Cheshire East supported housing strategy

Draft

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1. Introduction

The aim of this strategy is to support the delivery of supported accommodation in Cheshire East which:

- promotes living in the most independent setting possible;
- promotes independent living for as long as possible;
- provides choice in location, accommodation type, tenure, affordability and support arrangements; and
- maximises value for money

We must deliver this within the context of an aging population, budget cuts and changes to the welfare benefit system.

1.1. Strategic context

The strategic direction for social care and support services is one of increasing choice, independence and empowerment; it is set out in a number of initiatives and strategies both nationally and locally which are summarised in the box below. As a result, social care nationally is in the process of a transformation that is putting power into the hands of service users who are increasingly enabled to choose how their needs will be met and by whom.

There is also considerable emphasis on helping people maintain their independence, especially following crisis or hospital admission, rather than making a care placement as the first step. Reablement and intermediate care services are key tools in meeting these aims[1].

The Health and Social Care act 2012 is transferring public health functions to local authorities and commissioning of services to GP-led Clinical Commissioning Groups and NHS Commissioning Board Specialist Commissioning. . At the same time, changes to the benefits system, particularly housing benefits will be reducing the benefit payable for some households through the recent reductions in local housing allowance and this may impact on the housing options available for older people who are dependent on housing benefit. Households under retirement age on housing benefit who are under occupying their homes will have their housing benefit reduced. At the time of writing local housing providers are currently contacting those affected to discuss options.

The national strategic direction is set out in the following documents

- Lifetime homes, lifetime neighbourhoods – a national strategy for an ageing population (CLG 2008)
- Our health, our care, our say: a new direction for community services (Department of Health 2006)

[1] *Reablement aims to help people regain improved functioning, following hospitalisation or crisis, to return to independent living. Clients are provided with intensive support for a period of a few weeks with the aim withdrawing or reducing care at the end of this period. Intermediate care is an umbrella term for a range of integrated services designed to provide: an alternative to hospital admission; a way to support early discharge from hospital or rehabilitation packages to promote independence and avoid long term care.*

- Putting people first - concordat (Department of Health 2007) and the linked transforming adult social care (Department of Health 2008)
- Living well with dementia – a national dementia strategy (Department of Health 2009)
- Under pressure – tackling the financial challenge for councils of an ageing population' (Audit Commission 2010)
- The health and social care act 2012
- A vision for adult social care: capable communities & active citizens DoH 2010
- Housing our aging population; plan for implementation Happi2 (All Party Parliamentary group on housing and care for older people, 2012)
- Think local act personal
- No health without mental health, DoH 2011

1.2. Population pressures

The proportion of older people in Cheshire East is already above the national average and is set to rise at a greater rate than the rest of England. The projected increase in the population over 65 by 2030 is 43% for England and 46% for Cheshire East. Although many people aged 75 and over live relatively independently, this is the age group with the highest demand for care and health services and the increase in the size of the population has very significant implications for the council's care budgets. An increase of 70% in the population aged 75 and over is forecast between 2012 and 2030. Current forecasts from the Institute of Public Care are still based on the 2010 mid year population estimates not the 2011 census; data from the 2011 census is being released over the next 18 months. The forecast population growth for Cheshire East is set out below

Table: 1 forecast population of older people in Cheshire East

Age band	2012	2015	2020	2025	2030	% increase between 2012 and 2030
65-69	23,100	24,800	22,100	23,600	27,800	20
70-74	17,000	19,200	23,400	21,000	22,500	32
75-79	14,000	15,100	17,500	21,500	19,400	39
80-84	10,400	11,000	12,700	15,000	18,600	79
85-89	6,500	7,100	8,200	9,800	11,800	82
90 and over	3,700	4,300	5,400	7,000	9,100	146
65 and over total	74,700	81,500	89,300	97,900	109,200	46

75 and over total	34,600	37,500	43,800	53,300	58,900	70

Source Office for National Statistics (ONS) www.poppi.org.uk

In Cheshire East we have established 7 Local Area Partnerships (LAPs) with a remit to work with local people and partners to understand the issues, needs and preferences that are important in their area. The Laps vary in size with Congleton, the largest, having a population of over 90,000 and Poynton the smallest at about 23,000. The distribution of older people varies between the 7 LAPs: Poynton has the highest proportion of older people, being significantly above the national average for people over the age of 50 and especially for the age band 60-65; Congleton and Nantwich have slightly higher than average numbers of people aged 65 and over whilst Crewe is the only LAP with a younger age profile than the national average. More detail on LAP age profiles is available on our website[2]. All the LAPs, except Crewe, have a lower than average population of 20-40 year olds with this being particularly marked in Poynton. This population profile suggests that the younger adult family members of older households may not be living closely enough to provide family support.

There are differences in life expectancy and healthy life expectancy between the LAPS. Based on responses to the 2008 Communities of Cheshire Survey by Cheshire County Council , the proportion of the population with a long term limiting illness[3] varied as follows: Congleton 17%, Crewe 19%, Knutsford 16%, Macclesfield 17%, Nantwich 20%, Poynton 19%, Wilmslow 16% (England and Wales 2001, 18%). This data is set out in the LAP profiles. [4]

Table 2: life expectancy by local area partnership

LAP	Ward with lowest life expectancy (healthy life expectancy)	Ward with highest life expectancy (healthy life expectancy
Congleton	Congleton North 76 (66),	Dane Valley 82 (76)
Crewe	Valley 73 (64)	Wells Green 83 (77)
Knutsford	Knutsford Over 77 (70),	Knutsford Norbury Booths 86 (82)
Macclesfield	Macclesfield South 74 (66)	Macclesfield Tytherington 85 (78)
Nantwich:	Barony Weaver 78 (69),	Bunbury 82 (76)
Poynton:	Poynton East 79 (73),	Poynton West 83 (77)
Wilmslow:	Handforth 79 (71)	Fulshaw 83 (78)

2

http://www.cheshireeast.gov.uk/community_and_living/research_and_consultation/cheshire_east_area_profiles/local_area_partnership

3 A long term limiting illness (LLTI) is a self assessment of whether or not a person has 'any long-term illness, health problem or disability which limits work or daily activities' based on a question asked in the 2001 Census

4 http://www.doriconline.org.uk/search.aspx?txtQuery=lap+information+pack

Life expectancy varies by ward from 73 in Valley Ward, Crewe to 86 in Norbury Booths, Knutsford. Overall the data indicates that whilst Crewe has a lower proportion of older people compared with the rest of Cheshire East, compared to other areas it is a population in poorer health, lower life expectancy and living for a longer period of time with poor health, suggesting a greater demand on care and health services. Knutsford, on the other hand has the longest life expectancy and in Norbury Booths ward, the shortest average period of living in ill health at 4 years.

1.3. Prevalence of Dementia

The increase in the older population, particularly those aged 80 and over, will result in a huge increase in the numbers of people suffering from dementia, with a predicted increase of over 4,000 people, a 78% increase from current levels.

Table 3: People aged 65 and over predicted to have dementia in Cheshire East, by age

Age Band	2012	2015	2020	2025	2030	% increase
People aged 65-69	289	308	274	293	346	20
People aged 70-74	465	528	640	575	617	33
People aged 75-79	820	884	1,023	1,251	1,127	37
People aged 80-84	1,250	1,304	1,516	1,784	2,213	77
People aged 85-89	1,311	1,428	1,633	1,967	2,339	78
People aged 90 and over	1,105	1,281	1,605	2,046	2,693	144
Total population aged 65 and over	**5,240**	**5,732**	**6,690**	**7,915**	**9,335**	**78**

Source Office for National Statistics (ONS) www.poppi.org.uk

Overall this shows a very significant increase in the need for services for people with dementia over the next 18 years. The Joint Commissioning Plan for Dementia sets out a range of actions to be taken locally in meeting the needs of people with dementia.[5]

1.4. Age profile of our learning disabled population

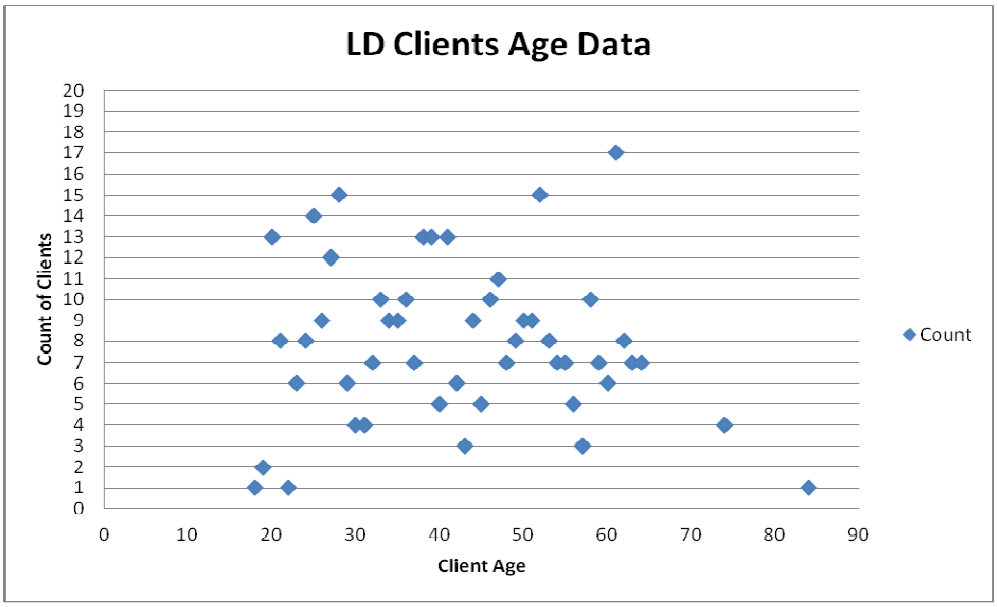
Our population of people with a learning disability is also aging and this population is prone to getting dementia at an early age than the majority of the population. The number of young people with multiple disabilities is also rising as medical advance help more premature babies survive for longer, many of whom have multiple disabilities.

The graph in Table 4 below shows that a third of our clients with a learning disability are aged 50 and over. For those living with parents, the age of the parents will be 70 and over and will be less able to care for their children. Table 4 shows the projected population growth over the period up to 2030.

[5] http://www.cheshireeast.gov.uk/social_care_and_health/health_advice/memory_issues/dementia_strategy.aspx

This is taken from the Institute of Public Care projecting adult needs and service information (PANSI) and Projecting Older People Population Information System (POPPI). The figures are not precise and are regarded as an overestimate for populations with a low population of South Asian heritage as this community has a higher prevalence of learning disability. Nevertheless it is a useful indication of the rate of population growth at about 10% overall, with larger percentage increases in the 65 and over age ranges, and a projected numerical increase of about 90 people by 2030. This suggests that we will need a small increase in supply of services over this period of time.

Table 4: Graph illustrating age profile of clients with a learning disability



Source: CEC Adults Finance Period 7 2011

Table 5 :People aged 18-64 predicted to have a moderate or severe learning disability, and hence likely to be in receipt of services, by age (this is not a direct correlation to people with critical and substantial needs under the fair access to care criteria)

Age band	2012	2015	2020	2025	2030	% age difference
People aged 18-24	166	161	148	148	164	0.9
People aged 25-34	195	217	241	243	240	-21.8
People aged 35-44	304	282	280	319	337	-12.0
People aged 45-54	298	306	287	253	259	13.0
People aged 55-64	235	235	266	282	262	-9.5
People aged 65-74	141	155	159	156	177	26
People aged 75-84	51	55	63	76	78	53
People aged 85 and over	18	21	24	30	33	110
Total population aged 18-64	1,408	1,431	1,466	1,509	1,534	

Source Office for National Statistics (ONS) www.poppi.org.uk; www.pansi.org.uk

These figures compare with a snap shot of service users showing 879 as at September 2010[6] . The difference between this figure and the predicted number of 1408 is likely to be due in part to differences between the proportion assessed as having critical or substantial needs under fair access to care and the prevalence data categories of severe and moderate. It is also consistent with the previously stated assumption that the methodology overstates the prevalence rate in areas with a low South Asian population.

1.5. The population with a severe and enduring mental health problem

The Institute of Public Health population projections show no significant increase in the numbers of people with a severe and enduring mental health problem up to 2030. As poor mental health is often associated with poorer physical health than the general population we can assume that we will be required to meet the needs of frail elderly people with mental health problems as their physical needs increase. The snap shot taken for our analysis of population pressures showed a total of 1,441 adult social care clients with a mental health problem in September 2010 (see footnote 6 below). This relates to people aged under 65 but is otherwise undifferentiated between ages. The total predicted population for people with mental health problems is 35,000. Only a relatively small proportion of this population are in receipt of care services and a very small proportion of these are using supported housing.

1.6. People with a physical disability

Predictions of the population of working age is based on prevalence rates from the health Survey for England 2001 and shows an increase up to 2025 based on the population profile. However, the proportion of this population that will need care services is low and predicted to remain largely stable.

Table 6: People aged 18-64 predicted to have a moderate or serious physical disability, by age, projected to 2030

Moderate disability	2012	2015	2020	2025	2030
People aged 18-24	1,091	1,058	963	959	1,054
People aged 25-34	1,655	1,798	1,907	1,835	1,739
People aged 35-44	2,761	2,554	2,531	2,873	3,024
People aged 45-54	5,529	5,665	5,286	4,627	4,637
People aged 55-64	7,167	7,122	7,986	8,567	8,016
Total population aged 18-64 predicted to have a moderate physical disability	18,202	18,196	18,674	18,862	18,469

[6] **ADULT SOCIAL CARE GROWTH PRESSURES, Cheshire East, March 2012**

Serious disability					
People aged 18-24	213	206	188	187	206
People aged 25-34	158	171	182	175	166
People aged 35-44	838	775	768	872	918
People aged 45-54	1,539	1,577	1,472	1,288	1,291
People aged 55-64	2,790	2,772	3,109	3,335	3,120
Total population aged 18-64 predicted to have a serious physical disability	5,537	5,502	5,718	5,857	5,700

Source Office for National Statistics (ONS) www.pansi.org.uk

Table 7: People aged 18-64 with a physical disability supported by social care in care homes, and those in receipt of social care through self directed support and/or direct payments, projected to 2030

	2012	2015	2020	2025	2030
People aged 18-64 with a physical disability in residential and nursing care during the year, purchased or provided by the CASSR	35	35	35	35	35
People aged 18-64 with a physical disability in receipt of social care through self directed support and/or direct payments provided or commissioned by the CASSR	488	488	492	496	494

Source Office for National Statistics (ONS) www.pansi.org.uk

1.7. Tenure

Based on the 2001 census, 78% of the population of Cheshire East and 75% of pensioners are owner occupiers. This is higher than the national average of 68%. A much lower percentage are in social rented accommodation with 11.5 % of pensioners and 12.5% of the population as a whole in the social rented sector compared with 17% and 19% across England as a whole. Some of these figures will change as the new census data becomes available, but the overall picture of a high percent of older people being owner occupiers in Cheshire East is unlikely to alter radically.

The average house price during the period July to September 2012 was £226,197, ranging from £341,559 for a detached house to £130,392 for a flat.[7] Some houses, especially in the Crewe and Nantwich areas, are on the market for as little as £80,000 which is much lower than the cost of new extra care and sheltered flats in the Cheshire East. Housing options will need to take into account that, whilst prices of retirement housing are very affordable compared with their house prices for many owner occupiers, there are still some older people who cannot sell and buy outright.

[7] http://news.bbc.co.uk/1/shared/spl/hi/in_depth/uk_house_prices/counties/html/county17.stm?t#table

1.8. Financial pressures

The 2012/13 net revenue budget for adult services is £91.4m. This represents 35% of the council's net budgeted spending on services of £259.8m. The adult service budget has overspent in each year since the inception of Cheshire East.

Table 8: Overspending against Budget (figures £m unless stated)

Year	Budget	Outturn	Overspend	%
2009/10	75.7	78.4	2.7)	3.6
2010/11	69.4	78.1	8.7	12.5
2011/12	95.0	97.9	2.9	3.0
2012/13 (projection)	91.4	96.4	5.0	5.4

For future years the budget process has an in-built factor to reflect demand and cost growth of approximately £5m pa (c4.5%). Thus the Adults' budget is currently planned to grow from £91.4m in 2012/13 to £102.8m in 2014/15. However the authority is currently modelling an expected funding shortfall of £13m in 2013/14 and a further £7m in 2014/15 and adult services will be expected to bear at least a proportion of the expected future funding shortfall.

The challenge for the authority, as with all local authorities, is to provide care services for a rapidly increasing population of older people with a shrinking budget. Modelling by the LGA of local authority expenditure compared with income shows the portion spent on social care increasing to over 50% [8] of income, whilst Barnet Council is predicting that by 2022/23, social care spending for adults and children will exceed the total council income in what is known as the 'Graph of Doom'.

1.9. Personal budgets

Direct payments are local council cash payments for people who have been assessed as needing help from social services, and who would like to arrange and pay for their own, independently contracted, care and support services. Personal budgets are an allocation of funding given to users after a social services assessment of their needs. Users can either take their personal budget as a direct payment, or - while still choosing how their care needs are met and by whom - leave councils with the responsibility to commission the services or nominate a service provider to manage their budget on their behalf (or they can have a combination of these options). These replace services that have in the past been provided by, or funded by, the local authority and are not in addition to these services. This is therefore a very different way of providing services and using the councils care budget.

The draft Care and Support Bill, Caring for our Future, which was published in July 2012, proposes that all service users be entitled to a personal budget as part of their support plan. This has implications for the financing of services including supported housing. Councils and providers will need to incorporate personal budgets into care planning. It is possible that service users may choose external providers for some or all non-core services.

[8] Funding outlook for councils from 2010/11 to 2019/20:preliminary findings LGA

Analysis of PSSEX1[9] data for 2010/11 shows that Cheshire East performs well compared with our statistical neighbours for the number of our clients using direct payments. However we have block contracts for many of our supported housing services and personal budgets will mean that contracting in this way for care services will no longer be possible for supported housing for people with statutory care needs. Contracts for support services will need reviewing.

[9] Personal Social Services Expenditure Data

2. Supported Housing for older people

2.1. Our local strategies

We have recognised in Cheshire East that our aging population will create a number of challenges for us. This challenge is set out clearly across a range of local strategies which aim to improve the quality of life for our residents and deliver sustainable development. These include:

- Ambition for all - Cheshire East's sustainable community strategy 2010 to 2025
- Moving forward 2011-2016 – Cheshire East housing strategy
- Extra care strategic housing market assessment
- Regional supporting people strategy
- Joint strategic needs assessment
- Cheshire East joint health and wellbeing strategy
- Aging well in Cheshire East programme
- Overview and scrutiny review of residential care
- Joint commissioning plan for dementia
- Draft adult social care market position statement April 2012

2.2. What do older people want?

There has been considerable research into the views of older people in Britain regarding their preferences for where they live as they age, how they would like services to be delivered and the difficulties faced in finding out about services.

The Wanless Report 2004[10] identified the following preferences for people should they need care:

Table 9: housing preferences of older people

Preference	%
Stay in my own home with care and support from friends and family	62
Stay in my own home but with care and support from trained care workers	56
Move to a smaller home of my own	35
Move to sheltered housing with a warden	27
Move to sheltered housing with a warden and other social care services such as hairdressing and organised social outings	25
Move in with my son or daughter	14
Move to a private residential home	11

[10] 'Securing Good Care for Older People', Derek Wanless, 2004, HMSO

Move to a local council residential home	7
Move to a residential home provided by a charitable organisation	3
None	1
Don't know	2

It is clear from this that whilst there is a strong preference for staying in the family home, at least 35% of respondents in this research would consider moving to a smaller home and abut 25% would consider sheltered housing of some sort. However older people can find it difficult to find the right information to help with making decisions about where to live whilst at the same time decisions involve strong emotional attachments to a family home. These difficulties result in older people feeling that they have little control over their future choices. '*They may find themselves in residential care before they are ready for it; or staying at home, at risk, when housing with care may be a better option. It is not uncommon for a decision to move to specialist housing to be made after an older person has been hospitalised, and without proper involvement of the older person themselves in the decision making process*.' (Lifetime homes, lifetime neighbourhoods, CLG 2008).

However, when asked about suitable housing options should they be unable to live independently in their own home, 80% of respondents to a 2011 YouGov poll for the National Housing Federation[11] were positive about downsizing to a smaller, more manageable home and 65% liked the idea of living in a self-contained home with support or care available if required.

A strategy to meet the housing and support needs of older people needs to ensure that there is a range of options available and that older people have access to adequate information, advice and support about these options in order that they can make real choices.

2.3. Views of older people in Cheshire East

Older people have been consulted on the development of a number of our strategies and we have carried out some specific consultation for the development of this strategy. The Ageing Well Plan identifies positive aspects and concerns from the point of view of older people:

Positive aspects

- Cheshire East is generally a good living environment where people feel safe
- We have good quality statutory services
- The police support local communities
- We have thriving voluntary organisations and faith organisations
- There are good opportunities for volunteering
- There is a good sense of community in some areas
- There is a good variety of accommodation available, including extra care housing
- Local colleges provide good opportunities for older people

[11] Breaking the mould, re-thinking housing for older people, National Housing Federation, 2011

- There is good access to transport in our more urban areas

Concerns

- Variation in quality of life and life expectancy across the area
- Levels of apathy among older people
- Our responses to social exclusion need to be more innovative and creative
- Services feel disjointed
- Communication about services available is ineffective
- Issues affecting our rural communities, including social isolation, fuel poverty, hidden poverty, decline in village life, closure of post offices, poor broadband access and poor public transport links
- Variable quality of care, particularly in care homes and making decisions about care
- Improving access to services is not just about addressing physical issues; we need to address people's perceptions

In a focus group of 14 older people living in more urban areas of Cheshire East a majority of the participants conducted for this strategy in autumn 2012 thought that it was best to consider moving to more suitable housing when it became difficult to manage and a number had already done so. Access to transport was identified as an important issue with several participants living in properties that they felt would not be suitable for people who could no longer drive even though adaptations would be very feasible. Participants felt that easy access to services was vital and adequate space for family visitors and for equipment in the event of disability was also very important. For some, good neighbours are one of the best things about where they live and conversely, those whose neighbours have moved, or who had moved home away from neighbours, felt their lack acutely. Living within a community is felt to be important; for some it is essential that this is within a mixed community whereas for others a community of older people is preferable.

Affordability of housing and care was a major consideration amongst the focus group, many of whom were familiar with extra care developments locally. These were identified as unaffordable with high housing costs and high care costs even for those with no care needs. Others were hoping to move but had been unable to sell their homes.

The Extra Care SHMA[12] identified considerable interest in Extra Care housing with 7.4% of the population over 45 indicating that they would consider move into Extra care housing with 12.9% willing to consider sheltered housing. The report states that a total of 3,000 families indicated that they would be interested in sheltered or extra care housing for relatives moving into Cheshire East ie people moving from outside the Borough. This indicates considerable potential demand for specialist housing in Cheshire East.

The table below sets out the reasons given for moving into extra care accommodation. These varied views indicate that meeting the needs of older people requires a range of housing options both with and without support or care and across a variety of tenures, but that affordability is an important consideration. These findings are similar to those set out in our housing strategy, Moving Forward 2011-2016.

[12] Cheshire East Strategic Housing Market Assessment: Extra Care Housing, 2012

Table 10: Reason for moving given by those considering extra care (from SHMA)

Reason for moving	% stating reason by age group		
	60 to 74	75 and over	All 60+
Want larger property or one that was better in some way	8.0	0.0	5.8
Need smaller property, difficult to manage	25.4	61.7	35.6
Need smaller property for other reasons	31.0	22.6	28.7
Cannot afford rent/mortgage payments	2.9	0.0	2.1
Need housing suitable for older/disabled person	27.7	62.4	37.5
Want to buy	17.6	18.3	17.8
Lacking or needed separate kitchen/bathroom/toilet	5.8	0.0	4.2
Major disrepair of home	0.0	1.7	0.5
Want own home/live independently	1.8	9.6	4.0
Divorce/separation/family stress	0.6	1.7	0.9
Marriage/to live together	0.0	0.0	0.0
Forced to move	1.9	0.0	1.3
To be closer to family/friends to give/receive support	6.6	29.3	13.0
To be closer to family/friends for social reasons	8.2	11.6	9.1
To move to a better neighbourhood/more pleasant area	18.6	18.1	18.5
To be closer to facilities e.g. shops, doctors	21.1	37.6	25.8
To be closer to work/new job	0.0	0.0	0.0
To be in a particular school catchment	0.0	0.0	0.0
Want smaller garden	18.3	48.7	26.9
Want larger garden	4.6	0.0	3.3
Harassment/Threat of Harassment/Crime	0.7	1.5	1.0
Overcrowding	0.0	0.0	0.0
Base	565	221	785

Source Cheshire East Strategic Housing Market Assessment: Extra Care Housing, 2012

2.4. Supply of housing with care and support for older people in Cheshire East

Registered care

In Cheshire East we have an extensive supply of registered care homes with and without nursing care. There are currently 4043 registered care home places in the borough provided by 103 homes; 46 of these provide some nursing care. However, less than 1400 of these places are currently funded by the council. The rest of the bed spaces are taken up by Cheshire East residents funding their own care and people who move in from outside the borough, many of whom are funding their own costs. Self funders who run out of money migrate to social care funding as the council has a

statutory duty to provide care for people who meet the criteria for care and who are assessed as being unable to afford to pay. Self payers who run out of money fall into this category. The Dilnot Commission 2011[13] has proposed setting a cap on the amount individuals should pay for care but as yet this has not been implemented.

Extra care housing

There is no single definition of Extra Care housing. The Strategic Housing for Older People Resource Pack, published by the *Housing Learning and Improvement Network* has the following description: 'primarily it is housing which has been designed, built or adapted to facilitate the care and support needs that its owners/tenants may have now or in the future, with access to care and support twenty four hours a day either on site or by call. It is generally based on the following principles:

- To promote independence – the provision of self-contained accommodation designed to enable individuals to live independently within the community, and promote their well-being and quality of life.
- To be empowering and enabling – the availability of flexible, person-centred care and support services which empower and enable individuals to maximise their independence and promote health and wellbeing.
- To promote social inclusion – services and buildings designed to promote social inclusion and alleviate social isolation.'

Although Extra Care schemes vary widely the Resource pack identifies three main types:

- Retirement village, which is a large scale development for which there are no entry requirements and which is predominantly housing for sale
- Large scheme, which aims for a balanced community on terms of care needs, often set as a third/a third/ a third in terms of high/medium/low needs, and with a mix of tenures; an allocation panel manages access at least for rental units.
- Small scheme for residents who already have care needs, often 100% rental and with nominations managed by a panel.

Extra care housing is still relatively new and until recently evidence on the impact, benefits and limitations was in relatively short supply. More recently a number of papers have built up clearer and more objective view of the outcomes from extra care.

Extra Care housing can provide increased independence and reduced care needs for its residents', however the often made claim that it provides a home for life is not necessarily the case as about a third of residents subsequently move into residential care. This can cause considerable resentment in residents who have really not expected to move again. For others however, extra care can deliver all the care necessary up to end of life[14]. Residents with dementia can live successfully in extra care housing but where their behaviour causes distress to other residents a move into residential and nursing care is more likely[15].

[13] http://www.dilnotcommission.dh.gov.uk/

[14] Improving housing with care choices for older people: an evaluation of extra care housing, 2011

[15] Extra Care' Housing and People with Dementia, Housing and Dementia Research Consortium, May 2009

Schemes that are intended to have a balanced community are frequently reported to experience difficulties in maintaining the balance of resident needs: a high proportion of high needs clients can prevent the allocation of further places to people with high needs. In Cheshire East the opposite problem prevails with a much higher proportion of low and medium level clients than originally intended when the schemes were first commissioned. A fixed ratio of tenure types can also be difficult to achieve, especially at the present time, with a depressed property market making it difficult to find buyers. The combination of a balance of needs and tenure types can make for a hugely complicated allocation process. [16]

The recently published HAPPI 2[17] report identifies that the current economic climate is making it harder to develop specialist housing for older people with adequate space standards within the new 'affordable rent' regime and within the private sector as the cost of larger accommodation and communal space is putting prices up.

2.5. Extra care in Cheshire East

Table 11: Extra care and registered provision by Local Area Partnership

Local Area Partnership	Registered care units	Extra care units
Congleton	905	116
Crewe	611	229
Knutsford	491	70
Macclesfield	826	75
Nantwich	413	119
Poynton	435	0
Wilmslow	362	53

We have a range of extra care provision in Cheshire East; there are 256 units in three schemes funded through a PFI initiative originally set up by Cheshire County Council, 236 units provided by Registered Providers (RPs previously known as RSLs) in 4 schemes and 202 units in 7 private schemes, most of which are small scale and between 12 and 20 units. This gives a total of 694 units of extra care across the borough as a whole. However the table illustrates the uneven distribution of extra care between the local area partnerships which in part reflects the different approaches of local RPs and the fact three PFI schemes were originally developed in one per council in 3 district council and therefore three of the LAPs did not benefit.

[16] Comparative evaluation of housing with care for later life, *2007, Croucher, Hicks, Bevan and Sanderson*
[17] Housing OLDER PEOPLE our Ageing Population: Plan for Implementation, all party parliamentary group on housing and care for older people, Nov 2012

The three PFI funded schemes were originally commissioned to deliver a third/ third/third split of high/medium/low needs and a 60/20/20 split between rented/shared ownership/full ownership. This has proved very difficult to deliver, with particular difficulties in allocating the high needs places; the current spilt is: 18% /20% /62%, as at September 2012. This has been attributed variously by stakeholders to weaknesses in the original allocation processes which did not have sufficient pre-allocation processes, so that the early occupiers did not meet the intended split; the short timescale for allocating vacancies and an strong emphasis amongst social care staff for keeping people in their own homes so that moving home whilst still managing with care is not necessarily one of the options discussed.

The problems in the housing market have also resulted in difficulties for the providers in selling the target proportion of the flats. 57 sale flats were transferred to social rent in April 2010; 11 of these have been re-sold, as at October 2012. Shared ownership has been popular.

When the PFI extra care housing was planned assumptions we made about savings to the social budget based on the planned proportion of high needs being taken up and that these residents would otherwise have been in residential care. Savings were estimated on the assumption that the care costs of residents in extra care would be less than if they were in registered care. The failure to allocate sufficient high care cases to extra care means that savings are not being realised.

Feedback on the extra care schemes in Cheshire East, gathered through the scrutiny review of registered care[18], concluded that most residents of these schemes were happy; most were able to live out their life at the scheme and residents with dementia were successfully accommodated. However there were concerns about the isolated nature of larger schemes and the separation of the residents within the extra care schemes from the wider community. A recent focus group considered the schemes to be expensive.

Elsewhere some providers are starting to pilot different financial arrangements to mitigate the cost of long term care. The Joseph Rowntree Housing Trust has introduced a range of flat fees for care and support costs at its Hartrigg Scheme. Residents pay the same fee over the whole of their residence. The fee is dependent on the age at which they move in and the level of service selected. The younger you move in the lower the fee. You can opt not to include care in the fee but if care is subsequently needed it has to be paid as and when it is needed.

The Extra Care Charitable Trust is piloting a product called 'Care for Life'; residents pay a premium and will receive care and support until the end of their life. Examples of the costs are: at age 73 a lump sum of £24,496 and £915; at age 80 £21,000 lump sum and £1,200 per annum. There is no need for residents to subsequently sell their home to sell for care. If the Dilnot report is implemented it may have an impact on these types of schemes, depending on the cap on contributions. The higher the cap the more such schemes remain cost effective solution.

2.6. Sheltered housing in Cheshire East

There is a considerable supply of sheltered housing (housing for older people with alarm services and in most cases a support service) both private sector and social housing sector, across the borough with considerable variation in the distribution. In the Macclesfield area there are over 550 units of private sector accommodation to buy or rent and 240 units of social sector sheltered housing provided by Peaks and Plains, the LSVT[19] RP, with other RPs providing a further 270 units of

[18] Residential Provision to Review Overview and Scrutiny Review ,Adult Social Care Scrutiny Committee, November 2011 – May 2012

[19] LSVT _ Large scale voluntary transfer – refers to the transfer of local authority housing stock

RSL sheltered housing that offers support, 100 with alarm only and 230 units of age specific housing with no alarms or support provided. In the Congleton area there are 300 units of private sector provision; 206 provided by Plus Dane the main RP provider and 161 units provided by other RPs.

Crewe and Nantwich have the smallest supply with 154 units in the private sector and 186 provided by Wulvern Housing. All three of the large RPs have reconfigured their sheltered housing and have decommissioned older outdated stock, although some bedsit stock still remains. The remaining stock is in the more urban areas and market towns where access to services is generally better than the surrounding rural areas.

Only Wulvern is currently actively engaged in the development of extra housing with two schemes, one of which has opened recently. Plus Dane Group has one extra care scheme which is a new development on an old a care home site. There is considerable concern about the risks inherent in further extra care developments because of the uncertainty around long term care funding and housing benefit levels. With the numbers of older people rising and the costs of care rising there are anxieties about the robustness of the current funding system. The latest report into the issue, the Dilnot Report[20] July 2011 recommended capping individual contributions to limit the amount an individual will pay. So far there are no definite plans for reform and concerns about funding remain. And although the local housing allowance caps do not apply to social housing, the ongoing changes to benefits are still causing uncertainty, especially linked to changes to funding for new social housing which is now required to have rents at 80% of market rents. Peaks and Plains Housing Trust are currently reviewing their strategy in relation to extra care housing and deciding whether to actively develop extra care.

The larger extra care schemes may compete with the existing supply of sheltered housing for those who can afford the service and care charges. However, as the PFI extra care schemes do not attract any Supporting People (SP) funding, residents on low incomes who are eligible to receive SP funding for the support charge in sheltered housing will only be able to access sheltered housing.

The imminent welfare changes have resulted in RPs contacting their under occupying tenants below retirement age whose housing benefit will be reduced; 'downsizers' have been placed in the highest priority band for choice based lettings to support this. Not unexpectedly, 80% of these residents wish to stay put, although this may change once the benefit reductions have been introduced. Officers from RPs report that tenants who are willing to consider a move expressed a very strong preference to stay on their current estate to stay in touch with their existing networks and bungalows are particularly popular. This highlights the importance of suitable local housing options in making a move viable for older people.

2.7. Staying put and maintaining independence

Housing and support for older people is not just about specialist schemes or personal care services. For the vast majority who wish to stay in their family home for also long as possible, it is important that the property can be adapted to meet changing needs. Our housing strategy, Moving Forward 2011-2016 identified the following priority:

Developing the Home Improvement Agency service across Cheshire East, to offer:

[20] http://www.dilnotcommission.dh.gov.uk/

- a wider range of practical low-level services such as handyperson services, home safety and security, and gardening;
- a rapid response to meeting older peoples needs for home adaptations;
- Guidance through the funding options for home repairs;
- Support to employ contractors to carry out home repairs and adaptations, reducing opportunities for rogue traders and bogus callers;
- A range of services for older people who aren't eligible for or don't want to access social care for equipment and adaptations.

For new developments the use of Lifetime Homes Standards[21] reduces the need for adaptations in later life by ensuring that properties are built in such a way that accessibility is maximised and adaptations can be easily installed. Again, this has already been addressed in our housing strategy within the following priority:

> *Working in partnership to provide accommodation with a greater range of tenure options that is of good quality and better design, and meets Lifetime Homes standards, offering longevity and flexibility for the changing needs of ageing*

Beyond buildings, where ever people live, whether it is in the family home, a downsized property or sheltered accommodation, an active social life and support network is important in keeping healthy both physically and mentally. With rising thresholds for accessing local authority funded social care finding ways for people with low to moderate needs to get the help and support they need will be increasingly important. The feedback from residents in the Aging Well Plan identified that whilst in some places there is a strong community in Cheshire East, there are areas of social isolation, disjointed services and poor communication.

Across the country, initiatives are developing to promote and support mutual support and care and social activity within the community. Southwark Circle[22] and Suffolk Circle[23] are examples of membership networks which provide practical help in exchange for tokens and enable people to organise social events with like minded people, including helping with transport. Care4Care[24] is a volunteer care network where volunteers can accrue care credits in exchange for care they provide. The credits can be banked for future use or used for care for a relative. The scheme is currently being piloted in the Isle of Wight and is once the pilot has been evaluated it will be worth assessing for local applicability.

2.8. Reablement and intermediate care

These are two important tools for helping older people maintain their independence for as long as possible. Cheshire East offers a free re-ablement service to clients who are likely to meet the critical or substantial levels under the FACS criteria at a time of increased need to help restore independence and enable people to stay in their own homes. The North West Joint Improvement Partnership Reablement Assessment March 2010 demonstrated that over 30% of clients in the

[21] http://www.lifetimehomes.org.uk
[22] http://www.southwarkcircle.org.uk
[23] http://www.suffolkcircle.org.uk/
[24] http://care4care.org

survey no longer needed care and over 20% had their package reduced at the end of the reablement period[25].

East Cheshire NHS Trust provides intermediate care in the community or in a number of specialist settings:

- Langley unit at Macclesfield district general hospital, which is a 30 bed unit (30 beds, 17 generic beds, up to 6 specialist rehab beds and 7 transitional beds)
- Aston Ward at Congleton war memorial which is a 28 bedded unit- 21 generic and 7 transitional beds.
- Hollins View Macclesfield is a support centre run by Cheshire East council which provides 10 residential beds.
- Belong Care Village in Macclesfield provides 11 beds in an independent nursing home.

The aim is to prevent unnecessary and avoidable hospital admission for people who have experienced an acute health event that has resulted in a change in physical functioning; help people recover faster and to achieve their full potential following illness or injury; facilitate safe and timely discharge from hospital where there is a rehabilitation need and/or potential to improve physical functioning and maximise independent living.

2.9. Need and demand for housing with care and support

The demand for most types of service is not directly related to need as factors such as knowledge of services, ability to pay and ability to access a service all play a part. There are particular difficulties for older people in making decisions about their best housing choices when they need to consider finance, care and housing issues whilst also considering leaving a place of great emotional attachment. One of the consequences of this is that '*it is not uncommon for a decision to move to specialist housing to be made after an older person has been hospitalised, and without the proper involvement of the older person themselves in the decision making process*.' (Lifetime homes, lifetime neighbourhoods, CLG 2008).

The Institute of Public Care provides projections for the demand for residential care through the Projecting Older People Population website (POPPI). Such projections are useful indicators of potential demand but should not be taken as precise figures as they are based on standard ratios across the country and do not take into account of such factors as health variations or the impact of availability of supply [how does this compare to 1400 funded beds; surely we can't be talking about 1700 self-funders? Baseline figure looks too high to me]. In Cheshire East is the projected demand up to 2030 is as follows:

Table 12: Projected demand for residential care

Residential care population projection for Cheshire East	2012	2015	2020	2025	2030

[25] "Making the Strategic Shift" Efficiency Programme, March 2010, A report of research carried out by North West Joint Improvement Programme and compiled by CN Research

Total population aged 65 and over living in a care home with or without nursing	3,126	3,443	4,022	4,854	5,722

Projecting Older People Population website (POPPI)

The supply of residential care places, at over 4,043 is almost 1,000 place in excess of the projected current demand for residential care services for Cheshire East and continues to be in excess of projected demand beyond 2020. Kerslake and Sitwell 2004[26], suggest that at least one third of residential care placements and as much as 2/3 (66%) could be avoided through an earlier move to housing with care. Although this work is now quite old and some practices may have improved since then, if only 20% of the projected residential care placements are avoided through the provision of alternatives, the projected demand for 2025 reduces to 3883 and remains below the current level of provision. This excess of residential care places, over and above the local demand, draws people from outside the borough including self payers who may migrate to social care funding at the point when their care costs are highest.

Our Scrutiny report on residential[27] care noted that

' it is in the interest of private care homes to accept residents before they are ready. It was explained that with Council funded care, residents are assessed and placed appropriately but with private care, homes were incentivised to accept 'healthier' residents as they would pay for care over a longer time period. The longer residents are in residential care, the more likely it is that their capital will be reduced to the extent that they will need to migrate to Council funded care.'

Cheshire East has a higher proportion of admissions to residential care directly from hospital than other authorities in the north west – 4.5% of hospital discharges for people aged 65 and over; this is second only to Cheshire West with 4.6%, whilst for the best performers the figure is less than 1.5%. (NHS North West). This is attributed to hospital admissions from care homes which result in a discharge back to the care home.

Social care managers are keen to keep people living independently at home as long as possible. An increased emphasis on reablement and interim care is reducing admission to residential care with the authority performing well overall on residential care admissions. However, Cheshire East has much higher number of resident weeks in nursing care placements than comparative councils at 35,000 compared with 19,000 for average of our statistical neighbours, indicating much longer average stays than is common elsewhere. The average weekly costs are lower at £440 compared with £513. In theory one explanation for longer stays could be relatively poorer health in Cheshire East; however the data on life expectancy and disability free life expectancy does not support this. If the reason is not poorer health then the explanation may be that a client in Cheshire East is more likely to be assessed as needing health care at an earlier stage than elsewhere in the country. This needs further investigation and there is some concern that the problem results, at least in part, from self payers migrating to social care funding. We will need review our processes in order to understand the issues in more detail.

As with registered care, estimating future demand for housing with support is not an accurate science and much depends on preferences, particularly for those who may chose to move before

[26] Kerslake A and Stilwell P (2004). What makes Older People choose Residential Care and are there alternatives? Housing Care and Support; 7 (4): 4-8.

[27] Residential Provision Review Nov 2011 – May 2021

they develop care needs. The Older Person's Housing Tool Kit[28] includes a set of prevalence figures that can be used to estimate demand but the paper does not set out the assumptions on which the prevalence data is based and the figures should be treated with some caution.

[28] Quoted in STRATEGIC HOUSING FOR OLDER PEOPLE Planning, designing and delivering housing that older people want, Housing Improvement and Learning network, 2011

Table 13: Estimated demand for sheltered and extra care housing in Cheshire East – based on model from the older person's housing toolkit:

	Number per 1,000 populations aged 75+	Year				
		2012	**2015**	**2020**	**2025**	**2030**
Cheshire East 75+ population		34,600	37,500	43,800	53,300	58,900
Conventional sheltered housing to rent	60	2076	2250	2628	3198	3534
Leasehold sheltered housing	120	4152	4500	5256	6396	7068
Enhanced sheltered housing (divided 50:50 between that for rent and sale)	20	692	750	876	1066	1178
Extra care housing for rent	15	519	563	657	800	884
Extra care housing for sale	30	1038	1125	1314	1599	1767
Housing based provision for dementia	6	208	225	263	320	353

The supply across Cheshire East is well below these estimated figures for all types of sheltered and extra care places and whilst it would be unwise to follow the figures too closely there is a clear indication that additional provision of extra care is needed. The Extra Care SHMA clearly demonstrates interest in extra care housing from both residents and their families. Providers of social sheltered housing have reduced their supply and decommissioned out dated stock. There is sufficient demand for the remaining stock, with reservations about the remaining bedsit accommodation, but despite the projections above, little indication of an undersupply of this traditional model. The larger extra care schemes, with their 'wellbeing' allocation, are in direct competition with traditional sheltered housing and the newer schemes may be more desirable.

Residents' difficulties in selling their homes are having an impact on demand. Redbridge Council is piloting a scheme called 'Free Space' which enables homeowners to lease their property to the council in exchange for a smaller home to address this issue. If this can be shown to be effective we may wish to consider implementing something similar.

2.10. The impact of welfare benefit changes

Changes to the welfare benefit system including housing benefits must also be taken into account in planning for extra care housing. There are two issues; firstly, the caps for local housing allowance, which vary across the borough set a maximum rent for extra care housing; tenants reliant on housing benefit may only be able to afford a one bedroom property at the LHA rate. These currently ranges between £78.46 and £102.49, depending on which Broad Market Rental Area applies, although in some areas a two bed property may be affordable with an LHA ranging from £91 to £126 The introduction of the universal credit may have further implications but the detail is not currently

available. This creates some uncertainty for potential developers as the long term affordability levels for tenants on housing benefit is uncertain.

As discussed previously, the introduction of an under-occupation rule, whereby tenants on housing benefit with empty bedrooms will have their housing benefit reduced is likely to lead to a number of older households whose children have left home needing to move home, although this does not apply to people of pensionable age. However, it is currently unclear how this applies to households where there is a both a member of pensionable age and one of working age but this is probably quite a small group. . Older households having to move as a result of these changes will need advice and guidance in deciding where to move to. Indeed this will be a useful point to consider whether a move to sheltered or extra care is advisable.

The introduction of universal credit will bring in a benefit cap which limits the total a household can receive in benefits. Again this does not apply to pensioner households but the same query exists regarding mixed households. Taken together this means that there is less uncertainty regarding the benefits payable to pensioner households than for those of working age.

3. Supported Housing for People with a learning disability

3.1. The supply of housing and support for people with a LD in Cheshire East

Cheshire East council is a major provider of supported housing for people with a learning disability in the borough with 169 units spread across the borough. Care is provided by our in house service Care4ce through 5 supported living networks. Our clients live in a mixture of small group homes, groups of flats some live in the wider community.

Table 14: Cheshire East support housing provision for people with a learning disability

Local area partnership	Cheshire East supported living network places	Number of placements with other providers
Congleton	42	39
Crewe	23	48
Knutsford	31	11
Macclesfield	40	65
Nantwich	11	36
Poynton		2
Wilmslow	22	7
Total	169	208

We are currently, at December 2012, funding an additional 219 placement**s**, 11 of which are out of borough . These are provided through a mixture of block and spot contracts. We have large block contract with Alternative Futures who are a major partner and with whom we currently have 83 placements. Lady Verdin Trust are another major provider with whom we have 39 placements and we work with a further 20 providers so there is a well developed local market. These placements however are not evenly spread across the borough as the table below shows. Poynton, Wilmslow and Knutsford have far fewer placements than the other LAPs.

Although some officers expressed concerns about a lack of places locally for people with the most complex needs, especially autism and co-diagnoses, we are currently only funding 11 out of borough placements and the majority of our high cost placements are in borough. We have 23 placements costing £3,000 per week or more and all but two of these are local.

Data from the personal social services expenditure return (PSSEX1 2010-11) analysis shows that we fund a much higher level of nursing care for clients with a learning disability than our statistical neighbours, with more than double the number of client weeks and our costs are about 10% higher. This means that we are spending about £1m per year more than our neighbours. With a shrinking budget it is important that we ensure that all referrals are appropriate and that effective reviews are

undertaken on a regular basis, with clients moved to a more independent setting if this is appropriate.

Much of the provision in Cheshire East is shared housing and there is a very strong consensus amongst stakeholders that this model is no longer fit for purpose. The schemes were originally established for small groups of people moving out of hospital with the introduction of care in the community and are predominantly shared houses or bungalows. Many of these households have lived together for some time and when a vacancy occurs it can be difficult to find a suitable candidate to fit in with the household. This is not to say that it is not possible to fill vacancies. Some that have been expected to be a challenge have worked well and others have not worked where a good fit had been expected. This leads to vacancies, but because of the nature of the contract, the cost remains the same.

We have also been identified as an example of good practice in the use of telecare for people with a learning disability[29]. Through the use of telecare such as door sensors, epilepsy sensors and bed sensors, we have enabled people with a learning disability to move from group homes to independent accommodation and reduced care package costs.

3.2. Service user views

We held a series of 4 focus groups with a total of 21 service users, both residents of supported housing and people living with family. In addition we held a small number of telephone conversations with carers who were unable to get to the focus groups. The participants had mixed views about the type of housing they would prefer. A majority expressed a preference for shared housing, largely because it would provide company and prevent loneliness and isolation. Some participants did express a preference for more independent living and their own front door and one group expressed a preference for their own kitchen and bathroom but with shared communal facilities. There was a recognition that that those sharing should have compatible needs and concerns was expressed about large age differences. The majority were content with their current housing and only a small proportion had any immediate plans to move home. These were not expressed in terms of dissatisfaction but were about readiness to move.

Participants highlighted the following aspects of support as important:

- Consistency of staff
- More female staff
- Help with money and budgeting
- Activities
- Household routines such as shopping, cooking and paying bills
- Help with getting out and about and transport

Participants also wanted greater support for 'letting go' and this was a very emotional issue for some participants and could prevent moving into greater independence. A number felt that did not have

[29] Putting People First Transforming Adult Social Care, 2012, DoH

much information about what was available and one carer reported difficulties in finding out how to access housing for the person he cared for.

There is some indication that carer's expectations of independent living may be very difficult to afford where one-one 24 hour care is needed for independent living.

There is clearly some divergence between the views of providers & commissioners and those of service users about the suitability of shared housing and any developments of more independent living will need to take on board the concerns expressed about the potential for loneliness.

3.3. Demand for supported accommodation for people with a learning disability

The population of people with a learning disability is projected to grow slightly between now and 2030. Drivers in terms of the need for supported housing are:

- people currently living with their parents who are approaching an age when they may no longer be able to look after them;
- people currently living in supported housing whose needs change e.g. through aging and who can no longer manage in their current home or who want to move to a more independent setting
- young people making the transition to adulthood

Our data shows that a third (approximately 300) of our clients are aged 50 and over and we can expect that for those who still live with their parents that an increasing number will need alternative housing as their parents struggle to cope or die.

3.4. Options for Future provision

Stakeholders are unanimous in seeing independent flats where each person has their own front door as the way forward and for some, small extra care type schemes are considered a good solution. This view is not however shared by service users, many of whom are much more positive about shared housing

Fully independent housing is also potentially more expensive. Firstly, single occupancy accommodation for people with considerable care needs may lead to increased care costs where care has to be provided individually instead of shared. Secondly, a reduction in the amount of shared housing is likely to be managed through the running down of existing provision as voids occur. This could result many shared properties running with voids for a long period of time, whilst staffing levels have to be maintained to provide adequate care. The cost of this will be very high. The alternative would be to encourage clients to move out of their home into alternative accommodation once voids occurred in their scheme.

If the cost of developing more independent accommodation proves prohibitive in the current financial context then we will need to consider how we can remodel our shared housing to better meet needs in the longer term.

The Department of Health has produced a very informative review[30] of the costs of a whole range of housing alternatives for people with learning disabilities. It covers the impact of recent changes to the housing benefit regime, capital and revenue costs. As both the capital and revenue housing finance has been subject to change in recent years, a close reading of the DoH report is essential reading in understanding the relative costs of different options for different providers as housing benefit eligibility will be crucial to scheme viability. Schemes for which only the local housing allowance (LHA) rates are payable appear unworkable for specialised housing and even enhanced LHA (for non-resident overnight carer support) produces a shortfall in most illustrations. Rental subsidy for 'exempt accommodation' which includes some supported housing will be excluded from universal credit and for the time being will continue under the existing housing benefit rules. So exempt accommodation allows for higher rents to be charged but future is uncertain.

Stakeholders have also identified the use of existing extra care schemes as having potential for clients with a learning disability. In general these schemes are currently aimed at older people. People with learning disabilities may benefit from extra care type provision at an earlier age than the general population, although it is not likely to be suitable for very much younger clients. Extra care may also provide a solution to providing a home for an aging parent with their learning disabled adult child.

A further consideration for us is whether or not to retain our services in house. There are a number of risks for us as a provider:

- the introduction of personal budgets for all social care clients may lead to reduced demand for some aspects of our services, impacting on viability
- remodelling or re-providing will be resource intensive and we may prefer to commission an external provider to deliver this
- there will inevitably be downward cost pressures and is the council best placed as a provider to manage these?

[30] Illustrative Cost Models in Learning Disabilities Social Care Provision, DoH 2011

4. Mental health services

The Cheshire and Wirral NHS Trust has recently reviewed the community mental health service and is reconfiguring its service to increase the emphasis on recovery using a stepped approach to recovery (StAR). There has been a comprehensive consultation with service users by the NHS Trust on the proposals. Housing is seen as a key factor in promoting recovery and for those living in housing with care and support. This is therefore an excellent opportunity to consider how supported housing services can support this model.

4.1. Supply of services

Adults social are services are currently funding 54 placements in a range of settings, 9 of which are out of borough. Of these 27 are with East Cheshire Housing and 10 are with the Richmond Fellowship and 8 are with Alternative Futures. Within Cheshire East we only use these three providers; this does not promote choice or competition and supported housing services have not been tendered. We have recently tendered our floating support services. Placements are concentrated in only three local area partnerships which means that some clients will be unable to be supported near to family if they live in the other LAPs

Table 15: distribution of mental health placements in Cheshire East

Local area partnership	Number of placements
Congleton Local Area Partnership	22
Crewe Local Area Partnership	3
Macclesfield Local Area Partnership	21

Clients access services through a placement panel which includes providers and following some changes in recent years, is considered to operate effectively. Officers have expressed some concerns about the lack of choice and a lack of emphasis on recovery in some services. Richmond Fellowship report that they have a waiting list of 5 people who are currently on a ward and ready for discharge which indicates a shortage of places at the moment. RFHT indicate that their clients generally stay about 2 years after which the majority of clients are ready for independent living and there is no shortage of suitable independent accommodation.

We will need to investigate further the extent to which our services promote recovery and moving into a more independent setting. If, as stakeholders believe, this is not happening consistently enough, generating greater through put will create better access to places by generating more frequent vacancies as well as having a positive impact on recovery.

The services in Cheshire East have been inherited from the previous authority and appear to have grown up over time without a clear strategic overview. With the changes underway at the mental health trust, we have an excellent opportunity to reconfigure our services for the future.

4.2. A pathways approach

A pathways approach to supported housing for people with mental health problems has been developed by Camden Council.[31] This approach identifies:

- a set of principles for the development of services,
- a number of different housing settings from care homes to independent housing with a number of entry points depending on need, and
- clear outcomes for service users.

Oxfordshire County Council and PCT have followed a similar approach[32] and have developed a pathway that sets out the role of services from universal and mainstream through to residential care. The benefit of such an approach is that it sets out a comprehensive range of services covering all clients. Developing a pathway like this for Cheshire East will involve looking beyond supported housing services and working with Cheshire and Wirral health trust and clinical commissioning groups (CCGs) to map the full range of services and build the pathway.

Oxfordshire County housing and support pathway

The services

Services provided within this framework have the following elements:

• The majority of provision is designed to be of 'short term' nature (i.e. an average stay of no more than two years).

• Floating support services are also specialist These services would be offered on short and long term basis depending on the level of presented need.

• The level of support provided would range from intensive to medium to low in both these services.

• Service availability would range from housing, support, and care services being available 24 hours a day, 365 days a year, to brief visiting support provided in people' own homes, depending on the type of service and level of need.

Six service types

The Oxfordshire pathway would contain the following six types of service:

• **Universal and mainstream services** – general needs housing, support and assistance from universal services (such as Citizens Advice Bureaux,

Jobcentre Plus, Shelter housing advice).

• **Floating support** – visiting at home service designed for people living in independent housing setting. Level of support would range from intensive less than 24 hours a day to medium and low, with on call service element where appropriate. Short and long term provision

• **Intensive supported housing** – designed to be a local alternative to residential care. Intensive support available on-site 24 hours a day, 7 days a week, Short term provision

[31] A good practice guide to mental health pathway services, LB Camden 2007, www.camden.gov.uk

[32] http://www.oxfordshirepct.nhs.uk/your-health/mental-health/documents/Appendix4-OxfordshireFrameworkDecember.pdf

• **Transitional supported housing –** designed to provide a bridge between more intensive services and independent living. The level of on-site rehabilitative support is generally higher than can be provided through home visiting floating support. Short term provision

• **Long-term supported housing –** designed for people who will not be able to make the transition to independent living. On-site support would be at medium to low level, with on call service element where appropriate. Long term provision

• **Residential care –** intensive, high level (24 hours a day, 7 days per week) care and support in a registered care home.

4.3. Options for future for services in Cheshire East

In developing our services we will need firstly to work with Cheshire and Wirral NHS trust to see how housing can fit into their developing model, understand the feedback from service users and whether that has any messages for the role of supported housing.

This is an excellent opportunity for us to use the pathways approach to map out the services that we need and the outcomes that we wish to achieve for our clients. We can then recommission supported housing to deliver the range of services and outcomes that will support recovery and independence. At this stage we will also be able to consider the spread of services across the borough and address the current uneven distribution

5. Services for people with a physical disability

We have a very small number of people with a physical disability. We are currently funding 7 placements in care homes and supported living and PSSeX1 data indicates that our costs are comparatively low. No issues regarding the supply of services have been identified during the research for this strategy from feedback from both officers and service users.

5 people with disabilities attended 2 focus groups, 3 of whom lived at home either on their own or with family. None of the participants had any issues with their housing or plans to move but awareness of supported living options was very limited. Focus group participants did indicate that extra care housing sounded like a good idea and may be appropriate in the future.

Whilst the lack of feedback does suggest that there are no burning issues, the overall lack of feedback may indicate that we are not sufficiently engaged with this sector. It would be prudent to review our links with carers and users groups and consider whether we should be doing more to around engagement.

6. Our Strategy

The aim of this strategy is to support the delivery of supported housing in Cheshire East that:

- promotes living in the most independent setting possible;
- promotes independent living for as long as possible;
- provides choice in location, accommodation type, tenure, affordability and support arrangements; and
- maximises value for money

The issues that we are addressing are, in the main, very different for each of the client groups covered by the strategy and we have therefore set these out in different sections below. There are however two issues that arise across the sector as a whole and these are covered first.

6.1. Cross client group issues

Personal budgets

The draft care and support bill, Caring for our future, will bring in personal budgeting arrangement for all social care clients (excepting those in residential care) and this will have an impact on our contracting arrangements and in particular, block contracts . We will need to revise our contracting arrangements to accommodate personal budgets. To do this we will:

- review contracting practices elsewhere that include an element of personal budgeting
- consult with providers on to make this work locally
- develop a contracting approach that meets the legislative requirements, taking account of good practice and the views of our stakeholders

The ultimate shape of any changes will be determined by the final legislation for which the timetable has not yet been published. We can therefore not be certain of our delivery timescales for this work or the detail of the legislative drivers.

Nursing care costs

Our costs of nursing care are higher than comparator authorities for older people, people with a learning disability and people with mental health problems. With all these client groups our number of client weeks is higher .i.e. we have more people /longer stays and for our learning disability clients the weekly costs are also higher. It is important that we get the level of care and its duration right both for quality of care and for cost reasons. It is best practice to support people to live in the most independent setting possible; this helps promote independence rather than dependence and clearly it is not cost effective to pay for care that is not needed. The reasons for a comparatively high use of registered care are not entirely clear; it could be the initial assessment processes, review process or a combination of both and may result from our organisational culture. We will have to explore the reasons behind our nursing care usage in order to bring it line with comparator authorities. The data on the proportion of people with a limiting long term illness does not in any way indicate that our population is of poorer health than the average. Indeed for many wards our population has very good health and therefore we would not expect to see higher than average demand for nursing care.

In order to reduce our nursing care usage and bring it more inline with our comparator authorities we will:

- review our assessment processes
- carry out case reviews of clients in receipt of nursing care to establish whether placements are still appropriate
- revise our processes in light of these reviews to ensure that people are only placed in nursing care when is fully appropriate and the duration is

6.2. Supported housing for older people

We want housing that enables older people to live in the most independent setting possible for as long as possible, with the right support services. This means that we need a range or housing types and tenures with varying affordability, in accessible locations and with different options for the delivery of care and support.

Our processes must enable older people to make timely choices about moving home or staying put. This means the availability of good information and a willingness to discuss moving home as well as staying put. We must ensure that care and support can be delivered in flexible ways and that support is available to those on low incomes who do not qualify for social funded help. There are four elements to this strategy.

The first element is an emphasis on processes that prioritise independent living to reduce unnecessary admissions to residential and nursing care or to hospital and maximise an individual's ability to manage independently. In Cheshire East we already have well established reablement and intermediate care services but there is further work to be done to reduce admissions to registered and nursing care directly from hospital and to reduce the average length of stay in nursing care in line with national averages.

At the moment, when considering how to help an individual maintain independence at home, the emphasis is on helping people to stay exactly where they are. Whilst this is clearly a well documented priority, there is also considerable evidence that older people are willing to consider downsizing providing the right accommodation is available. Bringing this into discussions about maintaining independence at an early stage may enable some older people to move into more suitable accommodation at an earlier age, preventing or reducing the need for expensive adaptations and avoiding the need for a sudden need to move following a crisis.

Secondly, we need to address the oversupply of registered care and undersupply of extra care housing and promote a range of housing options for older people including a mixture of tenure options and locations across the borough.

Thirdly, there needs to be a more co-ordinated approach to the provision of information so that it is easy to access and available consistently from a wide range of agencies as identified in both the Aging Well Plan and housing strategy.

Fourthly, there will be an increasing need for people below the FACS eligibility thresholds to receive help at home. We need to explore ways of promoting mutual support so that help is at hand for those who are unable to afford to pay for services or anxious about getting a trustworthy person.

6.3. Promoting independence

The data on admissions to residential care from hospital and the number of resident weeks in nursing care indicate that despite existing approaches that promote independent living there are weaknesses within the system. There is a lack of clarity regarding the reasons for these two issues and as a priority we should carry out a more detailed investigation into hospital discharge to residential care and the assessment processes for nursing care. Strategies will be dependent on the findings and it will be important to establish to what extent the issue is primarily one of a lack of appropriate placements such as intermediate care or housing with support for both short and long term placements or a result of patient, carer and social care worker expectations.

T here is some support amongst stakeholders for the use of some extra care housing as a supply of short- term housing and care provision to promote independence before returning home or pending a move. However there are some concerns about the affordability of this, especially under the current contracts for the PFI scheme. It is likely that the demand for intermediate care will increase as the population ages. We do have a high number of intermediate beds but we may also want to explore the use of extra care and sheltered housing for short term stays either, through adjustments to the contracts for the PFI schemes or with RSL providers.

It is also important that we include discussions about alternative independent housing with older people who come into contact with the council or voluntary services as a matter of routine. To do this we need to ensure that staff in housing and social care services are well briefed on the range of options available and change our culture so that discussing whether or not to move is seen as part of any discussion of long term needs. Our aim will be reduce hurried decisions at a time of crisis rather than promote any particular solution.

It will of course be essential that there are housing options to move to which brings us to the second priority, addressing supply.

To promote independence we will:

- Review how our residents move from hospital to residential (including nursing) care to identify why we have a high proportion of such moves and introduce strategies to bring the proportion in line with other authorities in the North West
- Review the process of assessment for nursing care to identify why we have such a high number of resident weeks in comparison with other authorities and put in place strategies to bring the number down to a level that is at least comparable with our statistical neighbours,
- In the light of the findings regarding our processes, we will assess whether we have enough housing with care and intermediate care to meet our needs and support discharge to alternatives to residential care
- We will work with our staff and other agencies to develop a culture that sees discussions about moving home to something more manageable as a natural part of any assessment of needs for older people

6.4. Improving the supply of accommodation for older people

At the moment, our supply of older people's accommodation is characterised by an oversupply of registered care and under supply of alternatives.

6.4.1 Registered care

The oversupply of registered care and the resulting inward migration of clients from outside of Cheshire East poses a considerable challenge as long term self paying residents who run out of funds migrate to social care funding. As the provision is privately run the council has little direct control on existing services and can only look planning controls to manage new developments.

6.4.2 The planning context

The planning landscape has changed considerably since May 2010 with substantial changes to the approach to both policy and decision-making. The National Planning Policy Framework was published in March 2012. The Framework replaces all existing national planning guidance and statements, including Planning Policy Statement 3: Housing. It makes a presumption in favour of 'sustainable development' and impacts policy and decision-making. The SHLAA and SMHA, core documents in the development of planning policy under PPS 3: Housing, continue to be key documents for understanding local housing need under the new National Planning Policy Framework. However, as noted in the SMHA, it may need to be updated if there is to be a move away from the current approach to the provision of housing for vulnerable people. The SMHA is based on:

- Review of extra care provision (Peter Fletcher Associates)
- Whole systems modelling project commissioned by Cheshire County council in 2005 based on 2005 population projections to 2010
- Older people's housing strategy 2006
- Cheshire supporting people strategy 2005-2010.

The Localities Act 2011 abolishes regional strategies as well as introducing more flexibility for decision making about social housing at a local level. Local authorities are still obliged to ensure that social homes go to the most vulnerable in society and those who need it most. The Secretary of State for Communities and Local Government has indicated that all regional strategies will be revoked over the coming months. The North West Regional Spatial Strategy has not yet been revoked. Some authorities continue to use regional spatial strategies as a material consideration when making planning decisions.

At a local level, the East Cheshire Local Plan is being prepared which will set the future direction for local planning decisions. This will continue to be a core planning document at a local level under the provisions of the new National Planning Policy Framework. In Cheshire East, Issues and Options, Sustainability Appraisal and Place Shaping consultations have been undertaken. There is an opportunity to influence the policies in the Local Plan while it is being developed. The following recommendations are taken from 'Housing our aging population – plan for implementation (HAPPI 2).

The local authority could:

- ensure their Local Plans give prominence explicitly to meeting the needs of their ageing population, encouraging private and social providers to bring forward HAPPI-style projects;
- recognise that housing for older people has environmental and sustainability advantages in its

density and lower traffic use, while being less likely to arouse public opposition;

- set the tariff for CIL (Community Infrastructure Levy) payments for retirement apartments for sale at levels that recognise the additional gains from such housing, e.g. with charges set on a per dwelling basis, rather than on a per square meter basis, to enable the larger internal floor areas of HAPPI standards to be met; and consider halving the CIL for specialist housing and waiving it where communal facilities are open to the wider public;

- act sensitively when negotiating Section 106 Agreements for affordable housing in recognition that retirement housing brings other benefits but costs more to develop than flats for young people

There is however concern that existing Council policies do not support the refusal of new applications for residential nursing home provision and enable new developments regardless of local need. A review of the existing saved policies for Cheshire East supports this view. At present, planners are reliant on the saved policies in existing local plans. There is limited scope within these plans to support the refusal of planning applications for residential nursing homes. Indeed, the Maccelsfield Saved Policies support the development of residential nursing homes. Policy DC5 sets out the criteria that must be used including proximity to local facilities, balance with residential use, car-parking provision and protection of amenity. Other relevant policies are contained in the Congleton Supplementary Planning Document: Affordable Housing and Mixed Communities (2006), which makes provision for extra care, supported and adapted housing.

The North West Regional Spatial Strategy, under policy L4, seeks to ensure an appropriate housing mix to '*ensure the construction of a mix of ensure that new housing development does not have an adverse cumulative impact on the existing housing stock and market'*. While it is the Government's intention to abolish this strategy under the provisions of the new Localities Act, there is scope to continue to use this policy for decision-making, in conjunction with other supporting policy developments.

The new National Planning Policy Framework should also be used. Until March 2013, the local authority has some discretion over the weight it gives the National Planning Policy Framework as a material consideration when determining planning applications. The framework states:
where the development plan is absent, silent or relevant policies are out-of-date, permission should be granted unless:

– *any adverse impacts of doing so would significantly and demonstrably outweigh the benefits, when assessed against the policies in this Framework taken as a whole*

The National Policy Framework also clearly states that:
Local planning authorities should seek opportunities to achieve each of the economic, social and environmental dimensions of sustainable development, and net gains across all three. Significant adverse impacts on any of these dimensions should be avoided and, wherever possible, alternative options, which reduce or eliminate such impacts should be pursued.

Until new planning policies are in place, it is considered the refusal of further residential nursing home development while new local plan policies are developed could be justified using a combination of:

- the SMHA and existing policies that support a move away from residential care to extra care housing

- supported by the National policy framework which supports sustainable development

In order to take this forward we will:

- follow the guidance from HAPPI 2 in developing our Local Plans so that they support us in turning down planning applications that will increase the supply of registered care and promote the development of alternatives

- use existing policies, as outline above, and our evidence of an oversupply of registered care to refuse applications for registered care until our Local Plan is finalised.

6.4.3 Increasing the supply of extra care housing

Table 7 shows the very uneven distribution of extra care provision across Cheshire East and our strategy must include addressing the inequality of supply, concentrating on those areas initially with the lowest supply.

The current economic climate is having an impact on the affordability of extra care housing (HAPPI 2) which is reflected in the views of Cheshire East stakeholders. As well as issues with amenities and space standards, providers are concerned about the viability of care services. Future developments may be restricted to larger developments with the full range of services or smaller schemes with less communal space and fewer services. The current affordable housing funding regime is causing some concern regarding the viability of developing affordable extra care housing with costs of higher space standards and communal space.

The long term development of extra care services will need to be an iterative process that takes account of changes to benefits, social care funding and social housing subsidy arrangements.

We will also want to consider how we can introduce a range of financing options such as those being piloted by the Joseph Rowntree Trust and Extra Care Housing Trust to give residents greater certainty over the charges.

Staffordshire County Council has adopted a definition of extra housing and the SHMA recommended that we follow suit. Developing a shared definition with partners and stakeholders will assist us in clarifying together how we want to develop extra care locally and contribute to a specification for future developments. However, the Staffordshire definition was developed prior to the impact of the current economic environment and needs to be tested against the current economic climate and local priorities.

The Staffordshire definition of Extra Care Housing

The basic principles of extra care:

- Living at home not in a home
- Having one's own front door
- Renting or owning a property

- Providing culturally sensitive services delivered within a familiar locality
- Delivering flexible care delivery based on individual need – that can increase and decrease according to the individual circumstances
- Affording the opportunity to maintain or improve independent living skills
- Providing accessible buildings with 'smart' technology that makes independent living possible for people with physical or cognitive disabilities including dementia (assistive technology1)
- Building a real community including mixed tenures and mixed abilities, which contributes to the wider community and benefits from other services (leisure, IT, art, culture etc)

Minimum standards

- Self contained flats with kitchen and bathroom facilities that support and enable independence and the delivery of care services
- Staff facilities- office and sleep over room
- Barrier free spaces that are accessible and aid residents mobility
- Communal facilities lounges, dining and day rooms
- Guest facilities and
- Staff on site to maintain the building and manage the delivery of care and support services

Aims:

- Promote and maintain independence and choice for older people regarding their housing, support and care
- Provide long term support and care in an independent housing setting
- Prevent unnecessary admission into hospitals or long term residential care
- Assist in the reduction of delayed discharge from hospitals
- Build and develop partnerships between Staffordshire County Council and the housing, health, voluntary and private sectors
- Assist in the meeting of performance assessment framework (PAF) targets to reduce the number of residential care admissions and increase the number of persons with packages at home

Support the development of Extra Care Housing both for people who wish to rent, and those

who are owner occupiers

There are a number of other challenges in delivering more extra care housing in addition to the economic issues. The current experience within Cheshire East and elsewhere demonstrates the difficulties in delivering balanced communities and pre determined splits in tenure. Uncertainties regarding the funding of personal care are making providers nervous about committing to new developments and feedback regarding some of the provision in Cheshire East highlights the potential for creating social isolation if the location is not extremely accessible.

Nevertheless, the experience of neighbouring Staffordshire indicates that with the right approach there is continuing interest in developing more schemes. Staffordshire have adopted a flexible approach so that providers can design their own schemes apart from core criteria laid down in the commissioning process. Providers are now keener to provide care in order for the scheme to stack up and larger schemes mitigate the uncertainties of personal budgets. The creation of hub and spoke models also enables providers to improve viability of care services by extending services beyond core scheme.

There are examples of extra care housing elsewhere which is successful in generating community use of communal rooms and services but this has not happened within Cheshire East. For successful community use it is important that the communal space can be separated from living accommodation.

A number of interviewees and the wider literature highlight the importance of pre-allocation of places for new schemes so that the initial allocation goes smoothly; high needs places need to be allocated last although an example was given of the use of temporary registered care accommodation to enable high needs clients to be pre-allocated places.

The prevailing climate supports the development of larger schemes or villages. The development of more extra care schemes in Cheshire East will be dependent on the availability of sites that can deliver a viable scheme whilst also providing good access to services and public transport.

With the current uncertainties surrounding the development of extra care housing setting long term targets for delivery may result in undeliverable aspirations. We can however clearly see that the distribution across Cheshire East is uneven. This means that, in Poynton, older residents seeking to stay in the area but move to older persons housing will only be able to consider registered care or ordinary sheltered housing and in Knutsford there is no affordable extra care offer, although there is a large private scheme. Our focus group indicated that it is important for some people to stay in their local area and therefore we need to ensure that choice is available locally across the borough. Macclesfield and Wilmslow both have lower levels of provision than Crewe, Nantwich and Congleton but Maccelsfield has a mix of providers whilst Wilmslow has an RP provider only.

We will therefore initially focus on addressing the current imbalance of provision which leads to a hierarchy of LAP areas for promoting further mixed tenure extra care.

First priority: Poynton and Knutsford

Second priority: Macclesfield and Wilmslow

Third priority: Crewe, Nantwich and Congleton

However affordability issues for low income households will mean that they are excluded from excluded from extra care housing as a preventative measure unless the support and care costs for low need or 'wellbeing ' households can be subsidised e.g. through Supporting People. Once they meet the threshold for social care funding these costs will be covered but there will be an inequality of access. Low income households needing to downsize may only be able to consider non-specialised or sheltered housing.

We also need to address the problems owner occupiers are having in selling their properties which are preventing downsizing and moving to extra care and other alternatives.

In order to take this forward we will:

- develop a Cheshire East definition of Extra Care Housing that takes account of the current economic climate and sets our core criteria for future Extra Care developments
- carry out an appraisal of potential sites to identify which meet our core criteria in terms of size, location and accessibility
- engage with potential providers to establish the appetite for new development locally and the degree of flexibility needed to create a viable option
- consider how we can reduce costs so that low income households have a choice to move to extra care housing if they are not eligible for social care
- consider how we can incorporate new financing arrangements to give residents greater financial security
- review deliverability and take up of schemes to assess the viability of further developments in the light of prevailing economic climate
- support the development of private extra care schemes within the planning process
- review the Redbridge 'Free Space' scheme and consider whether we can introduce something similar

6.4.4 Sheltered housing and un-supported accommodation

Sheltered housing has been suffering recent years from a change in expectations with many smaller schemes with bedsits and shared facilities being decommissioned or reconfigured. RP providers report an acceptable level of demand for the majority of their remaining schemes and it is important that this option remains. Bungalows remain a very popular option especially within general needs estates. Recent exercises with under-occupying tenants on housing benefit has highlighted the popularity of a move within the same estate to a bungalow, but also suggests that flats could also be on option if sufficiently desirable and with access to a garden.

Focus group feedback also indicates the importance of accommodation that is close to amenities and public transport. There are already a number of floating support services with Cheshire East and increasing telecare provision demonstrating that off site support and the increasing variety of electronic assistance can adequately support older people in non-specialised accommodation.

To meet the demand for downsizing to non-specialised housing we will

- promote the development of owner occupied, shared ownership and affordable accommodation built to life time home standards in urban centres where there are good amenities
- support the provision of accommodation for downsizing households within existing estates
- promote the use of lifetime home standards more widely
- monitor the demand for social sheltered housing to assess, on a regular basis whether the current supply is meeting demand

6.4.5 Improving information and guidance

The importance of having good information easily available has been highlighted in our Aging Well plan and housing strategy.

We will improve the availability of information to older people by:

- working with Age UK to create a local information pack on the options for moving home and staying put across Cheshire East
- helping local people who have successfully downsized to tell their stories and bring positive messages to the fore
- ensure that older people approaching our housing options service are provided comprehensive information on all their options, including extra care
- work with social care staff to ensure that they are able to sign post their clients to effective housing advice and information and see this as part of their role.

6.4.6 Promoting mutual support

Peer support schemes are one way to both promote help with practical jobs and provide a social network. Both are important in maintaining the health and well being for older people and will be increasingly important as more people are ineligible for assistance with social care but still in need of some help and assistance.

To promote mutual support we will:

- We will consider supporting the implementation of a peer support scheme, similar to the Suffolk and Southwark Circle schemes.

6.5. People with a learning disability

Our aim for people with a learning disability is to create a range of supported options that can meet the needs of our clients in the longer term in a cost effective way. This means catering for our current service users as they and their families' age and meeting the needs of the younger population as they reach adulthood. We need to consider:

- people living in supported housing who may prefer to move into a more independent setting ;
- adults currently living with their family who may chose to move out of the family home;
- adults currently living with their family whose carers are having difficulty managing and who therefore need to consider moving even if it is not what they really want;
- young people who will reach maturity over the next few years who may chose to live independently rather than stay at home

For some people the choice of whether to live independently will depend on what is available. Families will be more or less reluctant to promote independent living for the person they care for depending on their view of the suitability of the options.

The main issue raised has been a need for more independent accommodation although this is less of a priority amongst service users than commissioners and providers. With a substantial proportion of our clients aged 50 and over we also need to consider whether for some we will be able to meet their needs in supported housing that is traditionally considered to be for older people, such as sheltered housing and extra care. However, some of our extra care housing has been identified as remote from services and may not be suitable for people with a learning disability if it inhibits access to services.

Younger people with learning disabilities may have more complex needs than the current population because of medical advances that make survival following premature birth more likely. It is also likely that more and more adults with a learning disability will also have physical disability needs. We will need to ensure that we fully consider future needs, however the population projections do not indicate any significant increase in numbers.

However, given the potential for additional costs, for example in the provision of 24 hour cover, it is important to establish the costs of different models and how well they will meet the needs for both our existing future clients.

To consider in more detail the options for more independent housing we will:

- work with providers to model the care costs of providing more independent accommodation for our existing client profile in a range of different settings e.g. smaller units of shared accommodation, groups of independent flats with staff on site, fully independent flats.
- apply our modelling to the profile of young people approaching transition to establish if the future needs can be met through any preferred option for our existing clients
- model the financial impact of voids at our shared housing in the event of a proportion of clients choosing more independent alternatives
- use these modelling exercises to determine the extent to which more independent living is financially viable in the longer term and develop
- review the future of our in-house provision in the light of the outcome of the modelling exercises and the work on personal budgets

We also need to be more creative in thinking about the use of other types of supported accommodation such as sheltered housing and extra care for our older clients. We will

- explore with providers of sheltered and extra care housing their capacity to meet the needs of older people with a learning disability
- develop clear guidance on the availability and suitability of extra care housing
- ensure that commissioners are aware of the potential for using extra care housing and discuss this with clients where appropriate

6.6. People with mental health problems

Our aim for people with a mental health problem is to develop a housing pathway, with a choice of provider, which supports recovery and enables the majority of our clients to move into an independent setting after a period of time in supported housing. In order to achieve this we first need a clear picture of the extent to which our current provision supports recovery and moving on into independence and an assessment of how well we prioritise recovery in our working practices. We need to develop our pathway alongside the changes that are being implemented in the community mental health teams and with the local GP commissioning groups who will have responsibility for primary mental health care.

We firstly need to understand whether or not our current practices and the services we use are sufficiently focussed on recovery and support our clients in moving into independent living. We will therefore review our existing placements to identify how long each individual has been in their current setting and whether there is a clear plan in place to support their recovery and move into a more independent setting. This will also help inform our assessment of the number of places that we need. Although there is some indication of a shortfall in places, we may not need additional places if a greater focus on throughput generates more vacancies over time.

Secondly we will work with all our stakeholders to develop a Cheshire East housing pathway for people with mental health problems. We will work on this with our health partners at the mental health trust and GB commission consortia, service providers and service users**.**

Thirdly, once we have developed our pathway and understood how well our services currently perform we will recommission our services to deliver our pathway across Cheshire East with a focus on outcomes for clients.

The key actions in delivering refocused services are to:

- review our current services to establish how well they support recovery and movement into independent living;
- develop with our partners and service users a clear housing pathway with a focus on recovery;
- recommission our services in line with this pathway; and
- revise our contracting approach to focus on outcomes and moving on into independence

6.7. People with a physical disability

Our research for this project has not identified any particular issues with services for people with a physical disability and the level of provision is very low. This may mean that a low demand is adequately met and not further action is needed. However, the low level of response may also indicate that we are not sufficiently aware of the issues for people with a physical disability and we will therefore review our links and communication with this sector to ensure that we are indeed properly aware of the needs and issues of this group of people.