



Brighton & Hove

Brighton & Hove Strategy for Extra Care Housing for Older People in Brighton & Hove

1 Introduction

Within the city of Brighton & Hove, there is an emerging recognition of the important role that extra care housing has in meeting the needs of older people in the community. The development of this model of care is seen as a corporate priority by the council for a number of reasons:

[1] The health and well being of older people are important to the wider community. There are nearly 42000 people aged over 65 in Brighton & Hove, representing approximately 16% of the total population; they are consumers, voters, citizens and not just recipients of health and social care services. Almost one third of this group of people are aged over 80. National population projections produced by the Office of National Statistics* suggest that across the country as a whole the number of people aged over 80 will grow by 50% by 2025 and will double by 2040. Within two generations, therefore, it is possible that there will be nearly 27000 people aged over 80 living in the city.

* ONS 2000 based population projections

[2] Research and consultation (eg, Centre for Policy on Ageing, Age Concern, Audit Commission, Counsel and Care, Wagner Committee) nationally indicate that older people want to retain as much independence as possible and that they want to remain in their own homes. Community care and community based health services enable the majority of older people to do so. However, in some cases, the level of resources needed, or the appropriateness of accommodation, are such that it is not possible to support people in this way. A significant number of older people, as a result of such events as a fall or a hospital admission, require levels of care not normally provided at home and are admitted to residential care. Extra care housing, through the integration of the accommodation and care, has the potential to provide the level of support needed to enable such people to remain part of the community.

[3] There is an emerging policy shift towards reducing the traditional reliance on residential care to meet the long term care needs of older people. The council's own proposed targets within the Local Public Service Agreements process involves a *stretch* target of reducing the level of admission to residential care by 21% over a three year period. In the longer term there is no doubt that

there is a limited future for residential care and that more appropriate alternatives need to be developed.

[4] Delays in moving 'medically fit' older people into more suitable forms of provision have created significant pressure on acute hospital beds. While the shortage of suitable nursing home and residential care home places for people with very high level needs has contributed to these delays, there are also difficulties in creating the complex care packages that would enable people to return to their own homes. As a result it is possible that some people have been placed in residential care inappropriately. The availability of an additional service component through the provision of extra care housing, enabling people to return to the community with less complex care packages, would contribute to efforts to address the issue of delayed transfers.

[5] There is also concern that traditional models of sheltered housing are no longer appropriate to the needs of older people. A draft strategy paper prepared in 2002 by the council's Housing Strategy Team highlighted the following concerns:

- ❑ There is an over provision of traditional sheltered housing and an under provision of very sheltered housing with extra care support;
- ❑ 35-42% of tenants do not require the services associated with sheltered housing;
- ❑ Sheltered housing is being used to meet the general housing needs of older people, suggesting an excess supply of sheltered housing and a shortfall of general housing for older people;
- ❑ There are a number of sheltered housing schemes where units are 'hard to let'.

While the need to develop extra care housing for older people is recognised, the creation of an integrated approach to accommodation and care as a mainstream service for older people throughout the city requires detailed and long term planning. The council's sheltered housing stock of 893 units is largely accessed through a traditional *housing pathway* and is not a resource that is directly accessible to social care staff seeking to meet the long term care needs of older people.

However, within the Local Authority the integrated management of housing and social care services provides a platform from which existing service boundaries and responsibilities can be re-drawn. To support this approach, two posts have been created within the council that straddle housing and social care, and progress is being achieved in providing an integrated response to the care and accommodation needs of older people. Nevertheless, major change in the way in which sheltered housing is accessed, reflecting a focus on meeting the long term care needs of older people, cannot be achieved overnight.

There is a need, therefore, to develop a long term strategy that:

- seeks to achieve an integrated approach to accommodation and care, and
- is based on the provision of extra care housing as a mainstream resource in meeting the needs of older people – reducing the need for residential care, impacting on hospital admission and enabling the discharge of older people from acute hospital beds.

This strategy framework sets out the steps that need to be taken in order to achieve *on the ground* change and service modernisation.

2 Developing a strategy

A strategy for the development of extra care housing requires the following:

- an understanding of: the role and purpose of extra care housing and why it is an appropriate model for the long term care of older people;
- an understanding of the city's population of older people and their needs and the target population for extra care housing;
- information on current provision, including: sheltered housing (stock condition, value, location, level of support needed by tenants); residential care (number of admissions to care homes and the level of *inappropriate* admissions); and community care (number of people with intensive or complex care packages who may be at risk of not being able to continue to remain in their own homes);
- agreement concerning: the pathway to accommodation and care (joint assessment); admission processes and nomination rights ;
- agreement on a model of care for extra care housing that ensures that the necessary levels of care support can be provided;
- an assessment of the capital and revenue funding implications of implementing the proposed strategy.

The development of a strategy for extra care is supported by the Local Authority, the Primary Care Trust, the local NHS Health Trusts and the Supporting People Commissioning Body. A key objective of Brighton & Hove's *Joint Commissioning Strategy for Older People* is to ensure that there is sufficient local capacity for extra care housing to meet current and future need.

The Local Authority's *Housing Strategy 2004-2007* also recognises the need for extra care housing in Brighton & Hove and its contribution to a number of objectives, such as improving housing care and support, promoting health and well-being, and widening housing choices for local people.

The development and implementation of this strategy for extra care housing for older people will be overseen by the *Older Person's Accommodation Care and Support Group* which brings together representatives of all relevant agencies, including: the Local Authority (Adult Social Care, Housing Management, Housing Strategy, and Supporting People), South Downs Health NHS Trust, and Brighton & Hove Primary Care Trust.

3 Principles and values

The development of extra care or supported housing reflects key values and principles agreed by the council and include:

- the rights of older people to choice and independence in their lives
- a commitment to a preventative approach to enable people to remain in their own homes
- an inclusive approach ensuring that services are accessible to everyone
- participation and involvement of older people in community life and the planning and delivery of the services they receive.

One of the main considerations in developing a new approach to the accommodation and care of older people is the perception of residential care as an increasingly outmoded form of service provision. While progress has been made in improving both the physical and care environments within the residential setting, as a model of care it has its roots in the nineteenth century. There is a considerable body of evidence to suggest that its reform is long overdue

The effects of institutionalisation are well documented and there have over the years been a number of concerns expressed about the quality of life for older people in residential care. The physical environment in residential care militates against notions of privacy and dignity, with shared facilities and living space standards of only ten to twelve square metres. Within supported housing, people will live in units that have their own kitchen, bathroom, bedroom and living space - typically forty five square metres. The key difference, however, is that between *tenants* and *residents*, older people living in sheltered housing are *tenants* and have their own front doors. In contrast to the residents of care homes, tenants are perceived to have rights and self-determination, as *citizens* rather than recipients of care. As such the relationship between the service user and provider is more empowering than commonly found in residential care. Sheltered housing is consistent with the concept of care at home and supports independent living.

Government policy continues to emphasise the importance of enabling older people to stay in their own homes for as long as possible. The provision of appropriate housing and support services for older people is essential to the maintenance of their independence and quality of life (*Quality and choice for older people's housing – a strategic framework*, DETR/Department of Health 2001). Recent studies conducted by the Audit Commission (*Home Alone: The Role of Housing in Community Care*, Audit Commission, 1998) and the Social Services Inspectorate (*Promoting Independence: Preventative*

Strategies and Support for Older People, SSI, Department of Health, 1999) suggest the need for a more *joined-up* approach across Housing and Social Services.

Specifically, the Audit Commission argues that the provision of housing services such as community alarms, home improvement schemes, sheltered housing and housing with support must sit alongside social care and health services as part of an integrated approach to the care of older people.

The joint commissioning strategy for older people identifies 658 people aged 65 or over in Brighton & Hove who are from non-white backgrounds; this represents 1.6% of the total population of older people in the city. While these figures suggest that the need for appropriate cultural services will be on a relatively small scale, it is important that such services are available and that equality policies underpin staff attitudes and behaviour.

The Supporting People review of older people in Brighton & Hove has also identified the needs of gay, lesbian and bi-sexual older people who make up just under 3% of the older population. The processes of assessment, placement and care provision will all ensure that the specific needs of this group of people are met.

4 The need for extra care housing

Extra care housing is intended to meet both the accommodation and care needs of older people. It has the potential to provide an alternative to residential care for older people who can no longer be cared for in their own homes. Like residential care homes, extra care housing enables economies of scale to be achieved so people who are unable to remain in their own homes, because the level of care they need cannot economically be provided, have access to a level of care that will enable them to retain their sense of independence, albeit in a sheltered environment. The provision of flexible, on-site care, available when needed, is a key component of extra care housing.

The Department of Health publication *Extra care housing for older people: An introduction for commissioners* suggests that a housing model of care that represents a genuine alternative to residential care is likely to have the following defining characteristics:

- space standards of 40 square metres or more
- self contained living space including separate bathroom and kitchen facilities
- alarm system and other electronic technology
- social and health care delivered to individuals, including:
 - Meals
 - 24 hour community support
 - Personal care e.g., bathing, dressing, helping to use toilet
- practical care e.g., cleaning, handyperson
- tenancy based, not a registered care home
- access to support services at night
- communal facilities
- catering.

It is difficult to quantify the *need extra care housing*. It is estimated that approximately 18% of tenants* in the council's sheltered housing units are receiving domiciliary care. While this figure suggests that the majority of people in sheltered housing are independent and active, reinforcing the findings of the Best Value review that sheltered housing is not being appropriately targeted, there are, nevertheless, 162 tenants with care support needs for whom extra care may become necessary as their needs increase. In four of the council's 25 schemes, over 30% of tenants are receiving domiciliary care.

* This figure differs from previous estimates because it excludes those people receiving SP funded services.

Analysis of the reasons for people leaving the council's sheltered housing schemes shows that around 25% move into residential or nursing home care. Turnover varies from year to year: in the year ending March 2002, 238 people moved; while in 2003, this figure was 126. It can be safely assumed that a proportion of the moves to residential or nursing home care could have been avoided if extra care had been available.

Brighton & Hove has significantly reduced its level of admission to residential care over the last twelve months. In the twelve month period from October 2003 to September 2004, 209 older people (funded by the Local Authority) were admitted to residential care. The provision of extra care as an alternative to residential care would contribute to a further reduction in the level of admission and would represent an important step in Brighton & Hove's strategic commitment to avoid placing people who need long term care in a residential setting (Joint Commissioning Strategy for Older People: Improving Care and Capacity 2003 – 2006).

Of the people admitted to residential care during this twelve month period, 151 were assessed as being in the low or medium dependency category. Sample analysis of case files suggests that a majority of these people could be cared for within an extra care housing environment, where levels of care support would be sufficient to enable people to live more independently. For the purposes of quantifying need for extra care housing, a figure of half those people in the medium and low categories will be used as an initial target for the diversion of people away from residential care. Over time the council is committed to caring for all but the most vulnerable and dependent of older people behind their own front doors .

Work undertaken by the Mental Health for Older People Services indicates that there are fifty older people with mental health needs currently receiving services for whom extra care housing would be a suitable alternative:

	OLDER PEOPLE WITH FUNCTIONAL NEEDS	OLDER PEOPLE WITH ORGANIC NEEDS
Hove CMHT	1	10
West Brighton CMHT	11	0
East Brighton CMHT	22 – to be broken down into functional and organic	
Nevill Hospital	6	0

Approximately 20% of the 6422 people aged 85 or over in Brighton & Hove are linked to the council's call system, CareLink. This suggests that there are approaching 1300 people in this age group who could be at risk of losing their independence if the level of support they require to maintain them in the community can no longer be provided. *Extra care housing* would provide a next step in the continuum of care for this group of people and would potentially avoid the need for residential care or hospital admission.

The *Profiles of Older People in Brighton & Hove* attached at Appendix I represent a systematic attempt to identify how existing service responses should be modernised for key groups of older people. In particular, the development of extra care housing is identified as a potential response to:

- hospital patients requiring high level of support but not significant nursing care;
- people living at home/in sheltered housing requiring high levels of support.

As far as impact on hospital beds is concerned, the Housing LIN Factsheet on private provision states quotes evidence that extra care housing can reduce the burden on local health and social services. According to the Factsheet, the General Housing Survey shows that people over the age of 75 spend on average 17 nights a year in hospital; the records of a private sector provider show that residents (average age 82 years) of its extra care schemes spent 3.96 nights in hospital in 2003.

In developing this strategy framework further, detailed work will be undertaken to estimate the numbers of older people falling into the categories outlined in Appendix I. This work will enable a more accurate indication of the need for extra care housing to be achieved. However, it is clear from the information above that there is significant potential demand across the city for extra care housing and that its provision would represent an alternative to residential care for many older people.

The following table summarises the main indicators of need for extra care housing locally. While these figures are not precise measures of need, they do suggest that a significant baseline provision across the city could be justified.

Number of sheltered housing tenants receiving domiciliary care	162
Number of people being admitted to residential or nursing home care from sheltered housing schemes annually (average over the last three years)	47
Number of people inappropriately admitted residential care for whom extra care housing would be appropriate	75
Number of people aged over 85 supported by CareLink and at risk of admission to residential care (based on an assumption that 10% at risk)	130
Number of older people with mental health needs for whom extra care would be appropriate alternative to current services	50

5 Existing Sheltered Housing Provision

The Local Authority provides 893 units of sheltered housing across 25 schemes. A further 1100 units are provided by housing associations. The 37 units being developed by the Local Authority in partnership with Hanover Housing Association represent the only extra care provision in the city.

A recently undertaken independent review of the council's sheltered housing provision indicates that there are significant issues across the stock concerning the achievement of *Decent Homes Standards* and that the existing provision is not in line with the needs of older people.

While the development of extra care provision is not seen as a *solution* to bricks and mortar issues, the future role of sheltered housing does need to be tied into the contribution it is able to make to meeting the care as well as the accommodation needs of dependent and vulnerable older people. For future generations of older people, it is likely that there will be less demand for conventional sheltered housing than there has traditionally been.

This changing role of sheltered housing will have an impact on the scale of its provision and a smaller but more focused service is a clear option for the future, with many of the people who currently move into sheltered housing being accommodated in appropriate general needs housing settings.

The review identifies eight of the Local Authority's schemes as not achieving *Decent Homes Standards*. Of the remaining schemes, providing 689 units, there are some issues concerning whether they will continue to meet *Decent Homes Standards* by 2010: there are two schemes with no lift; 83 properties have shared bathroom facilities; there are 180 bed-sits. However, options are being examined to secure the capital investment necessary to achieve the required standards for at least a significant number of these schemes within these longer timescales.

6 Models of provision

This is an outline of the key areas where detailed work is needed in order to arrive at a care support model that fulfils the vision for extra care housing as a resource to meet the care and accommodation needs of very dependent older people who might otherwise be admitted to residential care.

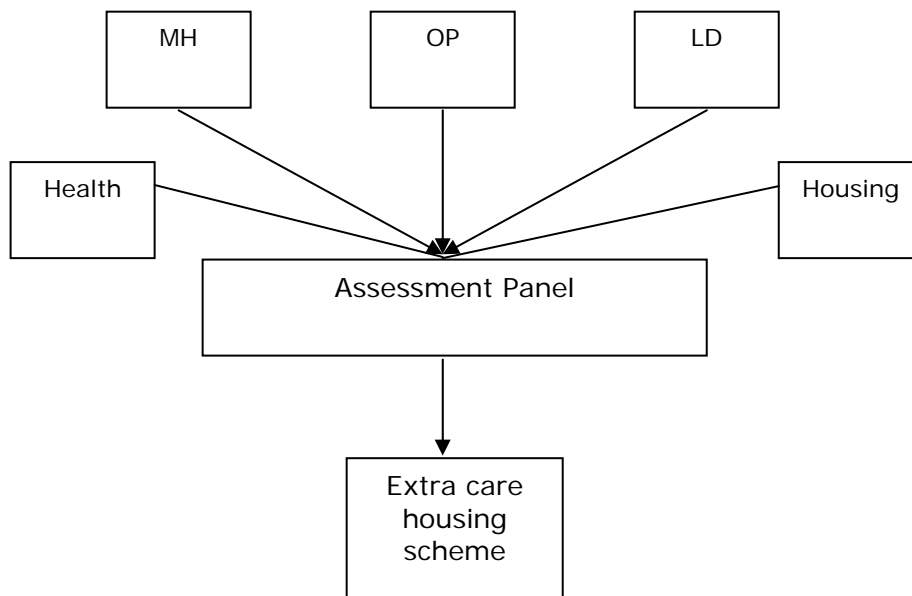
Assessment and care planning

An operational policy for any proposed extra care housing scheme will be established in order to provide an indication of the aim of the service, the type of care provided and the level of dependency appropriate to the care provided. The council's proposed scheme at Larchwood will provide an opportunity to develop and test the assessment and care support model outlined in this Strategy.

Initial assessment of individual needs will indicate whether extra care housing should be identified as part of the care plan. Because of the unique nature of the service model it is proposed that, following this initial assessment, an *assessment panel* should make the final decision concerning the allocation of tenancies within specific schemes. This panel will need to include representatives from Social Care, Health, Housing and also involve the scheme and care managers locally. Where accommodation is being provided through a Housing Association, this panel will in effect exercise the nomination rights held by the council.

Pathways to the service

The operational policy for the extra care housing schemes should confirm that they will not exclude older people simply because they have a mental health problem, cognitive impairment or learning disability. Initial assessments will, therefore, be undertaken within any part of the gate-keeping system, including *Older People's Services, Mental Health and Learning Disability services, Health and Housing*. However, where additional resources are likely to be necessary to accommodate the specific needs of older people with mental health issues or learning disability, then a commitment will be required from these services before a placement can be considered. Appendix 2 outlines the basis on which care support to older people with mental health needs would be provided.



Care Support

The key to extra care housing lies in the level of care support available to tenants. Older people needing to live in extra care housing will have levels of need that cannot be responded to in their own homes. It should be an

exception that people are placed in extra care housing when the level of care they require can be provided to them in their own homes.

One of the main reasons that people can no longer be cared for at home is the provision of night time care. It will be crucial, therefore, that for people in extra care housing there is an adequate level of night time care.

In general, care can be divided into two categories: *planned* or *routine* care (daily or nightly tasks identified within the care plan) and *unplanned* or *emergency* care. While it is relatively easy to quantify the level of planned care required, it is more difficult to assess the amount of unplanned care likely to be needed. However, having the flexibility to respond quickly to people's needs is an essential element of extra care housing, as it is for residential care. This means, therefore, that there needs to be a continuous care support presence.

The following options need to be considered:

- [i] whether the service is provided by the Local Authority or commissioned from an external provider (*in-house or external provision*):

While the bulk of home care is provided by the independent sector, it is arguable that the care support for extra care housing is consistent with the role of in-house services in testing out new ways of working in order to prepare the ground for commissioning.

- [ii] whether the service should be based on-site or care delivered to tenants in the same way as existing home care services (*on-site or off-site*):

The presence and flexibility required might more easily be achieved through an on-site model. However, an off-site care model achieves a clear cut differentiation from residential care.

- [iii] whether the service should focus on the scheme alone or whether it should embrace the local community (*scheme focused or community focused*):

While a scheme focused model has the benefit of simplicity, it is in the spirit of the proposed scheme that links are made with the local community. By delivering home care to people outside the scheme a community focused model will ensure that there is wider benefit from the proposed scheme.

These options give rise to eight possible service models:

In-house, on-site, scheme focused
In-house, off-site, scheme focused
In-house, on-site, community focused
In-house, off-site, community focused

External, on-site, scheme focused
External, off-site, scheme focused
External, on-site, community focused
External, off-site, community focused

For new schemes, the model favoured by the partners involved in the development of this strategy is:

- care support will be provided by the Local Authority;
- care support will be provided through the home care service and tenants will be charged for the service in line with the council's charging policy;
- an on-site care support team will focus on the needs of people in the scheme and the neighbouring community;
- night care staff will have a base within the scheme.

As more experience is gained in working within this care model, other commissioning options will be considered.

For existing sheltered housing schemes, where changes in the way in which services are accessed will support an incremental approach to extra care, the model of care support will be determined on a scheme by scheme basis depending upon the level and nature of existing home care provision.

Electronic technology

Electronic technology is a key ingredient in the economic provision of effective care. It has a particular role in managing unplanned or emergency care while at the same time providing tenants and their families with a sense of security; it adds to the capacity to manage risk. Technology is available to assist in the monitoring of individuals' everyday lives, and absence of movement or unusual behaviour patterns, for example, can signal that something is wrong. However, a balance does need to be struck between well intentioned surveillance and intrusion.

A priority for the installation of electronic technology in any proposed scheme is a *call system*. The ability of tenants to request help is an integral part of the care support model; a call system will deliver flexibility and provide a safety net for night time care.

In response to the recent Department of Health announcement concerning the allocation of specific funding for electronic technology, strategic work is being undertaken separately on the use of technology that will most effectively contribute to the care of dependent older people.

Supporting People

Supporting People monies have been agreed for the council's extra care scheme currently under development. While these monies are available for non-personal care, it makes sense to develop one integrated care model that embraces low level support needs as well as the higher dependency personal care needs.

Links with housing management

A management model needs to be developed that enables both the housing management and care management functions to be carried out effectively. While they are distinct in their focus there will be *grey areas* of responsibility and tenants are unlikely to be concerned about who is responsible for what. Effective working relationships between the two functions are crucial, whether as part of an integrated team or as two separate teams. A model management structure will be developed and a framework established for joint training and joint meetings.

7 Impact on other services

Extra care housing cannot be developed in isolation from other services. It must be based on adequate provision of general needs housing for older people where residents are enabled to continue to live safely in the community. Pressure on 'specialist' housing as a result of fear of crime, noise, poor environment or lack of manageable housing, will make it more difficult to set aside resources to meet the needs of older people who require high levels of care.

Older people in extra care housing also need access to community health services, otherwise the capacity to maintain their independence is compromised. The provision of day care and other services to combat isolation and increase independence is also important.

Built into the care model for the city's first extra care scheme is a post that is concerned specifically with the development of communal activities and links with the local community. The creation of an *open institution* as a focal point for providing community based services is an important feature of extra care housing.

8 Strategic options for the development of extra care housing

It is clear, based on the large proportion of tenants not receiving care support, that sheltered housing is not being exploited as a resource that could meet the needs of more dependent older people. In line with the national picture, there is an over-provision of conventional sheltered housing and an under-provision of extra care housing.

The successful development of extra care housing as a mainstream option for meeting the long term care needs of older people will depend upon the extent to which existing sheltered housing resources can be translated into extra care capacity.

An *incremental approach* is simply to extend the range and intensity of home care services currently provided to sheltered housing tenants. It is estimated that approximately 18% of LA sheltered housing tenants are already receiving home care. This approach recognises the position of sheltered housing tenants to be no different from that of people living in their own homes in a 'non-sheltered environment'.

Clearly, home care provision should seek to prolong the opportunities for people to remain in their own homes (sheltered or otherwise). Within the sheltered housing environment, there may be opportunities to achieve efficiencies of delivery where groups of service users are located in close proximity to each other.

In order, however, for this approach to qualify as *extra care*, the level of home care provision would need to exceed what might normally be provided in people's own homes. In particular, services would need to be available at night time. Where people with this level of need are dispersed across existing schemes, it may not be possible economically to provide this level of service. In addition, the physical environment in some schemes may not be capable of supporting people with high levels of dependency; there may be no lift, doorways too narrow for wheelchairs, toilets and bathrooms not suitable for physically frail people.

However, work will be undertaken to establish whether added value could be achieved by organising the provision of care support on a scheme basis. This will entail mapping the provision of home care services across the sheltered housing provision; work has already begun on this process.

The council favours an *integrated approach* to the provision of housing and care for older people. Its strategic vision is that sheltered housing should:

- provide for older people who need to move into a supported environment for housing reasons;
- enable people who have developed high levels of dependency since moving into sheltered housing to remain in their accommodation; and,
- provide an alternative to residential care for people whose care needs require a level of resources beyond those normally available to people in their own homes.

This model requires close co-operation between housing and care providers, particularly concerning admissions where the establishment of a care pathway into supported housing would need to be established alongside housing processes for letting vacant units. In particular, it would be necessary to establish a joint assessment process so that sheltered housing becomes an option for older people with social care needs

and can be accessed accordingly. The key to the successful development of extra care housing is the availability of the necessary levels of care support for individual tenants.

While there are issues concerning the extent to which the council's sheltered housing stock can meet the needs of physically frail older people (approximately 20% of units depend on shared facilities; 6 units do not have lifts to each floor), a significant number of extra care housing units could be achieved within existing resources. Indeed, if tenants are to have a *home for life*, then extra care is an essential ingredient of sheltered housing provision and not a separate resource.

As part of a five year first phase of an extra care strategy, the council will aim to develop and support 200 extra care tenancies based on the diversion of people away from residential care and the re-deployment of resources that would otherwise have funded residential care placements. The use of Supporting People monies to support the development of extra care housing is also seen as a priority locally for the Supporting People Commissioning Body.

This will be achieved by:

- identifying schemes where units are capable of supporting physically frail older people;
- designating vacancies as available to meet the accommodation and care needs of older people;
- establishing care pathways to supported housing through joint assessment and joint working between social care and housing staff;
- developing care support provision in line with the model of care outlined above that will enable inappropriate admissions to residential care to be avoided.

The achievement of a modern extra care housing service will, however, require schemes to provide improved facilities, particularly communal space, wheelchair accessibility and baths/toilets that are suitable for physically frail older people. The capital cost of re-modelling existing schemes in order to provide these improved facilities and to achieve Decent Homes Standards will need to be assessed and funding strategies identified.

8 Funding and finance

Initially, the council will seek Round 2 DoH funding for a new extra care scheme as the second stage in implementing this long term strategy following the development of 37 extra care units in Brighton & Hove as a result of the successful bid in Round 1. This would provide a significant baseline from which to achieve the above five year target for extra care.

Partnership opportunities with RSLs and the private sector will be explored as potential developments are identified. While the strategy framework focuses on the development of the council's own provision, the RSL sector provides a greater number of sheltered housing units across the city. Discussions have, therefore, begun with the

city's RSL Partnership to examine ways in which extra care can be developed by RSL providers in conjunction with the Local Authority.

While capital investment will be sought through grant funding or RSL partnership in order to consolidate the strategy *kick started* by the successful Round 1 bid, its longer term implementation will be accomplished by the reconfiguration of existing capital resources. More importantly, perhaps, is the identification of revenue funding required to provide the care support necessary for extra care schemes to succeed. Essential to this strategy framework is a commitment to:

- divert monies currently deployed in providing residential care;
- achieve economies of scale in relation to home care services currently being provided to people in sheltered housing;
- identify extra care housing as a priority for SP monies.

9 Consultation

This strategy framework will be subject to widespread consultation across all relevant stakeholders in the city. Consultation undertaken in the development of previous service strategies including Brighton & Hove's Preventative Strategy within the *Promoting Independence* programme, indicates there is clear support for services that enable older people to remain independent for as long as possible. Potential service users will be involved in developing the detail of proposed schemes. A consultative forum has been established to assist with the development of services for the scheme being developed following the successful Round 1 bid; this model will be replicated.

10 Monitoring and evaluation: quality and outcome measurement

A Project Monitoring and Evaluation Group (PMEG) will be established and performance targets agreed across the following areas of activity:

- Personal care and support
- Housing management and non-personal care and support
- Communal activity and community involvement
- Consultation and user involvement.

The PMEG will monitor and evaluate the processes of joint assessment, admission and 'discharge'.

Through the individual care plan, levels of dependency and service provision will be recorded and monitored. The care plan will also establish care objectives; these will be monitored as an indicator of the care provided.

Key statistics will be collected and evaluated; these will include: age on admission, dependency levels, amount of care provided, frequency of emergency calls, length of stay, involvement of tenants in community activity, levels of community activity based in scheme.

Surveys of staff, tenants and relatives will be undertaken on a regular basis.

Consultation meetings will also be held with tenants and carers/relatives on an annual basis.

Appendix I Profiles of Older People in Brighton & Hove

Description	Current Services/Comment	Implications for service development
Hospital patients needing ongoing medical care (continuing care)	Shortage of affordable nursing home places available for people with very high levels of dependency means that discharge from hospital likely to be delayed	[i] creation of dedicated continuing care beds [ii] 'Block' contract with existing providers
Hospital patients requiring high level of support including significant level of nursing care	Nursing home placement – but likely to result in delayed transfer because of shortage of suitable and affordable places; some placements inappropriate where rehab work could mean that people require 'lower' level of care	[i] 'Block' contract with existing providers where need for nursing home care clearly established [ii] creation of 'transition' period to establish potential to step down to lower category of care; use of LA beds to facilitate discharge and undertake further assessment
Hospital patients requiring high level of support but not significant nursing care	Independent sector residential care home – pressure from carers, need to free up hospital bed, availability of supply creates a 'path of least resistance' towards residential care with resulting inappropriate placements	[i] creation of alternative housing based models for long stay care (eg, extra care sheltered housing) [ii] higher levels of support available at home (including nursing care) [iii] 'transitional care' (see above)
Hospital patients who could 'step down' to a lower category of care through rehabilitative services (intermediate care)	13 Intermediate Care beds at Craven Vale; without IC beds people inappropriately placed in nursing homes or res care or discharge delayed	[i] creation of additional IC beds
People living at home/in sheltered housing requiring high level of support including significant level of nursing	Nursing home – some placements likely to be inappropriate	[i] higher level of community support [ii] creation of intensive supported housing where high levels of community

care		support can be provided within economies of scale [iii] short term care focused on assessment, therapeutic, preventive work designed to avoid nursing home admission
People living at home/in sheltered housing requiring high level of support but not significant level of nursing care	Residential care home – some placements likely to be inappropriate	[i] higher level of community support [ii] creation of intensive supported housing where high levels of community support can be provided within economies of scale [iii] short term care focused on assessment, therapeutic, preventive work designed to avoid care home admission
People living at home experiencing crisis	Nursing home or residential care home or possibly hospital admission – some people may access LA short term care	[i] short term care designed to help people through crisis and return home [ii] higher level of community support
People living at home who from time to time need high level of support	Some access to LA short term care; otherwise 'soldier on' or possible hospital admission	[i] short term care designed to provide time limited support [ii] higher level of community support
People who are vulnerable/exhibit challenging behaviour	Inappropriate placement in residential care/nursing home; continued support at home	short term care
People whose carers need a break on a regular basis (planned respite care)	Some 'rotating' respite care available	[i] planned respite care as part of flexible short term care services [ii] 'Block' contract for this form of respite care
People normally looked after at home but who are highly dependent (wheelchair dependent,	Some short term care available	Short term care for this group of people as part of flexible short term care service

bedfast, etc)		
People whose needs are complex	LA services	Development of case management model
People living at home who need support and who are isolated	Home care and attendance at day centres	Flexible community based day care programmes to meet individual need, from 'specific' service to reducing isolation

Appendix 2 Older people with mental health needs

Individuals with organic needs

People with dementia can live independent lives, with support from health and care services, until the illness develops to a moderate level. The rate in which the decline in health happens varies from individual to individual and close monitoring is needed. A sliding scale of support is interlinked with this continuous monitoring and assessment. Partnered to the organic developments resulting from dementia, is an increase in the individual's level of confusion, loss to memory and reasoning. These can result in individual being acutely sensitive to their environment and social interaction. In addition high levels of stress are seen to impact on daily living and affects individual ability to learn new skills or their ability to adapt to new situations.

As the illness develops, so too does the care package to counter-act any loss in abilities to function and to remove significant risks. Calculating individual's abilities to manage their own risk is a key factor in supporting them to live a fuller life. Care will be based on individual assessment of needs and can be more easily tailored to the individual – providing a flexibility and fluid care/service direct to their dwelling.

Care packages develop as the condition deteriorates - different people progress at different rates. This care package can consist of:

- Simply consists of getting someone ready for the day.
- Prompt for medication.
- Monitor eating habits – check they haven't forgotten to eat their meals.
- This will then develop into 3 to 4 visits a day – getting them up, breakfast, lunch late afternoon/evening and preparing them for bed and putting to bed.
- Care package supported with Day Centre – leading to respite and then residential care
- Emergency call system to community teams/wards to summon assistance.
- Review of their abilities to manage risk. When risks are identified they should be resolved in away that have the least impact on the person's life.
- The care should not take over the individual responsibilities, otherwise their independence is being taken away.

To manage the risk factors associated to dementia, support given in accommodation such as Extra Care Housing can enable people to live longer in their own homes, before moving into care or nursing homes. Any care provided to individual's needs to maximise resident's abilities to carry out their day to day activities. This helps to continue their awareness and therefore do not assist or accelerate any decline in their health.

To develop Extra Care Housing for residents with organic needs, dementia needs to be viewed as a 'disability' and designed around this 'disability'. Characteristics of this disability consist of:

1. Impaired memory

Ensure that resident's health, independence and their mental and physical ability are optimised by the environment and care. Assisted technology can be frightening for this care group and they find it difficult to learn to use the equipment. Changes to their lives can be very disturbing and can perpetuate illness. To prevent this, the point in which they can move into the scheme and move on from Extra Care Housing is paramount. Too early, and you foreshorten them from living in their own homes. Too late, will cause distress and inabilities to adjust to their new home. This window of supporting them in a scheme doesn't current exist in the patients pathway through services in Brighton & Hove. This can result in early admission to inpatient care, care or nursing homes. By developing an Extra Care Housing scheme, this service gap will enable individual residents to retain control over their own lives and receive support they need in a safe environment. Close working relationships between scheme providers, care providers, GP's community teams and primary health care teams is essential in the success of any such development.

2. Impaired reasoning

Scheme staff should respect and support tenants with excising their choice and making decisions. Supporting them in making decisions, which can incur risks, should be calculated to maximise their ability to achieve personal fulfilment. Access to an advocacy service will support individuals in making independent decisions.

3. Impaired ability to learn

Service also should be flexible and responsive to the wishes of the individual resident. Loss of control over the individual's day to day activities can increase the individual's dependency on services. Care to stimulate the individual - Reinforce their sense of well being by giving them an opportunity to use their skills and function to their fullest. Empowering residents with responsibilities helps them to have a sense of ownership and helps to retain their skills. This can be achieved by them assisting with daily tasks and work with staff in the operation of the homes. Input into the management of unit and the management of their personal affairs creates a culture for residents to identify the Extra Care Housing as a home, and not an institutional building.

4. High levels of stress

The whole needs of the residents should be considered. Staff's understanding of the individual's life history, personality, mental and physical health, relationships, attitudes and aspirations will help in the planning and delivery of services and care from the resident's perspective. Each tenant will be respected as a unique individual, with recognition being given to his/her particular intellectual, physical, psychological, social, emotional, cultural and spiritual needs.

5. Acute sensitivity to social and building environment

Extra Care Housing scheme needs to be designed as a domestic dwelling, creating a 'homely' environment which is familiar to the residents. This is a conscious move away from providing care in an 'institutional' setting such as a care home or inpatient unit. Staffing levels should reflect the needs of the tenants. The higher ratio of one to one support enables individual choice and erodes any need for structured activities and daily living. This removes an institutional model of the scheme and replaces it with a domestic style of dwelling. An integrated approach instead of a separate wing for individuals with dementia is preferable, as it removes loneliness and isolation for the residents.

Individuals with functional needs

People with functional needs can have a presentation of either depression, schizophrenia or long and enduring mental health problems, and have made the transition from adult to older people mental health services. Their needs are more variable than that of the organic care group. Support and monitoring of medication can prevent episodes of illness and therefore, if managed correctly can enable them to live full independent lives. Support from health and care services is provided for early intervention and crisis management. Individuals are prone to loneliness and benefit from a social and care network around them. This is conducive to their feeling of belonging.

Individuals with functional needs at present can either live on their own, or are housed in landlord accommodation. Invariably they are referred back to specialist services and admitted into inpatient care, when they are not well as their accommodation does not have residential support that can monitor them closely. These episodes break up any continuity of living arrangements and can magnify their displacement and isolation.

People with long and enduring mental health needs, who have 'graduated' from adult services find they are often excluded from older people's day services and care homes due to the differing presentation of their needs. Admission to the older people's inpatient unit can be the only option for them in time of crisis, which isn't the most appropriate place for them, but is the only place where they can be offered the support they need with medication or care. This care can be and would be more appropriate to be given in an Extra Care setting. This style of setting can provide access to 24-hour residential staff, support with medication. The sense of community in the day care activities and drop-in facilities/cafe would suit this care group. Their day-to-day needs can be managed with the support of the community team giving advice and support to individuals, carers and staff.

Care packages provided will consist of:

- Assisting them on personal care.
- Prompt for medication and monitoring
- CPN (Community Psychiatric Nurse) would manage any prevailing psychosis or breakdown.

- Support by internal care staff can liaise with CMHT on early detection of illness/symptoms.
- Regular input from wardens to prevent non-compliance with medication and stop the onset of symptoms. This client group will benefit from someone overseeing them on a daily basis.
- Regular reviews by Doctors through outpatient appointments.
- Liaison support from CMHT would continue for people with long enduring illness and assist in crisis management within the home.
- Direct call system into either the community teams or inpatient wards to summon assistance in an emergency.