



Housing and Care for Older People

An Introduction

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Introduction

Older age now lasts for a potentially long period from pre- retirement in the late 50's and early sixties to increasing numbers living into their 90's and beyond. This range encompasses a number of generations with very different life experiences, expectations and aspirations.

Where and how to live in these years is of concern to older people, families, social networks and the wider community. It is also an issue for housing health and social care planners, commissioners and service providers as they seek to fulfil their responsibilities within existing policy and legal frameworks and to deliver national and local strategic priorities and outcomes.

This information and advice is intended to assist local authorities and their local partners in considering the role of specialist housing for older people, perhaps most commonly known as sheltered housing but also including very sheltered and extra care housing, in meeting the needs of older people who require alternative accommodation, care and support. It sets specialist housing for older people within the national policy context of service modernisation, changing the balance of care and increasing personalisation and briefly considers community living options for older people in order to provide a clear appreciation of the potential role of specialist housing.

The need to review and possibly re-design much of the existing sheltered and very sheltered housing provision in Scotland is widely recognised. In England, extra care housing which provides for older people with higher level needs has benefited from substantial investment by the Department of Health through its Extra Care Housing Funding Initiative, but there is very little research-based evidence as to the delivered outcomes and cost efficiencies that these new developments offer.

Continuous evaluation of the Department of Health's Extra Care Housing Funding Initiative is being conducted by the Personal Social Services Research Unit (PSSRU). Further information on this work can be found at <http://www.pssru.ac.uk/>.

Specialist housing for older people comes in a variety of forms and the typology below reflects the key features of the principal types that are available. It is important to note however that there are no universally agreed definitions for this range of housing and therefore the accommodation and services that are available in any particular scheme may differ from those described.

Amenity Housing: dispersed housing built to accessible housing standards, usually with a community alarm fitted. No warden service is provided but

housing support or personal care may be provided on an individual basis following a needs assessment.

Sheltered Housing: accessible housing which is usually clustered, but may be dispersed and which benefits from a warden service and a community alarm service. Accommodation is rarely wheelchair accessible. The warden service provides housing support but not personal care, which if required, would be provided on an individual basis following assessment. No overnight cover or meals are provided.

Very Sheltered Housing: accessible housing which offers all of the above and a full or partial meals service. Admission is usually on the basis of an assessment of needs and the warden service may offer more support than in sheltered housing. Some accommodation may be wheelchair accessible. The warden service provides housing support but not personal care, which if required, would be provided on an individual basis following a needs assessment. Overnight sleep-in cover may be available.

Extra Care Housing: wheelchair accessible housing built and designed to facilitate the delivery of flexible, person centred housing support and personal care, available as required on a 24 hour basis. The support is provided within an enabling culture focused on maximising each person's capacity for a better quality of life. Accommodation is normally clustered but may operate on a hub and spoke or dispersed basis. Extra care housing schemes meet the spectrum of care and support requirements of older people with needs arising from physical frailty, mental health conditions or a complex mix of care need.

Strategic Context - Housing, Social Care and Health

Public services in Scotland are going through a continuous process of change and modernisation. Fundamental to advancing this agenda is a whole system approach which recognises the relationships between different public services and the importance of involving all sectors in new solutions that enhance outcomes for service users and family carers.

Ongoing policy initiatives to modernise services, shift the balance of care and take forward the personalisation agenda have highlighted the importance of bringing together health, housing and social care in order to develop joined up planning arrangements and models. In addition the projected growth in the number of older people over the coming decades presents major challenges to the delivery of health and social care.

From a housing perspective the need to build sufficient new stock to meet the demand for accessible, affordable housing for the growing number of older people poses no lesser investment and planning challenges.

Recent research funded by the Scottish Government and carried out by York University, has confirmed that sheltered housing in Scotland comes in many forms, each one delivering different outcomes for the diverse population who move to such accommodation. From bedsit schemes with an off-site warden to 2 bedroom apartments in modern, well equipped developments with an on-site care and support service, they all have a role to play in the current mix of provision, although bedsit schemes in particular do not seem to be that popular and often present accessibility and location problems . The important question is whether schemes deliver the living environment and type of services that older clients and their families will need and want in the future, or at least whether they have the potential to do so?

The Spectrum of Housing, Care and Support for Older People

The community living options available to older people fall into three principal categories:

- Staying put - alone or with partner/spouse/other relative
- Moving to live with family or others
- Moving to alternative accommodation

The timing for exercising these options depends on a number of factors not least the ready availability of information, individual circumstances, physical, mental, emotional and financial, motivation and perceptions of choice. Sometimes long-standing disability, chronic health conditions or mental health problems including dementia may mean that decisions have to be taken earlier. Some people like to plan ahead and anticipate changing needs, many prefer to wait and risk having to take decisions at a time of crisis.

It is important for local partnerships to develop an understanding of the significance of these options in order to inform their capacity planning, reviews of current housing options and services, and community care provision.

Staying Put

Staying put is often the preferred choice but this will depend on many factors not least:

- Access/availability of carers – informal or formal
- Suitability of accommodation - e.g. stairs, WC and shower/bath access
- Size of accommodation and garden
- Environment safety

Remaining in familiar surroundings can be helpful in sustaining neighbourly and friendship networks in a known community. Familiar surroundings in the home and outside provide useful prompts for those with memory problems to continue daily activities and avoid falls. Staying put is becoming a more feasible option due to the increased availability of assistive technology and Telecare, aids and adaptations, care and repair schemes, handy person services and more flexible home support. These services can be extended to include intensive home care, nursing input, support for carers and community supports such as short breaks and day opportunities.

However there are limits to staying in ones' own home and these are linked to issues around:

- The person - self care needs, risk, insecurity, anxiety
- Carers - own needs conflict or they are not sufficiently addressed because they are working or have other responsibilities
- Community concerns
- Provider capacity - difficult to provide level and type of support and care needed. Due to overnight or unpredictable nature.

The informal care provided by family and friends is invaluable and it makes sense to maintain and support this for as long as possible. In striving to deliver a substitute for such levels and types of informal care and support, formal services often struggle to provide care at home that is sufficiently tuned in to the person's particular needs and routines.

Self Directed Support is increasingly available to deliver flexible care and support solutions in the home, combined with social opportunities and flexible breaks. This enables carers, whether living with the person or not, to continue with reduced stress and physical and mental exhaustion, and specific care needs to be met at particular times of the day or night in the most cost effective way.

Repeat admissions to hospital

Short term illnesses, acute but treatable medical conditions or acute episodes related to chronic health conditions often lead to unplanned hospital admissions. In some cases repeat admissions may occur or the need for Intermediate Care or rehabilitation treatment can result in longer periods or more numerous episodes spent away from home. Discharge from hospital and the return home can be problematic if someone's house needs to be adapted, the required health and social care support is not readily available, or family carers cannot continue in their role or are unable to meet someone's growing care needs.

The longer someone is in an institutional setting the greater will be their loss of daily living skills and confidence and the greater the need for re-skilling or rehabilitation support. Many people will be able to return home for the long term, perhaps with some intermediate care or longer term additional support in the home. For others repeat hospital admissions and the associated loss of skills, confidence and robust health, combined with the disruption to established support networks and routines, may require further in-depth assessment in order to explore the available options for the future.

Moving to live with relatives

One option is to move to live with a relative. This may provide a sustainable solution that continues for a considerable period. In some cases however, it may create additional anxiety and depression especially if dementia is present. Moving to another area can also be socially isolating especially if the family members are out at work.

Even those with chronic medical conditions may be able to manage when they are relieved of the day to day worry of managing a home and help is available to manage medication and other self care tasks. Again, Self Directed Support along with an Assistive Technology package may be available.

For many though, this is not an option and if their home is no longer suitable and they are beginning to feel unsafe on their own, or family carers are concerned at the level at risk involved in them living alone, moving to specialist housing or a care home may need to be considered.

Moving to alternative accommodation

For many older people, the factors that 'push' them to want to move out of their long term home include their own physical health, a lack of services, coping with daily tasks and difficulty getting round their homes. The 'pull' factors that attract them to particular alternative accommodation include having their own front door

and tenancy rights, accessible bathroom and living arrangements, the size of the accommodation, the security offered by the scheme and care support on-site.

Moving may simply involve down-sizing to a smaller and more convenient house – e.g. bungalow, flat with lift, good access, better designed shower bath, WC. This housing can be dispersed or grouped or clustered on the same site. Some retirement communities or smaller private developments are of this type.

Grouping people with particular needs on the same site has both advantages and disadvantages to the different stakeholders. For residents it can offer a greater sense of safety and security especially within the complex; feelings of independence and opportunities to socialise. For providers it may be easier to deliver services, both generic and more specialised, when service users are grouped in the same location. For carers it can offer reassurance that help is on hand in an emergency and that potential problems may be spotted. Carers can still be involved but it is not entirely their responsibility.

But there are some potential disadvantages

- Can induce dependency
- Can increase expectations of support and care regardless of need
- Can create unforeseen impact – e.g. awareness of dementia and disability
- May encourage carers and community networks to withdraw – particularly at a distance or if transport is poor
- Moves from familiar surroundings can create usually temporary feelings of depression, increase levels of dementia or make people aware of dementia for first time. - anxiety and agitation – often temporary but upsetting

This means that the implications of moving have to be carefully considered. In the most extreme circumstances the move can precipitate the outcome most feared e.g. move to care home or hospital. The involvement of the person wishing to move in the decision-making is crucial as is taking time to consider things carefully and having a real choice of accommodation and location. Some people may find the size and scale of some developments off-putting and depressing. Locality will also have an impact. Small group living, shared tenancies or lifestyle communities may be more suited to their needs.

Where someone has a disability or is homeless this puts them in the position of being a priority for re-housing, although it is important that housing need does not get translated into a care need and thereby increase the potential for creating avoidable dependency. To avoid this happening, housing assessment and allocation and assessment for care and support need to be separate,,but linked.

The push to shift the balance of care is about increasing the length of time people live in ordinary or specialist housing in the community with maintained quality of life, ensuring that care homes, especially those providing nursing care,

are only used where other forms of care have been considered and found to be inappropriate.

Increasingly extra care housing is seen as a substitute for intensive care at home where this is not feasible or has failed, or for care homes providing residential care. This is particularly so for those who have higher levels of care and support needs but are motivated to self care, prefer an independent lifestyle and/or have the support of a co-resident carer or supportive family.

Extra care housing offers more than some of the forms of VSH that only provide the addition of a meals service on top of a part time warden service. The most helpful way to appreciate this distinction is to consider aspects of the regulatory regime, assessment process and eligibility criteria that extra care housing operates under.

Extra care housing provides housing support and care at home on the same site over 24 hours. As this service is targeted at those with higher levels of health and social care needs where unpredictable need is possible and problems are chronic, joint health and care assessment (Single Shared Assessment) is necessary. This means that there will be an agreed care plan, agreed level of care and support, monitoring review in place, providing a clear contractual relationship covering care, support and housing. The service user will remain a tenant/home owner with all that this entails. Funding can be maximised and costs adjusted as to need, over time. The services may be integrated or support and care provided separately. People will meet critical need eligibility criteria but there is an expectation that some needs will decrease as well as increase. Developments also provide specialist housing design and layout, Telecare and a variety of day and community opportunities.

Care homes

Extra care housing which provides for people with the highest level of needs within a housing setting, can operate as an alternative to care homes offering residential care. Care homes that offer nursing care are best suited for people who need additional environmental security or behavioural management or who's medical needs require continual nursing care.

Residents no longer have responsibilities as home owners or tenants so for those people whose health or frailty means that they are unlikely to recover their ability to manage these aspects of their life, this may be the best option. Care should still be personalised to address residents' particular needs, but the scope for residents to make decisions about their daily routines and lifestyle is less than in extra care housing. The use of Assistive Technology to aid caring is less widespread than in other settings but still offers the potential to provide more effective support to residents.

Whilst most care homes that provide nursing care offer a 'home for life' until people die, practices do vary and this leads to significant differences in their rates of admission to hospital. In the main however there are few conditions or nursing requirements that cannot be provided for, short of those requiring an emergency hospital admission. In some cases emergency admissions are avoided by primary and acute health services being delivered into a care home for individual residents. In some care homes, specialist Elderly Mental Infirm or Dementia Units provide specialist care predominantly for people with advanced dementia, but where these do not exist, practices and living arrangements within general nursing care settings are usually able to meet the full range of needs.