure patterns among older people are dominated by owner occupation which, in the younger cohorts of older people is in the lower seventy to lower eighty percent for Rushmoor and reaches almost ninety percent among people 60-64 in Hart.

The supply of specialised accommodation

The ratio of sheltered housing for rent to 75+ population is higher than the national average and higher than future patterns of demand are likely to support. When we take into account the proportion of the older population of Rushmoor in tenures other than home ownership we see that the ratio of provision is that for every thousand people not in owner occupation there are 367 units of sheltered housing for rent.

In Hart there has been a marked reduction in conventional sheltered housing units and some growth in both Very Sheltered units and sheltered housing offered for sale on leasehold.

The provision of both residential care and nursing home places in both Rushmoor and Hart is low when compared with the national averages whilst

the ratio of local authority to private sector provision in these areas is quite high.

In Rushmoor the provision of sheltered housing and its variants is significantly above the national average and the deficit in residential and nursing home places not so marked.

A review of national policies and initiatives

The foundations for the development of a pattern of provision within which people might expect to be supported and cared for within their own homes rather than in an institutional setting was laid in the NHS and Community Care Act 1990.

The NHS Plan : A Plan for Investment, A Plan for Reform (DH, 2000) recognises the importance of enhancing quality of life, not just increasing its length. The Plan gives prominence to the values of dignity and independence. Within the Plan there is an imperative to develop preventative strategies and services that will reduce the risk of illness and disability.

The National Service Framework for Older People (2001) sets out national standards of care, commits Government to ending discrimination in health and social care on grounds of age, and aims to promote active, healthy life in old age. There are 27 references to housing across the eight standards

The Priorities and Planning Framework 2003-2006 enables the NHS to plan over a three-year period. It is intended that the NHS lead on improving access, patient experience, and alleviating health inequalities. The NHS and Social Services will lead jointly on services for older people. A three-year Local Delivery Plan replaces all existing national planning requirements.

The housing context within which a future pattern of accommodation and care may be set is to be found in Quality and Choice in Housing for Older People (2001). This too looks for the majority of older people to remain in their existing housing but to access the services that makes their continued occupation viable: from assistance in addressing problems with the fabric of the house, through adaptations to services to support the occupier.

For those engaged in the operation of Residential Care Homes and Nursing Homes in both the private and public sectors the Care Standards Act 2000 is bringing major changes. Many smaller providers are leaving the market. Local Authorities, faced with the need for major re-investment, are considering transfer to voluntary or commercial organisations and re-provision, often with Very Sheltered Housing.

The changes to the funding of support services, brought into force through Supporting People (2000), provide opportunities for funding alternative services in a strategic way.

Better Care Higher Standards (1999) a joint publication of the Department of Health and the Office of the Deputy Prime Minister requires a joint approach across health, housing and social care on both service standards and the provision of information.

Responding to key issues identified in the brief

The Supporting People Review of home improvement agencies was completed in December and finds the Rushmoor and Hart Staying Put scheme to be meeting all required standards. The recommendation is therefore for funding from Supporting People to continue.

There is a perception that sheltered housing is well down the list for reviews, but an appreciation that preparing for Supporting People has driven the formalisation and documentation of procedures and protocols which has been helpful in clarifying the nature and status of services.

Our site visits to a range of sheltered schemes in Rushmoor and Hart revealed a number of ad hoc developments in provision. These were both in the enhancement of facilities and modification in the range of services provided. It underscored the need for all providers to be engaged in the ongoing discussion about the definition and role of the various models of sheltered housing within a comprehensive range of provision in the area.

The most significant change to have been achieved to date is the opening of Place Court, an ExtraCare scheme, in Rushmoor. This arose in part from recommendations made in the 1998 report.

In Hart the nature of the services to be provided in the two "extra care" schemes managed by Sentinel: Rosefield and Hedgecroft – is currently under review.

In both areas, in line with national trends, there is strong interest in developing leasehold retirement housing.

There is widespread appreciation that the ability to promote and market sheltered housing depends on having a product which will be attractive to older people, especially to those who may be currently under-occupying family-sized accommodation.

There is a general recognition that aspirations will continue to rise, particularly in relation to space standards.

The most obvious alternative use for conventional sheltered housing is for it to continue to be offered to older people able to live independently but without services, other than perhaps connection to a community alarm.

Alternatively, some sheltered schemes might be considered for the accommodation of other groups such as students, care leavers and single key workers.

In the course of the study we conducted interviews with officers of Waverley BC, Guildford BC and Surrey Heath DC. The situation of each is, as one would expect slightly different. Each is at a different stage in relation to developing their strategic approach top meeting the future needs of an ageing population and in the range of provision they currently offer.

There was also a feeling that some common definitions and protocols for allocation/ admission to the various forms of specialised accommodation for older people would be helpful. This may be an area in which a cross-border approach would be helpful.

Specialised accommodation for older people in Rushmoor and Hart

The specialised accommodation that may provide a context for the delivery of care, and already mapped in Section Three, is principally of four kinds:

- Conventional sheltered housing
- Very Sheltered or Extracare housing
- Residential care, whether provided by the local authority or by commercial or voluntary organisations
- Nursing Homes

We would propose a fifth category: Enhanced sheltered housing which, we suggest, provides facilities additional to those found in conventional sheltered housing but does not meet all the criteria for Very Sheltered or Extracare housing.

Whilst provision of conventional sheltered housing for rent in Rushmoor is high and will need to reduce significantly to achieve a balanced and sustainable pattern the level of provision in Hart is already quite low. In projecting future levels of provision in Hart our suggestion is that the level should remain stable, although with some renewal and even re-provision. The process of adjustment in capacity may be easier to manage if there is some flexibility in cross border allocations between Hart and Rushmoor.

Proposing a pattern of provision to respond to national trends and local needs

Our conclusions are broadly the same as those we reached in 1998:

- The demand for rented conventional sheltered housing is likely to decline
- The suitability of the older stock for letting will become increasingly problematic
- The potential for leasehold retirement housing will continue to grow
- Some existing schemes will lend themselves to refurbishment and remodelling to provide enhanced sheltered housing to supporting rising levels of frailty.

- Some of this enhanced sheltered housing should be offered for sale alongside that for rent.
- There is a need for an increasing proportion of extra care housing but its viability depends on a stronger strategic relationship between health, housing and social care agencies.
- Extracare housing should be provided for sale and rent.
- There is a need for housing-based models of accommodation and care for people with dementia.
- The proper design and use of Extracare housing should mitigate the demand for an increase in residential care provision and may allow some measure of re-provision.
- Housing-based models for dementia care will provide an alternative to nursing home based strategies for meeting the needs of those living with moderate to severe dementia

Our recommendations are set out in the following section, Section 2.

2 Recommendations

The key questions of the brief

In commissioning this study the Consortium posed three major questions:

1. Do we have sufficient accommodation and support for our older population for the next ten years?

2. Do we have the right type of accommodation and support, given what we know of the needs and wishes of older people?

3. What changes could we make in order to meet the demands and aspirations of the older people of this area

In a sense the answers to these questions are a connected whole:

The volume of specialised housing for older people may well be adequate but it is currently defective in six key respects:

- There is a predominance of rented accommodation that does not respond to the needs of the large and growing proportion of older people who are home owners.

- The design of some accommodation does not meet current standards, accessibility is poor, space standards and other facilities may be limited, location may no longer be so attractive through the retreat of amenities such as shops, post office, access to public transport, and so on.

- It is mainly directed toward meeting the needs of those who are largely or wholly capable of living independently whereas it will need increasingly to meet the needs of an ageing and therefore more highly dependent population.

- The accommodation provided for those who will be able to live relatively independently with little call on care services will need to provide enhanced levels of facility for educational, cultural and physical activities.

- The role to be fulfilled by particular housing models within a range of options for older people is not adequately differentiated or defined.

- There is very limited housing provision for people with dementia and their carers.

The short answer then is: “You may have sufficient accommodation but it is not necessarily of the right type, in tenure, facilities or services. To meet

future needs and aspirations you will need to continue the development of a differentiated and imaginative range of accommodation settings to meet the diversity of the requirements that will be presented by a future population of older people.”

Our Recommendations

On the basis of our study we offer the following recommendations:

That as a matter of urgency senior officers drawn from the Health, Housing and Social Care bodies working in Rushmoor and Hart should meet and undertake work to establish the strategic framework within which specialised housing for older people should be developed and managed.

It is evident that the intentions of housing providers in relation to enhanced and Extracare forms of housing for older people are not well understood in the health and social care community and that there may be strategic dissonance between them. The impetus given by central government thinking and funding to Extracare housing as an alternative to residential care is not reflected in the current policy frameworks and operational patterns of health and social care agencies in this area.

All the providers of conventional sheltered housing in Rushmoor and Hart should be brought together to discuss common definitions for the accommodation they currently provide or might provide in the future and to agree a common set of criteria for assessment and allocation

At present there is no common definition of what may be expected of the various categories of accommodation. Such an understanding is vital if the strategic pattern suggested at the end of this report are to be related to provision on the ground.

The major housing providers in Rushmoor and Hart need to complete their asset appraisal exercises and identify the volume, style and location they propose.

Sentinel is well advanced with its asset appraisal exercise and this does recognise the range of options available and how these might be pursued in relation to individual sites. Our impression is that Pavilion have waited on this study to inform their exercise but are no less aware of the options and the need to address the issues of ageing sheltered accommodation and the future diversity that will be required to meet changing patterns of population, tenure and frailty.

The partner agencies of health, housing and social care need to undertake further work to investigate the housing-based models of provision for supporting people with dementia and their carers.

Whilst the main focus of dementia care strategies will be support of those remaining in their existing accommodation there is a need for accommodation that will offer a good quality of life to people living with dementia. Housing providers have been understandably cautious in

this area and a genuinely corporate approach by statutory agencies and providers from voluntary and private sectors is needed.

Health, housing and social care partners need to revisit the potential role of Staying Put in delivering a range of preventative and support services to older people in all tenures, in addition to their existing role in relation to repairs and adaptations.

Although there have been changes in the management and operation of Staying Put there is only tenuous ownership by statutory authorities and a sense of disconnection by the service provider from the local strategic agenda.

3 The Older Population of Rushmoor and Hart

Both Rushmoor and Hart have substantial populations of older people with significant numbers in the oldest age categories. The age profile among retired people is broadly constant between the two local authority areas. Both demonstrate a typical gender imbalance among the older population with the ratio of women to men becoming more pronounced as age progresses. Whilst national projections for the next five decades indicate closer convergence between the genders in mortality rates, and therefore of survival into old age, in the short to medium term there will be a substantial number of older women living alone into advanced old age. The consequences of this become clear when we examine the differential rates of difficulty with tasks of personal care and household independence experienced by men and women in advanced old age set out in tables 11 & 12.

Table 1 Population of Rushmoor by age cohorts 2001

Age range	Total	Males	Females
0 - 4	6331	3259	3072
5 - 9	6365	3255	3110
10 - 14	5754	2983	2771
15 - 19	5556	2910	2646
20 - 24	6506	3493	3013
25 - 29	8115	4233	3882
30 - 34	8339	4310	4029
35 - 39	8301	4270	4031
40 - 44	6418	3369	3049
45 - 49	5462	2756	2706
50 - 54	5698	2993	2705
55 - 59	4181	2114	2067
60 - 64	3415	1690	1725
65 - 69	2984	1379	1605
70 - 74	2604	1098	1506
75 - 79	2193	849	1344
80 - 84	1469	528	941
85 - 89	877	292	585
90 and over	419	101	318
Totals	90987	45882	45105

(Source ONS 2001 Census)

Table 2 Population of Hart by age cohorts 2001

Age Range	Total	Males	Females
0 - 4	5078	2616	2462
5 - 9	5420	2805	2615
10 - 14	5472	2832	2640
15 - 19	5136	2831	2305
20 - 24	4214	2446	1768
25 - 29	5212	2803	2409
30 - 34	6296	3197	3099
35 - 39	7203	3591	3612
40 - 44	6640	3277	3363
45 - 49	5876	2898	2978
50 - 54	6651	3254	3397
55 - 59	5452	2715	2737
60 - 64	4219	2145	2074
65 - 69	3263	1631	1632
70 - 74	2598	1242	1356
75 - 79	2083	914	1169
80 - 84	1399	505	894
85 - 89	817	250	567
90 and over	476	107	369
Totals	83505	42059	41446

(Source ONS 2001 Census)

Whilst the total population of both Rushmoor and Hart are projected to rise over the current two decades these projections need to be handled with some care. The projections based on revisions of the 1991 census suggested a higher rate of rise in population in Hart than the 2001 census documented, whilst previous projections under-estimated the level of growth of population in Rushmoor. If the projections are to be believed then the total population of Hart will outstrip that of Rushmoor by 2021.

Table 3 Current and projected total population for Rushmoor 2001 to 2021 (000s)

	2001 census	2001	2006	2011	2016	2021
Total	91.0	87.9	90.8	93.2	95.5	97.7
Males	45.9	44	45.4	46.5	47.5	48.3
Females	45.1	43.9	45.4	46.7	48	49.3

(Source ONS 2001 census & 1997 based projections)

Table 4 Current and projected total population for Hart 2001 to 2021 (000s)

	2001 census	2001	2006	2011	2016	2021
Total	83.5	88.8	91.7	94.5	97	99.1
Males	42.1	45.3	46.7	47.9	48.9	49.7
Females	41.4	43.5	45.1	46.7	48.1	49.4

(Source ONS 2001 census & 1997 based projections)

Both Rushmoor and Hart are experiencing growth in all cohorts of their older populations. For Rushmoor this is projected to be around 100% increase in those 65-74 and 60% in those over 75. For Hart the projection is even more dramatic for the oldest age group, whilst the number of those 65 to 74 will rise by around 100% and the number of those 75 and over will increase by only just less than 100%.

Table 5 Current and total projected population 45+ by age cohorts for Rushmoor

		2001 census	2001	2006	2011	2016	2021
Total	45-64	18.8	19.5	22.9	26.5	28.3	28.8
	65-74	5.6	6	7	8.3	10.2	10.9
	75+	5.0	4.8	5.2	5.8	6.7	8
Males	45-64	9.6	9.6	11.2	12.9	13.6	13.9
	65-74	2.5	2.8	3.4	3.9	4.8	5.1
	75+	1.8	1.7	1.9	2.3	2.8	3.3
Females	45-64	9.2	9.8	11.7	13.6	14.6	15
	65-74	3.1	3.2	3.6	4.4	5.4	5.8
	75+	3.2	3.1	3.3	3.5	4	4.6

(Source ONS 2001 census & 1997 based projections)

Table 6 Current and total projected population 45+ by age cohorts for Hart

		2001 census	2001	2006	2011	2016	2021
Total	45-64	22.2	23.7	25.8	27.6	28.3	28.5
	65-74	5.9	6.4	7.8	9.7	11.7	11.9
	75+	4.8	4.8	5.4	6.3	7.5	9.2
Males	45-64	11.0	11.6	12.5	13.6	14	14
	65-74	2.9	3.2	3.9	4.7	5.4	5.6
	75+	1.8	1.9	2.2	2.8	3.4	4.1
Females	45-64	11.2	12.1	13.3	14	14.3	14.5
	65-74	3.0	3.2	3.9	5	6.2	6.4
	75+	3.0	2.9	3.1	3.5	4.1	5.1

(Source ONS 2001 census & 1997 based projections)

By 2021 those over 45 years of age will make up almost half the population of Rushmoor and Hart, those over 65 around 20% with people of 75 years and above approaching 10% of the population.

Table 7 Percentage of total population 45+ by age cohort for Rushmoor

	2001 census	2001	2006	2011	2016	2021
45+	32.2	34.5	38.7	43.6	47.3	48.8
65+	11.6	12.3	13.4	15.1	17.7	19.3
75+	5.4	5.5	5.7	6.2	7.0	8.2

(Source ONS 2001 census & 1997 based projections)

Table 8 Percentage of total population 45+ by age cohort for Hart

	2001 census	2001	2006	2011	2016	2021
45+	39.3	39.3	42.5	46.1	49.0	50.1
65+	12.7	12.6	14.4	16.9	19.8	21.3
75+	5.7	5.4	5.9	6.7	7.7	9.3

(Source ONS 2001 census & 1997 based projections)

The age profile of both Rushmoor and Hart leads to conclusions about the likely prevalence of a variety of conditions that are indicators of potential need for accessible, adapted or specially designed accommodation, and a range of supporting services. Tables 9 and 10 take national prevalence figures and model from them estimates of local incidence, showing that almost three thousand older people in Rushmoor and more than two and a half thousand in Hart are likely to be experiencing difficulties with mobility.

Table 9 Older People Reporting Problems with Mobility 2001 Rushmoor

	Men			Women			Total number of men & women indicated
Age Group	Population of older people in authority	% in National Survey	Number in authority	Population of older people in authority	% in National survey	Number in authority	
65-74	2,477	12%	297	3,111	15%	467	764
75-79	1,377	21%	289	2,285	23%	526	815
80-84	528	27%	143	941	42%	395	538
85+	393	48%	189	903	67%	605	794
TOTAL			**918**			**1,992**	**2,910**

(Source: Contact Consulting from GHS 1996 & ONS Mid-Year Estimates 1997)

Table 10 Older People reporting problems with mobility 2001 Hart

	Men			Women			Total number of men & women indicated
Age Group	Population of older people in authority	% in National Survey	Number in authority	population of older people in authority	% in National survey	number in authority	
65-74	2,873	12%	345	2,988	15%	448	793
75-79	914	21%	192	1,169	23%	269	461
80-84	505	27%	136	894	42%	375	512
85+	357	48%	171	936	67%	627	798
TOTAL			**844**			**1,720**	**2,564**

(Source: Contact Consulting from GHS 1996 & ONS Mid-Year Estimates 1997)

Tables 11 and 12 adopt a similar methodology to estimate the number of older people who, based on national prevalence figures, are likely to experience difficulties in maintaining their independence. Around a thousand older people in both Rushmoor and Hart are likely to have difficulty with at least one personal care task. (Rushmoor 1,015 & Hart 990). Difficulties with domestic tasks is even more prevalent with around eighteen hundred older people in Rushmoor and seventeen hundred and fifty in Hart likely to be facing such problems.

Table 13 models the likely incidence of cognitive impairment among older people, estimating that just under eight hundred people in Rushmoor and almost seven hundred in Hart will have some measure of moderate to severe cognitive impairment. The projected rise in the numbers of those in the two authorities in advanced old age will have a direct impact on these figures.

Tables 14 and 15 set out the results of the 2001 Census in relation to elders from Black and Minority Ethnic communities in Rushmoor and Hart. The numbers are small; those for BME elders over 75 years of age are in no more than single figures for any community. Any provision for elders drawn from particular communities will need to be small scale, closely related to the needs of the community concerned and developed in partnership with established community groups.

Table 11 Percentage of male and female population experiencing difficulty with various tasks by age group 2001 for Rushmoor

	75-84						85+					
	Men			Women			Men			Women		
7	Population of Authority area	% in national survey	Number in authority	Population of Authority area	% in national survey	Number in Authority	Population of Authority area	% in National survey	Number in Authority	Population of Authority area	% national Survey	Number in Authority
At least one personal care task very difficult or impossible	1,377	13%	179	2,285	13%	297	393	43%	169	903	41%	370
At least one domestic task very difficult or impossible	1,377	19%	262	2,285	34%	777	393	47%	185	903	65%	587
At least one locomotive task very difficult or impossible	1,377	12%	165	2,285	21%	480	393	35%	138	903	38%	343

(Source: Contact Consulting based on Census & GHS 2001)

Table 12 Percentage of male and female population experiencing difficulty with various tasks by age group 2001 for Hart

	75-84						85+					
	Men			Women			Men			Women		
	Population of Authority area	% in national survey	Number in authority	Population of Authority area	% in national survey	Number in Authority	Population of Authority area	% in National survey	Number in Authority	Population of Authority area	% in national survey	Number in Authority
At least one personal care task very difficult or impossible	1,419	13%	184	2,063	13%	268	357	43%	154	936	41%	384
At least one domestic task very difficult or impossible	1,419	19%	270	2,063	34%	701	357	47%	168	936	65%	608
At least one locomotive task very difficult or impossible	1,419	12%	170	2,063	21%	433	357	35%	125	936	38%	356

(Source: Contact Consulting based on Census & GHS 2001)

Table 13 Incidence of Cognitive Impairment 2001

	2001 Rushmoor				2001 Hart		
Age Group	Population within Authority	Prevalence %	Number within Authority	Age Group	Population within Authority	Prevalence %	Number within Authority
65 - 74	5,588	2.3	129	65 - 74	5,861	2.3	135
75 - 84	5,131	7.2	369	75 - 84	3,482	7.2	251
85 +	1,334	21.9	292	85 +	1,293	21.9	283
Total			790	**Total**			669

Table 14 Elders and Ethnic Groupings - Rushmoor

Elders & Ethnic Group - Rushmoor																	
Age	**All People**	**white British**	**white Irish**	**white Other**	**mxd wh/bl Carib**	**mxd wh/bl Af**	**mxd wh/Asian**	**other mxd**	**Indian**	**Pakistani**	**Banglad**	**Other Asian**	**Black Carib**	**Black African**	**other Black**	**Chinese**	**Other Ethnic**
60-64	3425	3159	90	60	9	3	12	0	15	9	0	9	29	0	0	21	9
65-69	2974	2791	71	46	3	3	0	3	19	8	0	0	18	0	0	9	3
70-74	2606	2423	66	44	3	0	3	0	21	3	3	6	3	0	0	28	3
75-79	2189	2076	50	37	0	3	6	0	11	0	0	0	6	0	0	0	0
80-84	1475	1384	43	24	6	0	0	0	8	0	0	0	0	0	0	10	0
85-89	885	838	15	18	0	0	3	0	3	0	0	0	0	0	0	5	3
90+	417	408	6	0	0	0	0	0	0	0	0	0	0	0	0	3	0

(Source: ONS 2001 census)

Table 15 Elders and Ethnic Groupings - Hart

Age	All People	white British	white Irish	white Other	mxd wh/bl Carib	mxd wh/bl Af	mxd wh/Asian	other mxd	Indian	Pakistani	Banglad	Other Asian	Black Carib	Black African	other Black	Chinese	Other Ethnic
60-64	4226	4022	52	92	3	0	12	0	12	6	0	3	6	0	0	15	3
65-69	3278	3131	56	64	0	0	3	0	9	0	3	9	0	0	0	0	3
70-74	2597	2495	47	43	0	0	6	0	3	0	0	0	0	0	0	3	0
75-79	2070	2015	21	31	0	0	0	0	3	0	0	0	0	0	0	0	0
80-84	1398	1349	21	25	0	0	0	0	0	0	0	0	0	0	0	3	0
85-89	824	794	12	15	0	0	0	0	0	0	0	0	0	0	3	0	0
90+	483	471	6	3	0	0	3	0	0	0	0	0	0	0	0	0	0

(Source: ONS 2001 census)

Tables 16 and 17 set out the tenure patterns among older people in Rushmoor and Hart. It will be immediately obvious that this is dominated by owner occupation which, in the younger cohorts of older people is in the lower seventy to lower eighty percent for Rushmoor and reaches almost ninety percent among people 60-64 in Hart. Only among the very old does it fall steeply, to forty percent in Rushmoor and fifty four percent in Hart. This is, in part, a consequence of the higher proportion of those in this age group who live in communal establishments. In Rushmoor, in the following cohorts, of those who will enter and advance through old age over the next two to three decades the proportion of ownership is even higher. This trend, identified in our report in 1998, will have a significant impact on demand for specialised accommodation for older people offered for rent. It also represents a major challenge in providing an offer that will be attractive to older owner-occupiers in the future.

(Note: Tables 16 & 17 show numbers of older people identified in census returns as local authority tenants although both authorities transferred their stock some considerable time before 2001. This anomaly arises through people mis-reporting their status. Those living in residential accommodation are enumerated under “communal establishments”.)

Table 16 Tenure by age cohort Rushmoor

	60-64			65-74			75-84			85+		
	Male	Female	All	Male	Female	All	Male	Female	All	Male	Female	All
Own Outright	758	936	1,694	1,572	1,997	2,569	823	1,208	2,031	210	207	417
Own with mortgage or loan	644	474	1,118	380	377	757	117	206	323	17	60	77
All owners Number			**2,812**			**3,326**			**2,354**			**494**
%			**82.2**			**72.6**			**64.2**			**40.9**
Shared ownership	9	9	18	9	3	12	0	15	15	3	3	6
Local Authority rented	16	33	49	30	53	83	13	53	66	12	20	32
Other social rented	191	219	410	373	542	915	297	551	848	70	228	298
Privately rented	49	31	80	56	64	120	44	75	119	17	27	44
Rent free	9	24	33	19	39	58	22	51	73	9	31	40
Communal establishments	7	9	16	28	37	65	57	136	193	50	243	293

Table 17 Tenure by age cohort Hart

	60-64			65-74			75-84			85+		
	Male	Female	All	Male	Female	All	Male	Female	All	Male	Female	All
Own Outright	1231	1380	2611	2164	2208	4372	1014	1295	2309	215	421	636
Own with mortgage or loan	714	473	1187	356	324	680	119	9	128	33	0	33
All owners Number			**3798**			**5052**			**2437**			**669**
%			**89.7**			**86.1**			**73.6**			**54.2**
Shared ownership	3	3	6	12	9	21	9	9	18	0	0	0
Local Authority rented	0	6	6	6	6	12	3	13	16	3	11	14
Other social rented	116	149	265	225	296	521	179	348	527	44	132	177
Privately rented	52	56	108	75	69	144	53	69	122	19	30	49
Rent free	25	21	46	27	49	76	28	48	76	9	37	46
Communal establishments	0	3	3	3	37	40	23	94	117	43	237	280

Table 18 Property prices July-September 2003 Rushmoor, Hart and comparison with England and Wales averages

Region/area	Detached		Semi-detached		Terraced		Flat/maisonette		All	
	Av price £	Sales	Av price £	Sales	Av price £	Sales	Av price £	Sales	Av price £	Sales
Rushmoor	276,354	78	179,822	161	152,860	129	117,271	100	175,113	468

Region/area	Detached		Semi-detached		Terraced		Flat/maisonette		All	
	Av price £	Sales	Av price £	Sales	Av price £	Sales	Av price £	Sales	Av price £	Sales
Hart	356,382	214	215,969	149	175,181	111	148,440	58	256,578	532

England/Wales (prices only)	Detached	Semi-detached	Terraced	Flat/maisonette	All	
	Av price £	Av price £	Av price £	Av price £	Av price £	
	250,715	145,576	120,685	152,446	161,665	

Table 18 sets out recent quarterly returns from the Land registry, generally acknowledged to be the most reliable indicator of achieved prices for house sales. From this data it is clear that for the majority of older people in Rushmoor and Hart who are home owners their home represents a substantial asset when considering options for accommodation in old age.

4 The supply of specialised accommodation

Consistency of data between our study of 1998 and the current review is difficult to achieve but it appears that the supply of conventional sheltered housing for rent has increased in Rushmoor, together with the provision of Very Sheltered or Extra Care accommodation. The amount of sheltered housing available on a leasehold basis has doubled. The second two of these trends are in line with our predictions and recommendations, made in 1998, although it is our view that the trend needs to continue and accelerate. The ratio of sheltered housing for rent to 75+ population is higher than the national average and higher than future patterns of demand are likely to support. When we take into account the proportion of the older population of Rushmoor in tenures other than home ownership we see that the ratio of provision is that for every thousand people not in owner occupation there are 367 units of sheltered housing for rent.

Table 19 Sheltered Housing and variants in Rushmoor

Provider		Totals	1997	Ratio to 75+	1997
Pavilion HA	422				
Shaftesbury HA	134				
Anchor Trust	86				
Housing 21	37				
Raglan HA	24				
Hanover HA	23				
Thames Valley	18				
Total		744	637 (?)	150	151.3
Very Sheltered		88 +102	Nil	38.3	-
Leasehold		171	82	34.5	19.5
All sheltered		1125	1052	227	

(Source: Contact Consulting from Rushmoor & Hart Directory)

In Hart there has been a marked reduction in conventional sheltered housing units and some growth in both Very Sheltered units and sheltered housing offered for sale on leasehold. We are concerned to learn of the likely re-designation of much if not all of the Very Sheltered Housing to a more conventional role and comment further on this elsewhere in the report. Given the overwhelming weight of owner-occupation among older people in Hart we would judge that there is significant scope for further development of leasehold retirement accommodation. The role of both enhanced sheltered housing (which is what we would judge the current schemes in Hart actually to be) and fully fledged Extracare housing within an emerging pattern of provision seems to us to rely not so much on the demonstration of potential demand or need but on better alignment of policy, strategic intention and even of basic understanding between housing, health and social care partners.

Table 20 Sheltered Housing and variants in Hart

Provider		Totals	1997	Ratio to 75+	1997
Sentinel	151				
Hanover	80				
Total		231	337	48.4	
Very Sheltered	95		77	19.9	19.4
Leasehold	193		140	40.4	35.3
Total		519		108	

(Source: Contact Consulting from Rushmoor & Hart Directory

From Tables 19 to 21 it is clear that the provision of both residential care and nursing home places in both Rushmoor and Hart is low when compared with the national averages whilst the ratio of local authority to private sector provision in these areas is quite high. This demonstrates at the same time a conformity to one set of central government indicators: less reliance on institutional care, and lack of conformity with another: that the direct provision by the local authority should be a minority of available places. The overall picture would seem to demonstrate that there is need for forms of accommodation that are not institutional but do provide contexts for care for those who, in other parts of the country, might be assessed as needing residential or even nursing home care.

Table 21 Residential Care beds, Dual Registered beds and Nursing Home beds in Rushmoor & Hart

Type		Rushmoor	Hart
Residential Care	Private & Voluntary	125	90
	Local Authority	116	52
Total Res Care		241	142
Dual Registered	Private & Voluntary	58	98
	Local Authority	-	-
Nursing Home		97	-
Total dual and Nursing		155	98

(Source: Contact Consulting from Hampshire CC Directory)

Levels of provision in all categories of specialised accommodation for older people are especially low in Hart. This is particularly marked in relation to residential care places at around 40% of national average levels of provision and only a little higher for Nursing Home places at around 50% of national average levels. In Rushmoor the provision of sheltered housing and its variants is significantly above the national average and the deficit in residential and nursing home places not so marked. We include the ratios calculated in our report of 1998 for comparison.

Table 22 Provision of places for older people in Rushmoor

	Number of units/places	Per 1,000 of the population 75 years and over 2004	Per 1,000 of the population 75 years and over 1998	Benchmark England & Wales Average
Sheltered and very Sheltered housing	1,125	227	251.6	136.2
Residential Care places	241	48.6	55.3	76.1
Nursing Home places	155	31.3	31.8	41.5

(Source: Contact Consulting)

Table 23 Provision of places for older people in Hart

	Number of units/places	Per 1,000 of the population 75 years and over 2004	Per 1,000 of the population 75 years and over 1998	Benchmark England & Wales Average
Sheltered and very Sheltered housing	519	108	139.7	136.2
Residential Care places	142	29.7	57	76.1
Nursing Home places	98	20.5	41.3	41.5

(Source: Contact Consulting)

Table 24 sets out the numbers of places established by the Royal Commission on Long Term Care and the ratio to the population of older people identified by the 1991 census. This provides a benchmark, quoted above as the “England and Wales average”. Its significance is only indicative but does offer a means of making comparisons on a standardized basis.

Table 24 Provision of places for older people in England

	Number of units/places	Per 1,000 of the population 65 years and over	Per 1,000 of the population 75 years and over	Per 1,000 of the population 85 years and over
Sheltered and very Sheltered housing	516,524	65.8	136.2	490.7
Residential Care places	288,750	36.8	76.1	274.3
Nursing Home places	157,500	20.1	41.5	149.6

(Source: Contact Consulting, based on PSSRU for the Royal Commission on Long Term Care and ONS projections)

5 A review of national policies and initiatives

The Policy context

The foundations for the development of a pattern of provision within which people might expect to be supported and cared for within their own homes rather than in an institutional setting was laid in the NHS and Community Care Act 1990. More than a decade later, the aspirations of that legislation have still to be realised, not least because it has proved difficult to liberate resources from institutional provision to fund new services. However, the last 5 years has seen a raft of new legislation, guidance and policy advice from central government which simultaneously informs, drives and constrains local planning with a view to supporting and sustaining older people in their own homes for as long as possible and to enable them to live as independently as possible.

Independence and Self-Care

Offering patients choice over when and where they are treated represents a major shift for the NHS. No longer are patients expected to be passive and compliant and leave all the decisions to others. The focus now is on ensuring that services are personalised, responsive and with the active involvement of service users and the wider public. When it works this offers patients choices that reflect their own priorities in terms of treatment options, support and care and location.

The NHS Plan : A Plan for Investment, A Plan for Reform (DH, 2000) recognises the importance of enhancing quality of life, not just increasing its length. The Plan gives prominence to the values of dignity and independence. Within the Plan there is an imperative to develop preventative strategies and services that will reduce the risk of illness and disability. It encourages a style of service delivery that is about working with older people rather than for them and supporting them in retaining their independence and capacity for self-care, rather than accelerating dependency.

The National Service Framework for Older People (2001) sets out national standards of care, commits Government to ending discrimination in health and social care on grounds of age, and aims to promote active, healthy life in old age. There are 27 references to housing across the eight standards. Whilst there are no specific targets related to housing, four of the standards in particular have implications for the design and delivery of accommodation services:

- Standard One: rooting out age discrimination
- Standard two: person centred care
- Standard three: intermediate care
- Standard eight: the promotion of health and active life on old age

The role of such services is central to the successful delivery of the NSF and there is a recognition that the provision of accommodation and care are closely linked.

The Priorities and Planning Framework 2003-2006 enables the NHS to plan over a three-year period. It is intended that the NHS lead on improving access, patient experience, and alleviating health inequalities. The NHS and Social Services will lead jointly on services for older people. A three-year Local Delivery Plan replaces all existing national planning requirements, mirroring changes recently seen in social care. It sets out a number of targets for improving services for older people including an increase of at least an additional 5,000 intermediate care beds and 1,700 more residential intermediate care places by April of 2004 compared with the 1999/2000 baseline. It also requires a single integrated equipment service to be in place in the same timescale. By December of 2004 it is intended that all assessment of older people will begin within 48 hours of their first contact with social services and be completed within 4 weeks – with 70% being completed within 2 weeks. By the same timescale all aids and minor adaptations are required to be provided by social services within 7 working days. In December of the same year all health and social care systems are required to have an integrated falls service. By March of 2006 the requirement is to "improve the quality of life and independence of older people so that they can live at home wherever possible, by increasing the numbers of those supported to live at home to 30% of the total being supported by social services at home or in residential care".

Modernising Social Services (1998) points the way to a pattern of service that is "convenient to use, can respond quickly to emergencies, and provides top quality services". Within the proposals is the suggestion that support to allow people to remain in their own homes should be further expanded.

Housing-Based Models

The housing context within which a future pattern of accommodation and care may be set is to be found in Quality and Choice in Housing for Older People (2001). This too looks for the majority of older people to remain in their existing housing but to access the services that makes their continued occupation viable: from assistance in addressing problems with the fabric of the house, through adaptations to services to support the occupier. The document recognises that the majority of older people in the future will be home owners and the impact that this will have upon the assistance they require and the way in which services are delivered to them.

The Best Value regime has now been established in all areas of public service. The emphasis placed upon establishing best practice, seeking value for money, engaging in continuous improvement and involving service users and carers in the design and evaluation of services are becoming core to the process of developing and managing services. The application of Best Value to Sheltered Housing has been illustrated, for example, in Fletcher's 1999 study.

Figure A: Best Value and Very Sheltered Housing

Best Value Dimension	Key information or process
Challenge	Gain information and evidence on local preferences for different forms of accommodation and care for older people. Undertake customer satisfaction surveys in existing services. Organise whole systems event to review current services and think about alternatives, beginning with a 'clean sheet' and not from existing services. Map the aspirations of current and future generations of older people locally and compare with national data and local services.
Compare	Identify unit costs for residential, sheltered, Very Sheltered Housing and resource centres under current service provider arrangements. Benchmark unit costs across authorities and sectors. Model unit costs under different management arrangements i.e. external solutions as well as in house ones. Identify quality dimensions to existing services and benchmark with other sectors and authorities. This may entail establishing benchmarking clubs and partnership arrangements if sensitive and serious attempts are to be made to measure quality.
Consult	Use whole system events to gain perspectives on the relative costs and quality of different services and any trade off between them i.e. greater control of environment in sheltered and Very Sheltered Housing against risks of gaining appropriate care into the unit. Use the whole system event outcomes as the basis for structured focus groups with users from different settings and different interests, for example from minority ethnic groups. Consult with a wide range of non-users including citizens of all ages who have a stake in the local area and the future.
Compete	Test the marketing of different strategic options with a range of providers via soft or informal methods. Soft marketing can identify the level and degree of interest of alternative providers in the market opportunity. Expose standard aspects of services to competition and market testing.

Fletcher, 1999[1]

[1] Fletcher P et al 1999 Citizenship and Services in Older Age: The Strategic Role of Very Sheltered Housing, Housing 21

For those engaged in the operation of Residential Care Homes and Nursing Homes in both the private and public sectors the Care Standards Act 2000 is bringing major changes. Many smaller providers are leaving the market. Local Authorities, faced with the need for major re-investment, are considering transfer to voluntary or commercial organisations and re-provision, often with Very Sheltered Housing. There are a number of issues to be addressed by those who pursue this course: without clear plans for future capacity and service differentiation problems may be merely exported to the private or voluntary sector rather than being constructively addressed. For some forms of Extracare housing that may be part of any re-provision exercise their status in relation to registration with the Care Standards Agency may not be clear. Precedent is still being established and careful negotiation will be needed at a local level to establish a common understanding of how matters are to be handled.

Quality & Choice for Older People's Housing advances a positive view of the role that sheltered housing with appropriate care provision can play in a good old age:

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

However there are some caveats:

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

Quality & Choice for Older People's Housing goes on to conclude that key outcomes to be achieved should be:

> a greater focus on solutions that enable people to stay in their own homes for as long as possible or live in a home that best suits their needs and aspirations;
>
> facilities to enable older people to use their own resources effectively to improve their housing;

the enhancement of technological solutions which help older people to feel safe and secure at home; and

joint planning of new provision which takes a more strategic, 'whole systems' and 'citizenship' approach to meeting needs.

and that:

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

Partnership and Integration

Whilst the report of the Royal Commission into Long Term Care (1999) was mainly noted for its recommendations concerning the costs of those who found themselves cared for on a long-term basis in residential or nursing homes, its findings were much wider than this. In the supporting research volumes in particular the Commission provided a range of examples of alternative patterns of care, commending them as alternatives and additions to existing provision.

The changes to the funding of support services, brought into force through Supporting People (2000), provide opportunities for funding alternative services in a strategic way. The key objective of the Supporting People programme is to relate support to the individual whatever their tenure and not just to people living in specialist housing and accommodation. Where the mapping exercises that have been undertaken to provide baseline information for Supporting People at a local level are complete they will include information about specialised housing for older people. Shadow strategies developed to guide the initial funding decisions of Supporting People Boards will provide a starting point for wider strategic discussion.

The Office of the Deputy Prime Minister and the Department of Health have issued joint guidance on the preparation of Older People's Strategies (2003) that link housing to health, social care and other local strategies. Its principal intention is that Primary Care Trusts and local social services incorporate the housing needs of older people when drawing up their Local Delivery Plans and that local authority housing strategies have a specific focus on the delivery of housing-based solutions that address the needs of older people.[2]

Following this substantial volume of enabling legislation and guidance, more recently the style of relationship between central and local government has changed. Whilst Central Government affords a degree of discretion to local authorities in the management of their own affairs they set firm targets and measure outcomes through an increasingly sophisticated range of

[2] See also Fletcher P 2000 that reflects local case studies from work that supported the development of the guidance.

performance indicators. This has developed into a comprehensive performance assessment. The future allocation of resources will increasingly be determined by performance against these indicators.

Modernising Social Services (1998) and the Health Act 1999 placed new responsibilities on Social Services and Health Agencies to work together as well as introducing joint proprieties for health and social care. Whilst joint working had always been encouraged it increasingly becomes a requirement, and the theme of partnership working and whole system approaches becomes a consistent and constant message in guidance. These themes, targets and performance expectations are supported and reflected in the criteria utilised in inspection by both the Social Services Inspectorate and the Audit Commission. Cross-agency working not only between health and social care agencies but also housing features prominently in Inspection and in the Comprehensive Performance Assessment ratings of local authorities.

The NHS Plan (2000) emphasises that new resourcing will depend on change and the ability to work in partnership. Building Capacity and Partnership in Care (2001) encourages and requires new partnerships between statutory and independent sectors to develop a more strategic, inclusive and consistent approach to capacity planning locally. The Local Capacity Planning Group provides a potential platform for monitoring need and reviewing planned provision across the two authorities.

Tackling Health Inequalities : A Programme for Action (2003) builds on the Treasury-led Cross-Cutting Review of Health Inequalities (2002) and calls for "concerted action through joined up policy making across-departmental boundaries". The purpose of the review was to look at how existing resources from a range of sources could be matched to health needs and to develop a long-term strategy to narrow the health gap. It identified a number of interventions that can narrow this health gap including reducing smoking in manual groups, environmental improvements to tackle cold and damp housing and increasing safety at home for older people as well as working to reduce hospital admission and excess winter deaths. The Department of Health has produced guidance for local authorities, particularly those authorities within or near the bottom fifth for life expectancy, who wish to adopt a local Public Service Agreement (PSA) target on health inequalities. Meanwhile, PSA Target 6 commits the NHS to enable older people to live as independently as possible by reducing preventable hospitalisation and ensuring a year on year reduction in delayed transfers of care for people over 75.

Better Care Higher Standards (1999) a joint publication of the Department of Health and the Office of the Deputy Prime Minister requires a joint approach across health, housing and social care on both service standards and the provision of information. The Office of the Deputy Prime Minister and the Department of Health worked together to revise the guidance on adaptations which is likely to be published later in 2003. This again stresses not only partnership working but the need for a person-centred whole system approach. Increasingly the partnerships, planning, commissioning and delivering service that are required are ones which include and involve those

who need services and their carers who should be empowered to make informed choices.

Most recently there has been a move to further constrain, if not directly control, the latitude or capacity of local authorities to determine process, policy and priority in the pursuit of consistent national standards. The Fair Access to Care Services Circular (2002) requires local authorities to review and make explicit their eligibility criteria. The Single Assessment Process for Older People Circular (2001-2002) standardised the assessment process and care management system for older people. However, Improvement, Expansion and Reform – The Next 3 Years: National Priorities and Planning Framework 2003-2006, places the stiffest targets yet on the nature and volume of services to older people.

Alongside the more explicit values, the greater prescription and tougher targets has developed a range of supportive mechanisms for driving the partnerships and reforms envisaged by central government. The most tangible example is the Health and Social Care Change Agent Team of the Department of Health who offer targeted interventions to support health and care systems struggling to meet system change requirements. They have also produced either directly or in partnership a range of best practice guidance including "Discharge from Hospital: Pathways, Processes and Practices (2003)" and "A Catalyst for Change: Driving Change in the Strategic Commissioning of Non-Acute Services for Older People (2003)". These two publications together with the Audit Commission "Integrated Services for Older People" (2002) major not only on the development of a whole system approach but on an increased role for housing in developing a quality system for older people.

Key to the success of all these initiatives is the active involvement of older people in the development and monitoring of services. The Government has signalled a desire to see more localism and diversity within an integrated health and social care system. New providers and the flexibility to develop new patterns of provision together with current and potential users give an opportunity to deliver quality public services that meet the changing needs and aspirations of older people. Housing-based solutions will be key to the effective implementation of preventative strategies and care pathways with patterns of service that allow people to exercise real choice.

The focus of service-planning is increasingly found in a "whole system" approach that attempts to reflect the service user's perspective. Older people do not experience need in tidy compartments that match the organisational structure of providers. Services should be connected in the ways that needs are connected. The most effective way of ensuring that this perspective informs service planning is to involve past and potential service users in the processes of service design, review and evaluation.

6 Key issues identified in the brief

The Commissioners, in their preparatory discussions, identified a number of key issues to be included in the study. In reporting the responses made by stakeholders to these issues we have aggregated some that seem to us to represent aspects of the same fundamental topic area.

The Impact of Supporting People

The impact of supporting people is seen to be different according to where you stand in the system. For many it is seen to have had little impact in the immediate term, whilst for others it seems that their working environment has been in turmoil. The reductions to be made in finance for future years are to be viewed with some trepidation, not least because it is felt that innovative and preventative schemes are most likely to suffer. Cuts of £3.8 million must be made in the Hampshire Supporting People budget. These savings will be achieved through the review process that will seek to identify duplication, potential improvements in service quality and the scope for achieving improvement in value for money. Investment in new services is expected in 2005/2006 following the completion of the initial period of Supporting People and a full round of service reviews. Some continue to experience anxiety about future funding levels and whilst the initial arrangements have left some room for manoeuvre, anxieties about future levels of funding may lead to a reduction in services for enhanced sheltered housing in Hart and have placed a severe brake on the bringing forward of new initiatives in both Rushmoor and Hart.

The Supporting People Review of home improvement agencies was completed in December and finds the Rushmoor and Hart Staying Put scheme to be meeting all required standards. The recommendation is therefore for funding from Supporting People to continue.

There is a perception that sheltered housing is well down the list for reviews, but an appreciation that preparing for Supporting People has driven the formalisation and documentation of procedures and protocols which has been helpful in clarifying the nature and status of services. Pavilion HA felt that Supporting People has not really influenced the shape of service but has led them to undertake a good deal of work to support wardens in developing their practice. They also have the benefit of a floating support worker, funded by Supporting People, to provide tenant support to older tenants in general stock. This is a very welcome development as it balances concerns for the future of sheltered housing with a quite proper desire to do something for that large proportion of older tenants who live in the general stock.

Sheltered Housing reviews and Asset Management reviews

While Sentinel Housing Group have carried out an asset management review that has included their sheltered stock they are, entirely understandably, a little reluctant to make the provisional outcomes widely known. It would not be unreasonable to expect that the Review will indicate that some schemes are sustainable as they stand; others either need investment or the exploration of alternative use, whilst others will pose more major problems so far as their future viability is concerned. In Pavilion HA various activities have been undertaken, including a tenant survey that sheds some light on the current situation within their sheltered stock. There is a feeling that the two major providers are looking to find an appropriate basis on which to develop an authoritative strategy for their sheltered stock. It has not been possible to establish what reviews if any have been undertaken by other providers within the area.

Our site visits to a range of sheltered schemes in Rushmoor and Hart revealed a number of ad hoc developments in provision. These were both in the enhancement of facilities and modification in the range of services provided. It underscored the need for all providers to be engaged in the ongoing discussion about the definition and role of the various models of sheltered housing within a comprehensive range of provision in the area.

There is a general feeling that some hard decisions will need to be made about the future of the older rented stock in both Rushmoor and Hart and that these issues have become clearer since the provision of our last report in January 1998.

Changing Provision

The most significant change to have been achieved to date is the opening of Place Court, an ExtraCare scheme, in Rushmoor. This arose in part from recommendations made in the 1998 report.

There are a number of issues around allocation to and perceptions of this scheme to which we shall return later in the report. In Hart the nature of the services to be provided in the two “extra care” schemes managed by Sentinel: Rosefield and Hedgecroft – is currently under review. In our judgment these schemes should meet our criteria for “enhanced sheltered housing” and we would endorse the views expressed to us that they do not meet current criteria for the definition of “extra care” housing. This anomaly clearly gives rise to a number of issues about the use of the schemes and consequently about the funding of the services.

Two conventional housing schemes have been closed, Place Court where re-provision has taken the form of an extra care scheme, and Bellevue House, that would hardly have been considered a conventional sheltered scheme in its design.

In both areas, in line with national trends, there is strong interest in developing leasehold retirement housing. This is most noticeable in Beaumont Village in Aldershot which will provide a retirement village which includes sheltered housing for rent, leasehold sheltered housing and residential care homes. There is continuing pressure here, and elsewhere from commercial developers, and this reflects the influences we identified in our first report coming from the rising proportion of older people who are owner-occupiers and wish to maintain their tenure into retirement.

Services for owner-occupiers

In addition to the need to respond to the aspirations of those who wish to move into specialised accommodation on a basis of ownership there is a continuing demand for services that will support older home owners in their existing property. With a reduction nationally in funding for renovation grants and an increasing emphasis, through the Regulatory Reform Order, on other ways of funding major repairs and improvements the role of Home Improvement Agencies is changing. In many areas the local HIA is the main vehicle for accessing equity based finance on behalf of clients, through schemes like House Proud, in order to finance repairs and improvements. Handyperson schemes that will provide a flexible service to meet small repair and maintenance needs have become more central in the operation of HIAs, such as the Staying Put scheme operating in Rushmoor and Hart. In many parts of the country HIAs have taken a more prominent role in the delivery of both minor and major adaptations. Many HIAs are also closely involved in delivering falls prevention programmes and other key elements of the health, housing and social care agenda. After a period of change and some uncertainty it seems that Staying Put in Rushmoor and Hart is well placed to work with the leading stakeholders in exploring such developments to its current range of services whilst consolidating those it already provides. At the time of our fieldwork it appeared that the sense of connection between the managing organisation, the local project and the statutory stakeholders seemed less secure than it had been in the past. The capacity of the project to engage with the wider health, housing and social care agenda will depend upon the ability of the stakeholders to share their aspirations for the service explicitly and explore the capacity issues if the agency is to fulfil its potential.

The adequacy of options available to older people in Rushmoor and Hart

Clearly, the sustaining of Staying Put services, the development in enhanced and extra care sheltered housing and the increasing provision of leasehold, are all enriching the range of options available to older people. The gaps would appear to be in a further sophistication of the range of services offered to people in their own homes, principally as owner-occupiers, the clarity of view about the future role of conventional sheltered housing and the volume that may be needed for rent, together with clarification of the role and purpose of enhanced and extra care housing. A lack of clarity in social care and health perceptions of the role and purpose of such accommodation is inhibiting further development and the achievement of its potential benefit in substituting for residential care.

Rushmoor's 50-plus scheme allowing choice in housing allocation has had the unlooked-for effect of filling bed-sit sheltered housing. Whilst in the short term this resolves a housing management issue, it raises other questions about how different groups of vulnerable people including those approaching or already in old age, are best accommodated. We shall return to this topic later in the report.

Promoting and marketing sheltered housing

There is widespread appreciation that the ability to promote and market sheltered housing depends on having a product which will be attractive to older people, especially to those who may be currently under-occupying family-sized accommodation. The current budget for offering inducement to under-occupiers to move to sheltered housing is, to put it politely, nominal. This gives rise to the question as to whether either the local authorities or the principal housing providers are serious about trying to attract older tenants in general housing into sheltered stock in order to release units for reallocation. It will be impossible to develop an effective marketing strategy for sheltered housing until the fundamental questions about its purpose within the local economy for housing and care for older people has been authoritatively answered. It would appear that location is as important as design and facilities in maintaining lettability of sheltered housing and therefore careful thought needs to be given to the sustainability of the location (by which we mean the likelihood that shopping and other local facilities remain viable and access to public transport will remain good) before making any major investment in remodelling or refurbishment

If an attempt is to be made to invest in the refurbishment or enhancement of sheltered housing it would seem sensible to involve some of those who are in the target group in the planning and design of such a project.

Good Practice example:
The ExtraCare Charitable Trust has developed a unique brand of marketing and consultation for its new-build village schemes. They mount a publicity campaign advertising the features of the scheme they propose to develop. They back this up with a mail shot to older people in the target area inviting people to an event, usually at a local entertainment venue. The programme for the event may use a format such as that for "Who wants to be a millionaire", complete with the audience participation keypads, to elicit views and aspirations over a wide range of topics. Participants will be invited to indicate their interest in the development and from this point onward contact will be maintained through newsletters and information events. As the development progresses potential residents will be invited to express a view or choose from options in relation to facilities and services. The fine design of social and recreational facilities, and the services to support their use, will be consulted upon. The pattern of consultation continues with those who actually move into the development in relation to the life and management of the scheme.

Future Aspirations

There is a general recognition that aspirations will continue to rise, particularly in relation to space standards. This does raise the questions about the worthwhileness of remodelling sheltered housing that has small units. There is recognition that if sheltered housing is to clearly associated with dependency then it will become stigmatised and achieving a balanced community will be even more difficult.

Research[3] identifies a wide range of elements to emerging aspirations for older people which we summarise as follows:

- More spacious accommodation; mentioning particularly the capacity to accommodate guests, greater storage space, more spacious kitchens, and the space to pursue hobbies within their own accommodation rather than in communal space.
- The opportunity to maintain a high degree of privacy in their personal life.
- Accommodation that is secure from both actual and perceived threats of crime and intrusion.
- Easy maintenance of both accommodation and gardens, or maintenance delegated to others at an affordable rate.
- Access to private transport: whether through continued car ownership or the use of a pavement scooter.
- Access to a range of quality facilities for shopping, banking, healthcare, and so on.
- Access to facilities for a wide range of educational and cultural pursuits.
- Access to facilities to maintain personal fitness.
- Opportunities to participate in the shaping of facilities and services that impact upon their quality of life.

[3] Appleton N 2002 Planning for the majority - the needs and aspirations of older people in general housing, York Publishing Services for the Joseph Rowntree Foundation

Alternative and complementary uses for conventional sheltered housing

The most obvious alternative use for conventional sheltered housing is for it to continue to be offered to older people able to live independently but without services, other than perhaps connection to a community alarm. Communal facilities for the exclusive use of tenants could be reduced by the re-designation of the common room as a community hall for general use. Priced appropriately such accommodation might be attractive to some who wish to have smaller accommodation but have no need of a warden service (whether resident or not). Investment in such a scheme to improve its appearance, upgrade security, and in marketing would provide continued life for the building whilst diversifying the stock being offered to those in early old age.

Alternatively, some sheltered schemes might be considered for the accommodation of other groups within the community. There are many examples of sheltered schemes being converted to student accommodation. Some smaller schemes might provide transitional accommodation for care leavers, either mixed with other groups or not.

A recent proposal has been for a de-commissioned conventional sheltered scheme to be used for care workers, specifically domiciliary and residential care home workers being recruited from the Accession States of the European Union and offered time limited accommodation as part of their package.

Neighbouring Authorities

In the course of the study we conducted interviews with officers of Waverley BC, Guildford BC and Surrey Heath DC. The situation of each is, as one would expect slightly different. Each is at a different stage in relation to developing their strategic approach top meeting the future needs of an ageing population and in the range of provision they currently offer. Surrey Heath, for example, felt that all key questions would need to be referred to providing organisations, Guildford take considerable provide in the fact that they were early in the field in modifying the role of their sheltered stock.

Common themes were around the identification of an over supply of conventional sheltered housing to rent. Some sheltered stock had been de-commissioned but over supply and low demand continued to be an issue. Various forms of enhancement of sheltered housing had been attempted and all recognised the need to move toward an increase in enhanced of extra care housing. All too recognised that rental options would have a limited appeal to the increasing proportion of older home owners.

There was also a feeling that some common definitions and protocols for allocation/ admission to the various forms of specialised accommodation for older people would be helpful. This may be an area in which a cross-border approach would be helpful.

7 Specialised accommodation for older people

Background

The provision of accommodation and care to meet the needs of older people involves the development of a whole system in which options to access care and decisions about accommodation operate in a way that maximises choice for the individual. The elements of both accommodation and care should be capable of being brought together in a configuration that best matches the needs of each individual. Thus an older person wanting to remain in their own home might receive a package of home care, coupled with assistance with making their home warm, secure and accessible. An older person already living in sheltered housing and experiencing a deterioration in their capacity to care for themselves might receive a package of support and access to specialised facilities within the scheme, without a requirement to move to residential care. The linkage between accommodation context and a "blanket" pattern of care in the traditional pattern of accommodation and care services is shown in Figure B

Figure B The traditional configuration of accommodation and care for older people

Accommodation Context	Characteristics
General Housing	Community personal social care. Community medical, nursing and para-medical services. Meals on wheels. Provision on demand according to need.
Sheltered Housing	As above but with support from a warden, generally resident on site. Provision on demand according to need.
Residential Care	Higher inputs of personal social care. Community medical and para-medical services. All meals provided. "Blanket" provision.
Nursing Homes	Frequent nursing and higher levels of personal social care. Special arrangements for medical and para-medical services. All meals provided. "Blanket" provision.

Current policy and practice requires a much more diverse pattern that allows a unique mix of accommodation setting and services to be matched to the needs of the individual. This is set out in detail in Annex B and provides a context for the diversification of accommodation forms and options that this report seeks to encourage.

Specialised accommodation as a context for care

The specialised accommodation that may provide a context for the delivery of care, and already mapped in Section Three, is principally of four kinds:

- Conventional sheltered housing
- Very Sheltered or Extracare housing
- Residential care, whether provided by the local authority or by commercial or voluntary organisations
- Nursing Homes

We would propose a fifth category: Enhanced sheltered housing which, we suggest, provides facilities additional to those found in conventional sheltered housing but does not meet all the criteria for Very Sheltered or Extracare housing. Whilst some would argue that the introduction of such a fifth category is unhelpful it does provide an opportunity to establish some definitions that are graduated according to the facilities and services offered. The distinction between conventional, enhanced and extra care housing is one that is appearing in good practice and related guidance, not least from the Change Agent Team at the Department of Health as they encourage the development of more sophisticated forms of specialised accommodation for older people.

Calling all such accommodation “retirement housing” may make good marketing sense, and provide a new “domain name” that encompasses all these models but it is an unhelpful blurring of distinctions that are crucial when trying to understand, in relation to meeting the needs of an individual older person, which model may be appropriate for which level of dependency.

Conventional Sheltered Housing By Conventional Sheltered Housing we mean a block of flats or development of bungalows designed specifically for exclusive occupation by older people with communal facilities and, generally, support provided by a warden who lives on site. The description Category Two Sheltered Housing arises from the Ministry of Housing and Local Government circular 82/69 which defined the two principal categories of sheltered housing then being developed by local authorities and emerging housing associations.

This has been a most popular form of provision and from the late 1960s to the mid 1980s large numbers of such schemes were developed throughout the country. The United Kingdom has around half a million such units for rent.

The enormous popularity of sheltered housing to rent was followed from the mid-1970s onwards by the development of leasehold sheltered housing in which owner-occupiers, often excluded from sheltered housing to rent, could purchase a long lease and pay a service charge for warden and estate services.

From the peak of its popularity in the late 1970s sheltered housing for rent has experienced something of a reversal in fortunes. Some schemes have proved difficult to let and in others existing facilities and patterns of service have been

found to have limitations in coping with the needs of an ageing and increasingly frail tenant population.

One response has been to radically alter the role of the warden. From providing background cover against emergencies and informal care in the style of a good neighbour the role of the warden has been transformed to become that of partner in the care process. New styles of working for wardens will generally involve working office hours, in many cases living off site and acting as liaison and advocate alongside health and social care colleagues in securing and monitoring the support provided to tenants.

Conventional sheltered housing is still directed principally toward those older people able to live independently and with only light or occasional need for care that can be accessed on the same basis as for older people living in general housing.

Demand for conventional sheltered housing in some areas appears to be driven by social rather than care needs: the desire to overcome isolation and loneliness, to feel more secure, and so on. This may argue for the designation of some sheltered housing schemes being reconsidered to reflect the actual profile of need within the scheme.

Most commentators expect the stock of conventional sheltered housing for rent to decline in the coming decade. This is in the face of four main factors:

- The small size of many of the flats, including many bedsits.
- Increased opportunities for remaining in existing housing.
- Higher age and greater frailty at transfer from existing housing moves directly to more supportive housing, missing out conventional sheltered housing.
- The increase in home ownership among older people makes renting sheltered housing less attractive.

Sheltered housing for rent will however remain an important option for many older people and sheltered schemes provide potential bases for activities open to the general community and for care teams serving the area in which they are set.

Whilst provision of conventional sheltered housing for rent in Rushmoor is high and will need to reduce significantly to achieve a balanced and sustainable pattern the level of provision in Hart is already quite low. In projecting future levels of provision in Hart our suggestion is that the level should remain stable, although with some renewal and even re-provision. The process of adjustment in capacity may be easier to manage if there is some flexibility in cross border allocations between Hart and Rushmoor.

Leasehold retirement accommodation Through the 1970s and 1980s older home owners were generally excluded from rented sheltered housing and leasehold sheltered housing began to be offered as an alternative. Some housing associations offered sheltered housing for sale on a 99 year lease to

home owners also offering some units on a “shared equity” basis to facilitate access by those who might be moving from relatively low value properties. A number of commercial providers entered the market, most notably McCarthy and Stone. The design and fundamental features of their schemes initially resembled rented models. The initial point of divergence tended to be in the absence of a resident warden service, withdrawn in response to leaseholders concerns around service charges. After a period of difficulty arising from the housing slump at the end of the 1980s the market is now buoyant and dominated by private sector providers. The product has generally moved up market and some schemes are enhanced, reflecting the trends in rented sheltered housing noted below. Such developments can play an important part in addressing the balance in provision to respond to the shift toward home ownership among older people and their desire to maintain that tenure on their move to specialist accommodation.

Enhanced Sheltered Housing We use this term to distinguish some schemes from conventional sheltered housing on the one hand and from full Very Sheltered or Extra Care sheltered schemes on the other. Confusingly many of these schemes will be referred to by providers as Very Sheltered or Extra Care sheltered housing.

In Enhanced Sheltered Housing the role of the warden will have been developed along the lines described above. Arrangements may have been entered into for a dedicated care team to be based in the scheme to achieve efficiency and flexibility in the match of care resources to changing needs among tenants. Additional facilities will normally have been provided for

assisted bathing and possibly a treatment room. Meals may be provided as a matter of course. In schemes, new built for this purpose, additional facilities may have been incorporated in the design of individual flats, level access showers for example in place of baths.

Allocation to this accommodation will generally be through protocols and procedures agreed with the housing authority and social services. Most providers will wish to maintain some balance in the scheme between those needing these additional facilities and services and those able to live, on admission, generally independent lives. Maintaining this balance poses problems in smaller schemes where the viability of dedicated care arrangements depends upon a critical mass of need for care.

Some Enhanced Sheltered schemes have been developed by the modification of existing sheltered housing and these will generally be around 35 to 40 units. Many of the schemes now built for this purpose will be of a slightly larger size.

Among the perceived advantages in this style of provision is the separation of housing costs and care costs. Those tenants not able to meet the full cost of their housing and related services will receive assistance through Housing Benefit. The Social Service authority will meet care costs on the same basis as in general housing. Where an older person receives care in this context,

rather than in residential care whether in the public or private sector, there is a significant saving to Social Service budgets. It may be argued that this is merely cost shunting but evidence produced by Baker in his study for Cambridgeshire County Council indicated that there was also an overall saving to the Public Purse in most circumstances.

Further provision of Enhanced Sheltered Housing may play a significant part in offering an alternative option for those who might otherwise move to residential care whilst extending the viability of independent living for existing sheltered housing tenants.

Extracare Housing We would distinguish between Enhanced Sheltered Housing and a fully worked Extracare model. In previous work[4] we have identified six features that one would wish to see in such a scheme:

- Occupation on the basis of a tenancy.
- Allocation through an inter-disciplinary panel operating to agreed criteria.
- Dedicated care arrangements integrated with the management of the scheme as a whole.
- Facilities and programmes to emphasise learning, personal growth and peer support.
- Individual accommodation designed to enhance independence and privacy.
- A range of social and recreational facilities.

In best practice a Very Sheltered scheme should represent a balanced community of those with varying degrees of need for care. The scheme should be capable of providing care up to and including high levels of nursing care.

The Extracare Charitable Trust is widely recognised as providing a benchmark for new developments of this kind. They are currently pursuing a policy of developing larger schemes in the belief that the economies of scale make it possible to include a more sophisticated range of communal facilities and that larger schemes provide a pool of residents capable of supporting a wide range of activities. In recent schemes Extracare have included units for sale, either outright or on a shared equity basis, with rented units.

Residential Care The roots of residential care in the public sector may be traced beyond the 1948 National Assistance Act[5] to Poor Law provisions stretching back into the nineteenth century. Much of the older provision was replaced in the 1960s and 1970s with subsequent legislation and practice leading to improvements in standards. The introduction of new regulatory regimes from 2002 with the requirement to meet new standards both for services and facilities has focused attention on local authority residential care

[4] Appleton N Extracare housing for older people, an introduction for commissioners, Department of Health, 2003
[5] National Assistance Act 1948, section 21.

in many parts of the country. The care provided through local authority residential care homes has been widely appreciated by residents, carers and the general community. Many commentators would see this style of provision as a dated model for care that places over-emphasis upon dependency. The difficulty of finding sufficient funds to make improvements to meet new standards, although highly significant, is not the pre-eminent consideration. Residential care provided in these settings must be set not only against care provided in private residential care homes but also against the overwhelming expressed desire of older people to remain in their own homes and the range of services that can now be delivered there.

Residential care in the private sector also has a long history. Until the 1980s much of the residential care provided in the private sector was for those able to meet their own care costs. The unintended consequence of changes in regulations in the early 1980s, so that financial support from public funds was available to those cared for in private residential care homes, was an enormous increase in the sector. Some homes are almost wholly dependent upon residents funded by the local authority and most would say that their fee levels are heavily influenced by local authority levels.

Both nationally and locally some contraction is apparent in the private residential care home sector. Some providers have withdrawn from the market because the cost of meeting rising standards seemed prohibitive and a boom in property prices offered an opportunity to leave with some return on capital invested. Within the sector many would argue that artificially depressed levels of payment by local authorities are forcing many homes out of business. In some areas the development of alternative services is having an impact on demand. Many older people and their families will delay a move to a residential care home for as long as possible because of the financial implications for those with additional income, savings or assets such as their own home.

Hampshire have sought to reduce reliance on residential care placement by enhancing and extending the range of support offered to those who continue to live in their existing property.

Nursing Home Care Like private residential care, private nursing homes have been in existence for many years but only in the last twenty years have they been generally accessible to people needing public funding to meet the cost of their care. The growth of this sector has been promoted by two principal factors:

- The availability of public funds to support care costs.
- The general withdrawal of provision for in-patient chronic care of older people within the NHS.

Some larger nursing homes have been developed specifically as re-provision following the closure of long-stay wards in NHS hospitals. These closures have followed upon a concentration within NHS hospitals on acute care and

the conviction that a hospital ward did not provide an appropriate setting for long term care.

Nursing Homes generally provide for those who have some need for frequent nursing attention in addition to social care, a level of care that does not require the constant supervision of a medically qualified person.

Residential Care and Nursing Home care for those experiencing mental frailty There is only limited provision in most areas of residential care specifically designed for people with mental frailty. The existing numbers of people with some degree of mental confusion are substantial and the increase in the oldest sections of the population will contribute to a significant increase in need for service.

Good Practice Example

Seven Oaks, Fold Housing Association, Londonderry, Northern Ireland

Developed in partnership with Foyle Health and Social Services Trust the Seven Oaks scheme incorporates many features of current best practice in providing accommodation for people with dementia. In addition to the flats and bungalows on site the scheme provides accommodation for the dementia care team of the Foyle Health and Social Services Trust and offices for the Alzheimer's Society from which they operate a domiciliary care service. The scheme provides a day centre for people with dementia and they can cater for between fifteen and twenty people a day.

From the main entrance visitors come into the foyer which is an open space under a large atrium where residents gather to watch the "comings and goings". Immediately off this area is a small pub providing familiar surroundings for socialising. Other communal facilities include the hairdressing salon, the café reminiscence lounge, therapy kitchen and other prompts to recollection such as a row of shop fronts and a working red telephone kiosk in one of the courtyards. The flats are set out in groupings each with dining facilities and living space, a small kitchen, assisted bathing facilities. The layout of these living areas give a domestic feel to the development and a whole range of prompts, from colour schemes to detailed fittings are designed to aid orientation and familiarity. The accommodation is laid out principally around two courtyards and all flatlets have either a view to the outside or to one of the inner courtyards. Each flatlet has en suite facilities with a walk-in shower.

The site also includes five bungalows that offer the opportunity for couples to stay together when one has developed dementia. The proximity to the main building and its staff provides re-assurance and relief to the carer in such a household. Each bungalow comprises a living room, double and single bedroom, a kitchen and bathroom, in which both a bath and walk-in shower have been provided. The bungalows are designed to accessibility standards with level access and good manoeuvring space in all areas.

The scheme is partially registered in line with the Registered Care Homes NI Regulations. Ten of the flatlets are designated for those with moderate dementia and six are for people whose dementia requires more than one to one input from staff. The other fourteen flats provide a housing option for people with mild dementia who require the security and support afforded by the scheme design and the re-assurance of having a staff team available twenty-four hours a day.

8 Proposing a pattern of provision for Rushmoor and Hart to respond to national trends and local needs

Our conclusions are broadly the same as those we reached in 1998:

- The demand for rented conventional sheltered housing is likely to decline
- The suitability of the older stock for letting will become increasingly problematic
- The potential for leasehold retirement housing will continue to grow
- Some existing schemes will lend themselves to refurbishment and remodelling to provide enhanced sheltered housing to supporting rising levels of frailty.
- Some of this enhanced sheltered housing should be offered for sale alongside that for rent.
- There is a need for an increasing proportion of extra care housing but its viability depends on a stronger strategic relationship between health, housing and social care agencies.
- Extracare housing should be provided for sale and rent.
- There is a need for housing-based models of accommodation and care for people with dementia.
- The proper design and use of Extracare housing should mitigate the demand for an increase in residential care provision and may allow some measure of re-provision.
- Housing-based models for dementia care will provide an alternative to nursing home based strategies for meeting the needs of those living with moderate to severe dementia

Projecting a range of needs to be matched to categories of provision we are led to suggest target ratios per thousand of the seventy-five plus population.

Projecting a balanced range of provision

The model developed in work with the Change Agent Team and drawing also on the studies we have undertaken for a wide range of local authorities assumes that a “norm” for conventional sheltered housing to rent would be around 50 units per 1,000 of the population over 75 years of age and around 75 units per 1,000 of leasehold conventional sheltered housing. This inverts the current levels of provision in most places but reflects the rapidly changing tenure balance where around 70% of those over 75 years of age are home owners.

Some of the loss in conventional sheltered housing for rent will be off set by the provision of enhanced sheltered housing with a projection of around 20 places per 1,000 people over 75, divided equally between ownership and renting. Full Extra Care Housing offers the possibility of housing a balanced community of people with relatively limited care needs through to those who might otherwise be living in residential care, total provision is projected at 25

per 1,000, again divided between rent and sale. In each model a modest provision is made for the development of housing forms to provide a context for the care of those people with dementia who cannot be supported in their existing home but require an alternative to residential or nursing home care, the norm here is 6 places per 1,000.

In relation to residential care in all sectors it is our assumption that capacity can be allowed to decline below the current national average of around 76 places per thousand people over seventy-five years of age to around 65 places per thousand. This reflects the capacity to support older people who would otherwise be allocated to residential care in other forms of accommodation, such as extra care housing and improved support to people in their existing home. The decline in capacity is likely to be achieved largely by the continuing exodus of small and medium providers, or the enhancement of services to provide nursing home care.

In relation to nursing home care we expect the national level of provision to remain at approximately its current level and have used the norm of 40 places per thousand of those seventy-five years and over.

These norms are all set at 2001 population levels, projected forward this means that, as numbers in the upper age groups increases, the ratio of institutional and specialised housing provision will decline, in line with national government targets to support an increasing proportion of older people in their existing homes.

These “norms” are inevitably arbitrary and have been moderated to take account of the rate of change that would be required to meet them in Rushmoor and Hart. The pattern projected is for the medium to long-term and may need to be adjusted as newer forms are developed and mature.

Applied to Rushmoor and Hart there are some particular anomalies that arise from the current under-provision of residential and nursing home places and from confusion about the exact current role of some accommodation designated as Very Sheltered. We have, for example, suggested a higher than norm provision of Enhanced sheltered housing and Extracare to compensate in part for the deficit in Residential Care and Nursing Home capacity.

It is our experience that Housing Needs Studies often generate predicted demand for conventional sheltered housing which are in contradiction to our suggested trends. This difficulty is inherent in the unavoidable limitations of such surveys: they measure what the public expect they will want in the future and respondents can only generally identify choices from options that already exist and that they have knowledge of. The predictions of demand for sheltered housing, for example, may be best taken as indicators of demand for specialised housing in one of its variants and therefore relates to the total quantum of specialised accommodation and specialised services, rather than to those established forms that already exist.

In Hampshire there is a further complication in relation to our projections. We have operated upon assumptions about the reduction in dependency upon institutional forms of accommodation, such as nursing home places, in line with the main thrust of central government policy. Hampshire has adopted a policy of increasing the capacity of nursing home care to ease current and predicted pressures on high dependency capacity, in line with more particular government initiatives. We would argue that this lies at the heart of the strategic misalignment between district councils pursuing housing based models whilst the county council, in concert with health partners, is focused on a strategy that looks to support people in their own homes and alongside that to depend on nursing home care for high dependency cases. We offer our own projections as material for the exploration of that strategic challenge.

In summary we therefore would suggest a future pattern set out in Tables 25 and 26.

Table 25 — Proposed levels of provision of various forms of accommodation for older people - Rushmoor

		Current provision	**Increase or decrease**	**Resulting number of units**	**Provision per 1,000 of Population 75+**
Conventional sheltered housing		744	-496	248	50
Leasehold sheltered housing		171	+77	248	50
Enhanced sheltered housing	For rent	102	+22	124	25
	For sale	Nil	+50	50	10
Extracare sheltered housing	For rent	88	No change	88	18
	For sale	Nil	+74	74	15
Housing-based provision for dementia		Nil	+30	30	6
Residential Care	Local Authority	116	No change	241	49
	Private	125			
Nursing Homes		155	+15	170	35

`Table 26 Proposed levels of provision of various forms of accommodation for older people - Hart

<table>
<tr><th colspan="2"></th><th>Current provision</th><th>Increase or decrease</th><th>Resulting number of units</th><th>Provision per 1,000 of Population 75+</th></tr>
<tr><td colspan="2">Conventional sheltered housing</td><td>231</td><td>No change</td><td>231</td><td>49</td></tr>
<tr><td colspan="2">Leasehold sheltered housing</td><td>193</td><td>+45</td><td>238</td><td>50</td></tr>
<tr><td rowspan="2">Enhanced sheltered housing</td><td>For rent</td><td>95</td><td>+25</td><td>120</td><td>25</td></tr>
<tr><td>For sale</td><td>Nil</td><td>+48</td><td>48</td><td>10</td></tr>
<tr><td rowspan="2">Extracare sheltered housing</td><td>For rent</td><td>Nil</td><td>+72</td><td>72</td><td>15</td></tr>
<tr><td>For sale</td><td>Nil</td><td>+72</td><td>72</td><td>15</td></tr>
<tr><td colspan="2">Housing-based provision for dementia</td><td>Nil</td><td>+29</td><td>29</td><td>6</td></tr>
<tr><td rowspan="2">Residential Care</td><td>Local Authority</td><td>52</td><td rowspan="2">No change</td><td rowspan="2">142</td><td rowspan="2">30</td></tr>
<tr><td>Private</td><td>90</td></tr>
<tr><td colspan="2">Nursing Homes</td><td>98</td><td>+69</td><td>167</td><td>35</td></tr>
</table>

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Annex B Elements of a whole system for accommodation and care for older people

Background to the elements of whole system

The provision of accommodation and care to meet the needs of older people involves the development of an whole system in which options to access care and decisions about accommodation operate in a way that maximises choice for the individual. The elements of both accommodation and care should be capable of being brought together in a configuration that best matches the needs of each individual. Thus an older person wanting to remain in their own home might receive a package of home care, coupled with assistance with making their home warm, secure and accessible. An older person already living in sheltered housing and experiencing a deterioration in their capacity to care for themselves might receive a package of support and access to specialised facilities within the scheme, without a requirement to move to residential care.

The exercise of choice needs good information and appropriate arrangements for providing individual information, advice and assessment, that respond to the needs of whole situations, taking account of personal preference, family and community setting, financial issues, as well as medical condition and functional capacity. To provide such a function we suggest the development of a single portal for connection to service and an integrated front-end to service, such as that provided by a Care Direct model.

The situation and needs of older owner occupiers

This is the majority tenure among older people but the attention directed toward it has generally been far out-weighed by that given to social rented housing. Services that might respond to the specific needs of older owner occupiers broadly fall into three categories:

1. Support in maintaining or adapting their home in a way that makes it an appropriate and viable context for maintaining an independent lifestyle.

2. Services that will meet needs arising from deficits in the capacity to cope with the tasks of personal or domiciliary care.

3. Specific health care needs.

Services to meet needs in the second two categories are offered without reference to tenure and those living in their own homes have the same rights of access to assessment and service as other older people. Whilst older home owners have had access to assistance through the renovation grant arrangements and to assistance with the funding of adaptations through the Disabled Facilities Grant arrangements the pattern of service has been less than comprehensive.

Grants to owner-occupiers to enable them to carry our both major repairs to their homes (using renovation grants) and more minor works (using Home Repairs Assistance grants) have until 2002 been provided through powers contained in the Housing Grants, Construction and Regeneration Act, 1996 and preceding legislation. This targeted assistance towards those in greatest need, principally older home-owners in property in poor repair. That part of the Act dealing with grants for these purposes has been reformed by a Regulatory Reform Order that became effective in 2002.

The Regulatory Reform Order does provide significant opportunities for the local authority to use grant aid to facilitate small works that may assist in the delivery of wider objectives than those simply related to the condition of the housing stock. It is possible to provide grants that will facilitate work that forms part of a Falls Prevention strategy.

The decision made by older people to leave their existing home and accept a move to specialised accommodation is not only influenced by judgements about their own health and functional capacity. Concerns about a range of things from their ability to maintain the garden to their vulnerability to burglary may influence their decision. A strategy that aims to encourage frail older people to remain at home needs also to take account of these concerns. For the increasing proportion of older people who are home owners concerns about maintenance and repairs may be added to these particular anxieties.

There are well established services capable of responding to these needs through Home Improvement Agencies (Staying Put or Care & Repair projects) and "handyperson" schemes of various kinds.

Home Improvement Agencies will support older home owners in establishing the nature of the work that may be needed to repair, improve or adapt their home[6]. They will assist in preparing specification of work, identifying reliable builders, evaluating tenders, supervising work and dealing with any problems. They will also advise and assist in seeking funding for the work. This may be by application for a grant from the Authority through the Grant procedures, or by raising loans or advising on the use of their own resources. The project will also offer general advice and reassurance to the older person and act as a focus for communication and liaison between the home owner and the various professionals and organisations involved.

Handyperson schemes are often operated as an adjunct to a Home Improvement Agency and may provide a variety of services[7]. The foundation for most such services will be a tradesman with a van who can provide a flexible and relatively inexpensive response to requirements for small repairs. Some services specialise in safety and security, providing new door and window locks, door chains and door viewers, smoke alarms and similar equipment. This is often accompanied by an inspection to identify and rectify other hazards in the home such as overloaded electrical outlets, tripping

[6] There is a large literature on these schemes but see Leather & Mackintosh Maintaining Home Ownership the agency approach, Longman, 1992
[7] Appleton N Handyperson schemes – making them work, 1996

hazards and so on. Often funded as part of a preventative strategy a flexible service offering small repairs and safety and security measures should be part of an overall strategy for supporting vulnerable older people in their own homes. Such services can generally make around six hundred interventions in a year, depending upon the area covered and the exact nature of the service offered.

Adaptations

In addition to the provisions made to encourage renovation and repair the Housing Grants, Construction and Regeneration Act 1996 set out the basis on which both mandatory and discretionary Disabled Facilities grants might be made by the local authority. The regulations that affect mandatory DFGs are unchanged by the Regulatory Reform Order 2002.

The Office of the Deputy Prime Minister and the Department of Health have consulted on draft guidance on the delivery and management of adaptation services and a joint circular is expected in the Spring of 2004. This looks for greater integration of effort between the principal agencies concerned: Private Sector Housing Grants and Community Occupational Therapy service to provide a coherent and comprehensive service, generally supported by an “agency approach”, whether through a Home Improvement Agency or otherwise. The contribution that such services can make to delivering timely transfers of care, to prevention strategies and the maintenance of independence is well documented. The relationship between an integrated adaptations service that meets the requirements of Good Practice, as set out in the draft guidance, and the proposed pattern for an Integrated Community Equipment service needs further exploration.

Equipment

After a period of neglect guidance from central government has recognised the crucial role of equipment and adaptations in supporting the independence of older people. The Modernising Community Equipment Services initiative, launched by the Department of Health in March 2001[8], has three principal objectives:

- To establish by 2004 an integrated service between heath and social service authorities for the delivery of equipment needed by disabled people.
- To establish joint structures for managing and developing the equipment service.
- By 2004 to increase the number of people benefiting from the service by 50%. Most of these additional service recipients will be older people.

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[8] Community Equipment Services HSC 2001/008:LAC (2001)13 & associated Guide to Integrating Community Equipment Services

To support these developments Government committed additional funding for both health and social service authorities and set a timetable for reporting progress.

Progress has been made in implementing this programme the targets for implementation of integration laid down in the guidance have been met by the majority of local authorities. The potential for further development and linkage to other elements of service, such as expedited access to adaptations, is considerable.

Services to support people in a variety of accommodation settings

Home Care

In various places the guidance provided by central government encourages local authorities to increase their provision of support to frail older people in their own homes through intensive packages of care. The definition of what constitutes an "intensive" package generally centres around the number of hours of care provided. Packages involving more than ten hours of care per week are generally considered to be intensive.

The provision of such a level of service to people in a range of circumstances, not just older people, is not new. This has not however been seen until recently as a major alternative to residential care for older people.

Whilst the emphasis is upon supporting the tasks of personal care and managing risk the intention is to take a holistic view of the requirements of each individual. This may include some household tasks and also recognises the importance of social interaction to the well-being of the individual. Good practice in this area increasingly looks to give autonomy to service users and carers in defining the package, in dialogue with the Care Manager and home care organiser.

Intensive Home Care is an integral part of Intermediate Care services and may also be supported by the introduction of technology in the home to assist in communication, pro-active monitoring and risk minimisation.

Meals Service

The importance of good nutrition to remaining well in old age is well documented. The provision of meals to older people in their own homes was one of the early strands in the pattern of social care promoted by local authorities. Changing circumstances and expectations have had an impact upon the ways in which this service is provided. If older people are to be encouraged to accept remaining in their own homes as an alternative to residential care the provision of meals is an important element in the package of support.

Current thinking would advocate that where the older person is able to prepare some or all of their own meals they should be encouraged to do so, with help with shopping and some preparation as necessary. In other cases some meals may be prepared by the care assistant within the care package provided. In other circumstances the increasing range of chilled or frozen meals available from commercial outlets to be used in a conventional oven or microwave offer an alternative. In some communities local restaurants or pubs may offer meals that can be delivered or collected. Families and neighbours have also traditionally supported older people in the provision of meals.

The key element is that a pattern should be developed that meets the requirements and circumstances of the individual.

Rapid Response

Rapid response services may cover a range of services delivered in emergency or exceptional circumstances. Thus a rapid response service may deliver minor adaptations and equipment for those being discharged from hospital or facing a breakdown in their care arrangements. It may also describe a nursing or social care service (in some cases both delivered by an integrated workforce) to support individuals through a particular crisis or on return from hospital. Speed and flexibility of response in the distinguishing feature**.** They may form part of Intermediate Care services or operate with a wider brief.

Care Management and review

It is our view that assessment of initial needs and identification of service responses ought to form part of the “integrated front-end” to services that we describe below. However, for those who are to receive services on an on-going basis it is important that the process of review is effective and timely and that the provision of care continues as a managed process that will be sensitive to changing circumstances and individual needs.

Community Alarm Services

The provision of a community alarm is part of the basic pattern of service for supporting older people who are living independently, whether in general housing or in a sheltered scheme.

Day Centres and Resource Centres

Day centres provide opportunities for social contact and activity, with the added benefit of respite to carers. To the core programme can be added meals, craft and exercise sessions, information and advice giving, together with opportunities for inter-generational inter-action. Generally dedicated

transport arrangements will be needed if the facility is to be accessible to those who may need it most.

On the foundation of that pattern of activity may be built more sophisticated services that provide a resource centre for the support of older people in the community. This will include a range of therapeutic activities and will offer access to health and social care services. The resource centre may also offer a base for multi-disciplinary teams, an access point for wide range of information and a store for a variety of equipment to be delivered in the community. There are a number possible models but local patterns are best developed in collaboration between local older people, carers and a broad range of health, housing and social care professionals.

Specialised accommodation as a context for care

An account of the varieties o specialised accommodation for older people is set out in the body of the report.

Intermediate Care

The introduction of services and facilities to provide care that prevents admission to hospital, or expedites return home after a hospital admission, is an important part of the emerging pattern of health and social care. Generally it will 9invove focusing the skills of an inter-disciplinary team on specific goals in relation to the rehabilitation or re-ablement of an individual with the goal of returning them to their customary housing context and to a high level of independence.

It differs from much of the provision described in this section in that it is explicitly time limited. Thus although many, if not all, the forms of accommodation described may provide a context for the delivery of Intermediate Care they will normally be allocated on the expectation of long-term occupation. Whilst some units may be designated for use for Intermediate Care these will need to be designed, managed and allocated on a different basis to what may be regarded as the “mainstream” provision in the same scheme.

A summary of the elements of a whole system

We suggest that an whole system to deliver a flexible and varied range of accommodation and care may be summarised as follows, the system will require:

A clear vision of life in old age that reflects the needs and aspirations of older people themselves, is not dominated by compensation for deficit and offers genuine choice.

A single portal through which the whole pattern of a person’s needs and aspirations may be connected to the full range of care services and

accommodation options that may respond to those needs. Such a single portal may be provided through an enhanced call centre that is connected to.

An integrated front-end to service. Through the single portal enquirers and those making referrals may access a co-located and singly managed multi-disciplinary and multi-agency team that is able to provide:

- Signposting to a wide range of agencies covering accommodation, care, health services, community safety, benefits and rights advice.
- Advice on housing options and housing rights, regardless of tenure.
- Benefits advice and a single financial assessment process that gives access to all national and local benefits that are governed by a test of resources.
- Initial assessment for care services.
- Initial screening for community equipment and adaptations.
- Access to rapid response health and social care services.
- Interim Care Management.

A diverse and interactive **range of accommodation options and service offers**, to include those that are directed toward the health and social care needs of the individual and those that address elements of their housing circumstances. Figure Two attempts to represent this range.

Monitoring of outcomes across whole systems.

Structures for **the participation of older people and carers** in the determination of the service they receive, the review and re-design of services and the measurement of outcomes.

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