EVALUATION OF
REEVE COURT RETIREMENT
VILLAGE, ST HELEN’S

AN EXTRACT

JULY 2008
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I would like to thank everybody who took part in this evaluation, providing information, making arrangements, and especially those residents and staff who took part in lengthy interviews. I would particularly like to thank the Joseph Rowntree Foundation and the other providers who supplied information for use in the evaluation and costs for comparative purposes.
This evaluation was commissioned by the three key partners involved in the commissioning and operation of Reeve Court Retirement Village: St Helen’s Council, the Extra Care Charitable Trust and Arena Options Ltd.

A number of key questions defined the focus of the evaluation. Some of these have been identified as being of general interest to those involved in the development of housing with care provision. It is these areas which have been included in this extract, while commercially-sensitive, operational and organisation-specific topics have been excluded.

The extract covers the following areas:

**Section 3 – Well-being**

- What are the health and well-being outcomes for people who live in the village, and what contributes to these?

**Section 4 – Commissioning**

- What are the advantages and disadvantages of the way in which the care is commissioned?
- How will this fit in with an increasingly self-directed approach to commissioning?

**Section 5 – Community Mix**

- What level and range of needs can be met by living at the village?
- To what extent does the mix and balance of ages and abilities contribute to the well-being of the village community as a whole?
- Can this be maintained over time and what are the implications if the rate of deterioration outstrips the vacancy rate?

Specific costs have been edited out for commercial reasons, but otherwise the three inter-linked sections remain unchanged. Since each retirement village and Extra Care scheme is unique, the level of detail should enable readers to assess which findings are transferable to their situation.

Although the section on value for money has not been included because so much of the data is commercially sensitive, the Executive Summary touches briefly on some of the general conclusions on that topic.

Sue Garwood
INTRODUCTION

This independent evaluation of Reeve Court retirement village was jointly commissioned by St Helen’s Council, Arena Options Limited and the Extra Care Charitable Trust.

The partners provided a range of factual information and quantitative data. These have been used in combination with material from interviews with staff from the three partner organisations and the PCT, and formal and informal interviews with residents. Of these, some received care and some did not.

The evaluation set out to answer specific questions in relation to: health and well-being outcomes; the way in which care and housing-related support are commissioned and delivered; the range and level of needs met at the village; community mix; value for money; and the effectiveness of processes at the village.

THE VILLAGE

Reeve Court was opened in October 2004 and comprises 206 dwellings, 103 for rent and 103 for various ownership tenures. Arena Housing Group owns the land and its subsidiary, Arena Options, manages the landlord function for the group.

The Extra Care Charitable Trust (The Trust) manages the village and all on-site services apart from the housing element.

The village provides a wide range of facilities and services, including 24 hour care commissioned by St Helen’s Council for about a third of the residents.

The Trust’s mission statement is: “In a safe, secure housing environment, we will promote a positive image of ageing and encourage healthy, active lifestyles based on the imagination and ambitions of our residents, staff and volunteers.”

HEALTH AND WELL-BEING

What are the health and well-being outcomes for people who live in the village, and what are the contributory factors?

St Helen’s block contract for care is divided into bands: Band 1 for those needing the least care and support, and band 5 needing the most, including nursing care. Residents move between bands if their care needs change significantly. Since the scheme opened, 50 residents have remained in the same band while 21 have needed more care, and 27 less.

A chi square calculation suggests that the number of people needing reduced levels of care is unlikely to be attributable purely to chance, and that living at Reeve Court appears to improve residents’ independence more than might be expected from traditional home care in the wider community. A sense of improved well-being and satisfaction with having moved to Reeve Court was supported by interviews with “support” residents, some of whom had moved from residential care to the village.

1 Residents who receive care as part of the block contract
“I had nobody to talk to in my care home. I read about the village and decided to apply. I was very pleased to be offered a flat. It was a solution to my problems. I’m very pleased – my life has improved considerably. I now have two choices. To be on my own or talk to others. I feel safer and protected. I have four rooms instead of one and I feel included instead of excluded.” (Support Resident)

Care and support is delivered by a dedicated “Support Team”. It appears to be delivered in a holistic, responsive and person-centred way so that the individual feels in control.

“The care is better here although I need less of it [than in residential care]. They never let you down.” (Support Resident)

However, it was apparent that whilst the culture of care is a significant factor in contributing to perceived improvements in well-being, many other aspects of living at Reeve Court are also important. Also, not only people with care needs experience positive well-being living at Reeve Court.

“I have peace of mind, a lot of outside interests, nice staff and always something to do. Moving here is the finest thing that has happened to me.” (Core resident)

The following elements (explored in depth in Section 3 of the report) all appear to make a positive contribution:

- A sense of safety and security – both physical and psychological – deriving from, amongst other things, physical features of the village such as progressive privacy, and round the clock availability of care and support.

  “Come what may, we can manage here. Security from knowing help is at hand.” (Core resident)

- Opportunities for social interaction, friendship and social inclusion.

  “I used to be very isolated. Now I’ve got friends around. I think that’s what I like most about living at the village – talking to people – that’s worth getting up for.” (Support resident)

- The wide range of activities to keep body and mind active.

  “There’s always something going on. There is so much going on, I no longer have time to do any needlework.” (Support resident)

- A wide range of facilities enabling residents to meet with others formally and informally and to pursue interests.

  “We loved socialising. We would go to the bar lounge every night and he would play the piano” (Core resident)

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2 A resident not in receipt of care
• Opportunities for involvement including volunteering; around 65 residents undertake a range of volunteering activities, including day-to-day running of the village and arranging activities.

• A range of services in addition to care provided by staff from the Trust and Arena, who are generally perceived as friendly and approachable:
  o The well-being service is led by a trained nurse to promote good health and prevent ill-health. For example there is evidence of well-being checks detecting conditions early.
  o The “Enriched Opportunities Programme” gives extra support to particularly vulnerable tenants, including those with dementia and learning disabilities, to help fulfil their potential.
  o A pay-as-you go catering service provides meals and refreshments.
  o Repairs and small-jobs services remove the burden from residents, provided they are done speedily.

• Design features of the properties and communal facilities, which are mostly disability-friendly.

Whilst all these elements play a part in optimising well-being, it is the Trust’s holistic ethos and the synergy of all these factors combining in different ways for different people that maximise many residents’ sense of well-being.

It was also clear that in order to benefit from living at Reeve Court, people needed to be attracted to the lifestyle offered, and feel able – albeit with support – to take part in some of the opportunities on offer. It does not suit everybody.

“It does improve people’s health and well-being. The opportunity it presents for continued activity – physical, mental and social, and the way it enables you to get levels of care you wouldn’t get in your own home – on tap at the pull of a cord...well-being nurse, maintenance of properties...put it together in a pot and it has the desired effect.” (Core resident)

**CARE AND HOUSING-RELATED SUPPORT**

*What are the advantages and disadvantages of the way in which the care and housing-related support are commissioned and delivered?*

**Care Commissioning Model**

St Helen’s has a block contract with the Trust to provide care for 65 residents at a given cost, made up of price per band multiplied by the agreed number in each band. The council also has the facility to spot purchase care for an additional 5 people. Although, in reality, the number in each band changes, St Helen’s has not exercised its right to review payments accordingly, and the Trust has regularly provided care to more than 65 people without calling on the spot purchase facility. It is an approach based upon reasonable give-and-take and mutual trust.
Some advantages of the model include:

- It is not as crude as a single amount per person would be, but is also not as rigid as an arrangement based on delivery of a prescribed number of care hours to an individual
- It is outcome-focused and enables the service to be person-centred and flexible
- It minimises bureaucracy whilst enabling St Helen’s to keep track of significant changes, saving on administrative and care management costs
- It provides predictability and certainty to both the Trust and St Helen’s
- It complements, and to a degree facilitates the cohesive, holistic approach of the Trust and Arena, which – together with the elements outlined in Section 3 – achieves health and well-being outcomes and optimises independent living

Disadvantages include:

- Care from the Trust only being accessible to residents via St Helen’s block contract
- Complexity of band definitions which, whilst enabling flexibility, necessitate skilled judgement and reduce transparency

Value for money to St Helen’s and individuals?

A snapshot from an HH1 form showed the actual number of residents in each band, and the average number of care hours provided. It shows that for the whole group, had St Helen’s had to pay for the same level of domiciliary care in the wider community, they would have paid an extra £46K annually.

If the council had also paid the net cost for meals, day care and night time care (not routinely available) in line with the proportion in a sample of domiciliary care recipients, they would have paid £70K more.

At present, the gross costs to St Helen’s for band 4 is just under £65K less p.a. than they would pay for these people in residential care, and for band 5, just under £11K less p.a. than they would pay for these people in a nursing home. These comparisons do not take into account that St Helen’s would almost certainly receive higher contributions to charges from both home-owners and those on full benefits if they were in a care home. A net comparison if the whole group were on full benefits shows a saving to the council for the band 4/residential care group but extra expenditure for the band 5/nursing home group.

Overall, the arrangement appears to provide good value for money to St Helen’s for the block as a whole, especially when the additional services such as night care and other value-added elements of living at Reeve Court are taken into account.

However, some crude calculations of unit costs within bands suggest that the services and costs within each band are not properly aligned, so that income for services to the lower two bands subsidise the services in the upper bands.
This is particularly relevant to self-funders at the lower end of bands 1 and 2 who are unlikely to require planned care at night, and are likely to consider that the charge is expensive for the amount of care they receive. This is likely to become much more relevant with the introduction of individual budgets.

The issue is compounded because under St Helen’s charging policy there is no cap on the amount self-funders pay towards care in extra care, whereas the hourly charge for domiciliary care is less than the full unit cost.

**Individual Budgets**

This evaluation concludes that living at Reeve Court fulfils the objectives of self-directed support to a considerable degree. Depending on how they are implemented, individual budgets risk undermining these outcomes.

Whilst it is important that people are free to choose who provides their services, insufficient amounts allowed in individual budgets and extensive off-site micro-commissioning could risk the viability of round the clock care provision and other services which enable delivery of a cohesive, responsive and holistic service – thus putting in jeopardy the well-being outcomes that current arrangements enable.

It is therefore important that:

- the Trust ensures that costs and services are aligned as transparently as possible, and the services and benefits are clearly spelt out
- St Helen’s reaches an agreement with the Trust that offers as much certainty as possible and ensures that the way IBs are calculated and implemented makes choosing on-site services at Reeve Court possible

**Housing-Related Support**

As the main provider of housing-related support, the Trust is responsible for the contract with St Helen’s and the residents.

The future of Supporting People funding is unclear. Assuming its continuation for the time-being, St Helen’s is advised to jointly commission the care and housing-related support for “support” residents, and include the charge in the individual budget calculation. Integrated commissioning and service monitoring would complement integrated service delivery.

**RANGE AND LEVEL OF NEEDS AND COMMUNITY MIX**

- **What level and range of needs can be met by living at the village?**

- **To what extent does the mix and balance of ages and abilities contribute to the well-being of the village community as a whole, can this be maintained over time and what are the implications if the rate of deterioration outstrips the vacancy rate?**

**Range and Level of Needs Within the Support Group**

People at moderate, substantial or critical risk within FACS criteria may all form part of the “support” group. The group comprises people aged 55 and over with a wide
range of needs, including physical frailties and disabilities, learning disabilities and mental health issues.

At point of entry, the last group does not normally include people with dementia, although couples where one has dementia are not barred, and, once there, people with dementia are supported to remain there as long as possible. Given the size and layout of the village this exclusion does not seem unreasonable.

The village supports people who would otherwise be in residential care. Twenty-one people moved to it from care homes. As has been seen, they generally thrive.

“I lived in an independent home for vulnerable people with mental health problems. I needed more care than I was getting and didn’t want to move to a nursing home. I was completely institutionalised and had to learn how to live again independently - how to use money, run a home, and pay bills. Since moving here my life has improved dramatically. I used to feel very isolated. I now have friends and better mental health. It came as quite a shock to realise that I was accepted. I have never looked back.”

For people in band 5, the nursing service can be seen as a much more flexible and responsive alternative to the district nursing service. The PCT is to said to recognise that it is a cost-effective service.

There are at least two, and probably more, people in band 5 who would otherwise be in a nursing home, where they would be unlikely to derive the many benefits of living independently at Reeve Court. However, band 5 could not be a complete replacement for nursing home care. The reasons for this are explored in the full report.

“A home for life” has so far been a reality for many residents. At the time of the study, 19 residents had lived at the village till death, although it is not known how many actually died at home. Only three people in the “support” group had moved to more intensive care.

Community Mix and Expectations

In addition to the one-third of residents with care needs, anyone over the age of 60 (or 55 with disability) can apply to live at Reeve Court, and the vast majority of the core group are completely independent. People come to the village from a diverse range of socio-economic backgrounds.

There is a vocal minority within the “core” group who complain about the number and types of disabilities manifest in the “support” group, say they were not expecting such diversity, and are concerned about the impact of such a visible group on attracting “younger”, fit applicants who can take over the volunteering. These attitudes appear to create some community tension and appear to be a mix of intolerance, unfulfilled expectations and possibly some valid concerns.

Trust and Arena staff do their best to calm these issues. They do not de-rail community life, but prevent some of the positive benefits of a mixed community being fully realised.

“There are different groups but mostly a united community.” (Core resident)
All these issues are explored in greater depth in the full report, both in the context of “Community Mix and Expectations” and “Health and Well-being”.

These attitudes need to be taken into account should St Helen’s ever wish to see a shift in the ratio of “support” to “core” residents in order to house more people with care needs at Reeve Court.

**Changing Needs over Time**

Over the years that Reeve Court has been open, fewer people with care needs have moved in than have vacated properties. This has enabled care to be provided to existing residents without increasing the size of St Helen’s block contract. The implication of this may be that, over time, a decreasing number of people with care needs will be able to move to the village from the wider community.

Nevertheless, it is recommended that the size of the block should not be increased unless a time comes when it insufficient to meet the needs of people living in the village who come to require care.

Apart from a study over a 2-year period at Berryhill village\(^3\), and the Trust’s reported experience thus far, there seems to be little evidence in the UK to draw conclusions as to what might happen in the distant future. So far, it appears that the rate at which residents have declined and needed care has not outstripped the rate at which others fall out of the block. If this were to happen, it may become necessary to increase the size of the block contract, thereby altering the ratio of support to core residents.

**VALUE FOR MONEY**

*Does the village provide value for money to those investing in its services – both statutory funders and residents themselves?*

Whereas Section 4 considered value for money of care and housing-related support to St Helen’s and individual residents, Section 6 includes accommodation and related costs. It considers these from the perspective of individuals, and – in relation to residential care – from the perspective of the state generally, rather than care and support commissioners only.

Depending on tenure, property type and care status, there are 72 different permutations and therefore potential revenue cost totals to stakeholders. Value for money may be perceived quite differently by residents who are in receipt of the full suite of state benefits and those who are responsible for paying all charges themselves. Thus the picture is extremely complex and it has only been possible to give a “flavour”.

Some self-funders raised particular concerns which they perceived as unfair. They were also concerned about rising costs. The Residents’ Association has ongoing discussions with Arena and the Trust, and residents were pleased that a way was found to reduce gardening costs.

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Comparisons with other housing settings

There is nothing precisely parallel to Reeve Court in the surrounding area against which to compare costs, so comparisons were made with a range of other housing settings and similar developments elsewhere, to gain an impression of whether costs at Reeve Court deliver value for money. In summary:

- Rents at Reeve Court seem to offer good value for money. Some state contribution to the capital costs will have made these rents possible.
- The prices at which the properties were bought appear to be reasonable and were generally perceived to be so by those who commented.
- Taking into account the range of facilities at Reeve Court, the combined accommodation-related service charge and support charge for tenants seem about average and reasonable for what they cover.
- The same charges plus additional management and maintenance charges for leaseholders seemed reasonable, being slightly more expensive than a scheme with many fewer facilities, but less than a similar development and a private one elsewhere in the country.

“It looks a lot because it includes a lot. Generally people do think that they are getting value for money.” (Residents’ Association representative)

Comparisons with Care Homes

Two scenarios out of the many possible permutations werecosted for comparison.

All the fixed costs associated with someone in Band 5 renting a one-bedroom apartment were compared to the cost of nursing home care, based on St Helen’s indicative price and the PCT contributions. In this scenario, the fixed costs at Reeve Court are higher than the costs of a nursing home to both full cost self-funder, and to the state for someone on full benefits, with a difference in the overall costs being in the region of £110 per week. As previously described, living at Reeve Court arguably offers many benefits over nursing home care.

The same calculation was made based on an outright owner of a one-bedroom apartment in band 4 compared to residential care. Reeve Court costs less to a self-funder than residential care, but doesn’t take into account food costs which would be extra. If the minimum £98.60 contribution to residential care costs from someone on full benefits is seen as coming from the state, then Reeve Court also costs less than residential care to the state.

Conclusion

Provided partners continue working to keep costs to a minimum, it seems reasonable to conclude that the added value to most residents at Reeve Court delivers value for money to all stakeholders.
CONCLUSIONS

Reeve Court appears to maximise health and emotional well-being for many of the people who live there, providing a wide range of opportunities to achieve and enjoy life, and supporting vulnerable residents to do so. It is likely that this has the effect of prolonging independent living. At the same time it is not for everyone, and positive outcomes will not apply in every case. It is a lifestyle choice and potential applicants need to understand what that lifestyle involves.

Priorities for action include:

- Jointly developing a commissioning approach compatible with “Putting People First” which maintains or strengthens the current good record on personalisation, well-being, choice and control outcomes. Assuming bands continue to apply, work needs to include re-alignment of band costs and services

- Continuing work to promote inclusion and tolerance within the community

- A number of practical measures: seating areas along streets, and wire shopping baskets.

“Whilst not a universal panacea it does what it aims to do – for the most part – very well.” (St Helen’s interviewee)
SECTION 1
INTRODUCTION TO EVALUATION

1. PURPOSE

1.1. The Extra Care Charitable Trust, Arena Options and St Helen’s Council jointly commissioned an independent evaluation of Reeve Court Village. Rather than provide a comprehensive assessment of every aspect of the village, its purpose was to address specific questions of particular interest to the three commissioners to help to improve current provision and inform future service development.

2. METHODOLOGY

2.1. Relevant information from each organisation was combined with observation at the village and a series of formal interviews and informal conversations. These were held with residents and staff, the intention being to achieve optimum validity within the constraints of limited resources.

2.2. Several visits were made to the village including:
- A three-day fact-finding visit to gather core information
- A three-day visit to interview a sample of residents and interact informally with others
- A nine-day visit to interview staff, remaining residents and post-holders of the Residents’ Association, and interact informally with others

2.3. Information provided by commissioners of the evaluation included:
- General information on the village including details of properties, facilities and activities; age profiles; tenure details; resident information packs
- Agreements between the parties
- Application, assessment and allocation processes and documentation
- Resident turnover, and reason for vacancy
- Costs and charges within Reeve Court
- Care related information including commissioning model and support levels, details of band changes, HH1 form, unit costs of social care services outside Reeve Court
- Supporting People data including meeting minutes
- Survey results including those from:
  - “Millionaire” resident survey undertaken by ECCT Chief Executive in August 2007 – approximately one third of residents took part
  - Arena customer satisfaction survey undertaken in January 2006 – 21% response rate at Reeve Court
  - ECCT well-being survey
- Complaints

Information requested was not always available, and some turned out to be less informative than anticipated.

2.4. Staff Interviews

2.4.1. Formal interviews were arranged with seventeen staff members, some interviewed in pairs. They were identified for interviewing by each
organisation on the basis of their role in relation to Reeve Court. They represented a cross-section of perspectives and included:

- From ECCT – Scheme Manager; Operational Coach (senior manager); care team manager; Volunteer and Activities Organiser; Financial Controller
- From Arena Options – Village Services Co-ordinator (on-site housing manager) Village Service Manager; and Managing Director
- From St Helen’s ASSD – Care Manager, Review Team Manager, Contracts Manager, Business Support Manager, Customer Finance Manager, Strategy and Development Manager, and Contracts Manager
- From St Helen’s Supporting People – Reviewing Officer (The Supporting People Manager was off sick so could not be interviewed)
- From St Helen's PCT - Joint Service Commissioner for Older People.

2.4.2. A semi-structured approach to staff interviews was adopted, with interviewees having sight of the outline questions in advance, but with the interviewer probing within those questions with the aid of sub-topics and supplementary questions based on the role of the interviewee. This allowed for a significant degree of latitude in what information was volunteered by the interviewee before the questions became more detailed.

2.4.3. The purpose of these interviews was both to obtain supplementary information and to ascertain staff members’ views. See staff letter and outline interview schedule(s) in the Appendix.

2.5. Resident Interviews

2.5.1. Thirteen formal interviews were arranged with residents. They were invited to take part by letter. Three declined. Interviewees were:

- Five residents not in receipt of care\(^4\), at least one from each tenure, selected randomly.

- Six residents in receipt of care. The intention was to interview three who had shown significant improvement since moving to Reeve Court, and three who required a significant increase in care, as assessed by band changes. This did not work quite according to plan, and in the event, two had reduced care needs and four increased care needs. Someone who had moved from residential care and a couple were included in the sample.

2.5.2. The interviews with residents were also semi-structured. They allowed considerable scope for raising issues and sharing their own experiences but there were more questions of a specific nature.

2.5.3. The purpose of the interviews with residents was to:

\(^4\) In this report resident interviewees not in receipt of care are called “core” residents. Those in receipt of care are called “support” residents.
- Hear about their experiences and ascertain their views on the core questions
- Flesh out information provided by ECCT, St Helen’s and Arena
- Triangulate their views with data and views provided by staff

2.5.4. Letters to residents and interview frameworks may be found in the Appendix.

2.5.5. The chair and secretary of the Residents’ Association were interviewed as people likely to have an overview of residents’ views and concerns. Their interview framework was similar to that of staff, with broad questions allowing a significant degree of latitude in responses, and some specific issues.

2.6. Informal contacts and observation

2.6.1. Residents were to be informed of the evaluation by the scheme manager in a newsletter, and each was sent a letter (See Appendix) from the researcher explaining the purpose. They were informed that the researcher would be available in the lounge or at activities, should anyone wish to share any views informally. A number of residents took this opportunity to raise issues of concern.

2.6.2. Staying in the village guest room and being able to observe the dynamics between different groups, the level of activity at different times of the day etc, helped to get a more realistic sense of life at the village.

2.7. Timing

2.7.1. The research work took place over a period of 4 months with 40 days designated to undertake the work.

2.7.2. The first fact-finding visit took place at the beginning of November, with two further visits in December 2007 and January 2008, and a completion target-date of the end of February.

2.7.3. Some information and data covered the period since the village opened whilst much was based on survey or snapshot data from 2007.

3. EVALUATION REPORT

3.1. The report will be divided up by topic rather than information source.

3.2. The next section will provide a description of key features of the village as a starting point.

3.3. Subsequent sections and sub-sections will correspond broadly to one of the core questions. In most cases an explanation of the current arrangements or position will form the introduction. Thereafter, relevant information obtained from all the different sources will be drawn upon to address the questions and explore relevant issues, with sources of information being cited as appropriate.
SECTION 2
INTRODUCTION TO THE VILLAGE – A THUMBNAIL SKETCH

1. INTRODUCTION

1.1. Reeve Court is a 206 property retirement village opened in October 2004 in St Helen’s, North West England.

2. KEY PARTNERS

2.1. There are two organisations principally involved in managing the village. Arena Housing Group owns the land, and Arena Options – a subsidiary – manages the landlord function for the Group. The Extra Care Charitable Trust manages the village and all on-site services with the exception of the housing element.

2.2. St Helen’s Council has an interest in the village as commissioner both of care and of housing-related support services.

3. ETHOS AND OBJECTIVES

3.1. The Trust places a lot of emphasis on active ageing and the need to have a balanced community reflecting a range of ages, backgrounds and abilities.

3.2. Its “mission is to give older people the time of their lives.

“In a safe, secure housing environment, we will promote a positive image of ageing and encourage healthy, active lifestyles based on the imagination and ambitions of our residents, staff and volunteers.

“Our charitable promise to our residents is to achieve this irrespective of their wealth or health”

3.3. “The Arena Group wish to create valued relationships with customers, colleagues and stakeholders by

• Being fair and honest in all our relationships to foster loyalty, trust and respect
• Maximising value for money
• Delivering the highest quality possible”
and to
• “provide high quality homes and diverse services that contribute to strengthening communities”

3.4. St Helen’s care contract pre-dates the White Paper, “Our Health, Our Care, Our Say”, but the following outcomes have been included in their latest referral procedures. These should be objectives of any social and health care services:

• Improved health and emotional well-being
• Improved quality of life
• Making a positive contribution
• Increased choice and control
• Freedom from discrimination and harassment
• Economic well-being
3.5. St Helen’s Supporting People contract refers to the DCLG Outcomes Framework which should be what any housing or housing-related provider seeks to deliver:
- Economic well-being
- Enjoy and achieve
- Be healthy
- Stay safe
- Make a positive contribution

4. PROPERTIES AND TENURE

4.1. Reeve Court Retirement Village comprises 32 bungalows and 176 apartments – a total of 206 homes in all, of which 106 have one bedroom and the remainder have two.

4.2. Half of the properties are available for rent while the other half are for purchase, with a fixed number of properties available for 50%, 75% and outright ownership.

4.3. All properties are built to wheelchair standards and included fitted kitchens, walk-in showers and central heating.

5. LOCATION AND LAYOUT

5.1. Reeve Court Retirement Village is located in Rainhill about three miles from the centre of St Helen’s and set in attractive gardens. It is bounded to one side by a small wood beyond which is Rainhill Road (B5413), a main bus route. The entrance to the village is from a roundabout off Elton Head Road (B5204), with the village centre located a few hundred yards down the road.

5.2. The bungalows are arranged along the entrance and circular road around the village, with the main building at its heart.

5.3. Within the building, the reception and office area is at one end of an internal street, with most of the communal facilities arranged along it like shop fronts.

5.4. At the end of this street, the apartments are accessed via a fob-controlled set of doors accessible only to staff and residents, ensuring progressive privacy.

5.5. There are three storeys of apartments (including the ground floor), the upper floors accessed by two lifts or stairs. The apartments are arranged along three branches of wide corridors.

6. FACILITIES

6.1. Reeve Court boasts a wide range of communal facilities. These will be detailed in Section 3.

7. COMMUNITY MIX

7.1. The village is intended to house people aged 60 plus, or 55 plus if disabled, according to a ratio of approximately one third (up to 70) residents with care
needs, and the remaining two-thirds without.

7.2. It caters for a wide range of needs and abilities, from those who are totally independent at one end of the spectrum, to those who need care supervised by nurses at the other.

8. ON-SITE ACTIVITIES

8.1. A wide range of activities take place at the village, some arranged by the activities organiser and others by groups of residents. These will be described further in Section 3.

9. RUNNING THE VILLAGE

9.1. Arena Housing Group as owner and landlord (principal) has appointed the Extra Care Charitable Trust as their Agent to manage the facilities and services on site. This excludes repairs and property maintenance as well as housing management. The latter includes granting of leases and tenancies, and collecting rents and service charges. These activities are undertaken by Arena Options.

9.2. The ECCT employs around 74 staff while Arena Options has two dedicated staff members on site.

9.3. Over 130 volunteers both from the village and outside play a significant role in running the village, staffing the reception, shop and bar, for example.

10. ON-SITE SERVICES

10.1. St Helen’s Council block contracts care services from the ECCT for 65 residents. Care and support is delivered to these residents by an on-site “support” team.

10.2. House-keeping services are provided by the “support” team to those assessed as needing them.

10.3. The Trust and Arena Options both deliver some Supporting People services, but the Trust provides the bulk of these.

10.4. The restaurant is open every lunch-time on a pay as you go basis and has a carvery on Friday evenings.

10.5. A coffee bar serving teas, coffees and snacks is open all day, and offers light meals in the evening and alcoholic beverages at night.

11. LISTENING AND COMMUNICATION OPPORTUNITIES

11.1. These include formal opportunities through monthly street meetings followed up by “Streetwise” (a newsletter), Residents’ Association meetings, specific topic panels, surveys, suggestions, compliments and complaints as well as continuous informal opportunities for exchange. These also include regular meetings with Arena’s Executive team and service panels.

11.2. Notice boards and white boards around the village are used for posting information, including “what’s on”.

Section 2 – Introduction to the Village  Page 20
SECTION 3
HEALTH AND WELL-BEING

What are the health and well-being outcomes for people who live in the village, and what are the contributory factors?

1. INTRODUCTION

1.1. “Health and well-being” includes social and psychological as well as physical well-being.

1.2. Simon Evans and Sarah Vallelley recently undertook a literature review of best practice in promoting social well-being in Extra Care housing (Evans and Vallelley August 2007a) and a research study which involving 6 Extra Care schemes in England (Evans and Vallelley August 2007b).

1.3. Key factors highlighted by their literature review (2007a) as promoting social well-being included: the availability of inclusive and diverse activities, both social and creative; the provision of a range of facilities as venues for social interaction – particularly a shop, restaurant and garden; imaginative and accessible design that promotes a sense of community; access to social networks beyond the housing scheme; opportunities for service users to be involved in decisions about care delivery and service development; and a person-centred approach to care provision.

1.4. Factors identified by their research study (2007b) as playing a part in promoting social well-being in Extra Care housing included: friendship and social interaction; the role of family carers (not a particular focus of this evaluation); engaging with the wider community; the role of facilities; design, location and layout; and staffing systems and the culture of care.

1.5. In looking at health and well-being at Reeve Court, the situation there will be considered in the context of their findings.

2. IMPROVEMENTS IN WELL-BEING AMONGST “SUPPORT” RESIDENTS

2.1. How care and support is delivered

- People receiving care are allocated to bands based upon a holistic assessment of their needs and the amount and level of “support” they are likely to need.
- Those in band 1 need the least amount of support whilst those in band 5 require the most, including nursing care. (For more details of bands see Sections 4 and 5).
- Provision of care and support within bands allows considerable flexibility and responsiveness, enabling the support to be holistic and person-centred. It combines planned input with day-to-day response to fluctuating needs and preferences.
- The band level is changed if the amount of help needed changes significantly (i.e. more than temporary fluctuations within the parameters of each band). Thus movement up and down bands may be seen as a likely indicator of decline or improvement in levels of independent functioning, provided that other

\[ \text{“Support” in quotation marks means the care and support provided by the on-site Support Team to residents who receive services under St Helen’s block contract – see glossary} \]
explanations can be ruled out, such as the same help coming from elsewhere or changes to band definitions/eligibility. Improved independence may in turn be seen as one aspect of well-being.

2.2. Changes in Band Levels

2.2.1. Data was provided tracking individuals on a monthly basis from the time the scheme opened or they moved in, until care ceased. The changes in bands and how many bands an individual moved up or down were then analysed. Table 1 shows the movement between bands.

Table 1
Movement between bands since scheme opened

<table>
<thead>
<tr>
<th>Number of band movements</th>
<th>Number of residents to whom these changes applied</th>
<th>Number of residents who died</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>+ nos: denote higher levels of care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- nos: denote reduced levels of care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(Includes those who subsequently died)</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>1</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>No change</td>
<td>50</td>
<td>12</td>
</tr>
<tr>
<td>-1</td>
<td>13</td>
<td>1</td>
</tr>
<tr>
<td>-2</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>-3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>-4</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>-5</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>98</td>
<td>19</td>
</tr>
</tbody>
</table>

Note: Not all residents were receiving care from day 1
These figures show that the level of support needed by 50 residents has remained fairly static, while 21 needed more care and 27 less.

Figure 1

Summary of Band Movements
What do these findings signify? How might these changes in level of care compare to other settings?

**Chi-square Calculations**

2.2.2. Data about changes in levels of dependency in residential care are available. However, given that over one-third of people in care homes move there from hospital in response to a crisis, that did not seem to be a valid point of comparison. A comparison with changes to levels of domiciliary care provided in the wider community seemed more appropriate. Unfortunately, research on such changes appears to be extremely limited. There has however, been a recently published study into the effectiveness of re-ablement homecare (CSED Nov 2007). This cites a study undertaken by De Montfort University in which changes in levels of care in the re-ablement group were compared to a control group who received standard domiciliary care.

2.2.3. The changes in levels of care at first review in the control group were used as a starting point for comparison with changes in bands at Reeve Court, using a chi square test. This test compares observed changes with a range of notional “expected” changes. The latter are scenarios which attempt to make a realistic estimate of what might apply with traditional homecare in the wider community, varying these in plausible ways to test the limits of probability. The test is used to assess the probability that differences between actual changes (observed) and notional changes (expected) have not been caused simply by chance.

**Table 2a.**
Chi-square table including those who have died where deterioration observed and expected are equal

<table>
<thead>
<tr>
<th></th>
<th>Decliners</th>
<th>Status Quo</th>
<th>Improvers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Up 3, 4 or 5 bands* %</td>
<td>Up 1or 2 bands %</td>
<td>Stayed the same %</td>
</tr>
<tr>
<td>Observed</td>
<td>6.12</td>
<td>15.31</td>
<td>51.02</td>
</tr>
<tr>
<td>Expected</td>
<td>6.12</td>
<td>15.31</td>
<td>69.57</td>
</tr>
<tr>
<td>Deviation</td>
<td>0</td>
<td>0</td>
<td>-18.55</td>
</tr>
<tr>
<td>Deviation Sq</td>
<td>0</td>
<td>0</td>
<td>344.09</td>
</tr>
<tr>
<td>Dev Sq/e</td>
<td>0</td>
<td>0</td>
<td>4.95</td>
</tr>
<tr>
<td>Chi-sq</td>
<td>43.85</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Moving up bands denotes more care input and moving down bands denotes less care input

2.2.4. In the above chi-square calculation, the expected percentage of care packages or band levels that “stayed the same” was set at the level of De Montfort’s control group. The effect of differences in movement up bands (i.e.
increased care provision) on the chi square score\textsuperscript{vi} was neutralised by making the expected level of increase the same as that observed at Reeve Court. This has the effect of contributing 0 to the chi-square score so that only differences in the other classes would affect it. This particular model seemed the most realistic and to indicate most about the meaning of movements down bands. It used data relating to all residents at Reeve Court who received care (Table 2a) and for all excluding those people who had died (Table 2b).

2.2.5. In this test, with four degrees of freedom, any chi square score above 13.277 tells us with 99\% confidence that the changes were not caused by chance. The chi-square scores in the above scenarios are well above that level.

2.2.6. Over a dozen alternative models were explored, based on changing the expected percentage in each class to test the limits of likelihood in the chi-square test. The following hypothetical scenarios were explored for both groups – i.e. including and excluding those who died:

\begin{itemize}
  \item a) The status quo percentage as in the control group (around 70\%), and the proportion of people expected to go up or down bands kept equal to one another – as in a normal curve – so 3\% up or down 3, 4 or 5 bands, and 12\% up or down 1 or two bands.
  \item b) As in a) but decreasing the percentage of the status quo group, and increasing the proportions by 2\% points each for improvers and decliners to maintain the 100\% total
\end{itemize}

2.2.7. In reality, it is probably more likely that a higher proportion of people will require extra care over time than will need less. Therefore, the following were explored:

\begin{itemize}
  \item c) Increasing the percentage of people expected to deteriorate (up bands) and decreasing the proportion expected to improve, while maintaining the “stayed the same” group at 70\%.
  \item d) Increasing further the level of expected deterioration whilst reducing the proportion of people who stayed the same.
\end{itemize}

2.2.8. In scenarios a) to d), the chi-square value remained above 13.277, provided that the status quo level did not drop below 67\% for the group including those who died, and 65\% excluding them. Chi-square scores were consistently higher in the group which excluded people who died.

2.2.9. The chi-square scores in a) to d) will have been affected by differences in both increased and decreased levels of care, making it less clear that movement down bands in Reeve Court are attributable to anything other than chance. For this reason, it was felt that the calculation which nullified the effect of movement up bands, as in Tables 2a and b would be the most informative.

\textsuperscript{vi} The more colloquial term “Chi-square score” will be used rather than “chi-square statistic”
• e) This model was varied by reducing the proportion who stayed the same, and correspondingly increasing the two improver classes. The chi-square score still remained above 13.277.

• f) The above approach was varied by combining those who stayed on the same level of care with those who needed more, producing three classes and two degrees of freedom. A chi-square score of 12.42 was higher than the 9.210 needed to indicate with 99% confidence that the reduced level of care was not produced by chance. Removing decliners from the calculation, and counting only improvers and those who stayed the same as the total sample was not undertaken as it seemed too unrealistic.

• g) The final variations were to reduce the classes to three – movement up bands, status quo and movement down bands – and use the proportions from the De Montfort control group. With two degrees of freedom, chi-scores above 9.210 mean that there is a 99% probability that the changes were not caused by chance. The chi-square score in this scenario was 20.58.

• h) When the effect of decliners is neutralised, but status quo kept the same, the chi-square score is even higher.

2.3. Conclusion

2.3.1. These figures demonstrate that the movements in band levels at Reeve Court are unlikely to have been caused by chance, but we cannot be absolutely certain what caused them. Movements down bands might illustrate genuine improvements in independent functioning, much as movements up bands are likely to be caused by a decline in independent functioning. It is possible, however, that other factors come into play; for example, a different member of staff who interpreted the bands differently and so moved people. The Trust reports that no such factors apply.

2.3.2. It seems reasonable, therefore, to infer that living at Reeve Court appears to promote residents' well-being – as defined by independent functioning – more than might be expected without any intervention or with traditional home care.

2.3.3. Assuming this conclusion is correct, what is it about living at Reeve Court which contributes to the effect? Although we only considered data relating to residents who received care, the contributory factors are likely to be complex and unlikely to be caused by the care alone. However, care almost certainly played a part.

What follows is an attempt to explore possible contributory factors to this effect, and also what is likely to enhance the health and well-being of all residents at the village, and what may detract. The discussion is based on a range of subjective information obtained from residents and staff as well as observation and a small amount of hard data. It should not be seen as conclusive.
3. CULTURE OF CARE

3.1. This section considers whether the care contributes to health and well-being. Particular issues in relation to service delivery are explored in the section devoted specifically to “Care and Support” (Section 4), and also in Section 5 which deals with the range and level of needs which can be met at Reeve Court.

3.2. Evans and Valleley (2007b) state that “it is evident that the culture of care that operates within an Extra Care housing scheme is a major factor in tenants’ overall quality of life and well-being.” A person-centred approach to identifying and addressing the needs of older people, including “the maximisation of their quality of life, well-being and independence” is seen to be important.

3.3. Aspects of delivery at Reeve Court may not be perfect, but the culture and approach – holistic, flexible and responsive, person-centred and involving the individual in shaping the care – meet that requirement, as does the Trust’s focus on individual interests and aspirations, and supporting individuals to achieve them.

3.4. One “support” interviewee, who had been in a residential home for 8 years following a stroke, had moved up bands but still described herself as being more independent and needing less help than at the care home. “The care is better here although I need less of it. They never let you down. At the residential home they automatically did everything for you. You didn’t have to try. Here you are motivated to do things for yourself. And there are more opportunities - like making a drink.” “My life has improved no end!”

3.5. Another service user who moved from level 5 to level “0”, when asked to what she attributed the change replied “The support I’ve had - being there for me if I need them. That fact is enough for me. It’s kind of given me the confidence.”

3.6. All the “support” resident interviewees said they were fully involved in deciding what help they should have. One used the expression, “I drive it”. The ExtraOrdinary book of life demonstrates the focus on aspirations and personal interests which residents seem to be supported in expressing and achieving. A member of St Helen’s Council commented “The care is far more person-centred here than in the wider community.”

3.7. Evans and Valleley (2007b) explore the negative impact of a task-orientated approach, contract and charging policy on opportunities for staff to interact with tenants in the schemes they studied. At Reeve Court, the holistic approach to assessments, the absence of strict distinctions between care, general support and housing-related support, the presence of staff other than care staff to contribute to residents’ holistic needs, a bands-based system allowing flexibility within and between bands, and a charging policy not based on an hourly rate of care input, all help to avoid these negative impacts.

3.8. Evans and Valleley (2007b) highlight the problems caused when fewer staff are on duty in the evenings and at weekends, which limits opportunities for residents with impaired mobility to leave their properties and take part in...
3. Social activities. At Reeve Court there are waking night staff available so people can go to bed quite late if they are taking part in activities. An additional staff member is due to be employed from 7 – 11 p.m. specifically to take residents to and from activities with less waiting around. The level of cover at weekends is the same as on weekdays.

3.9. It is not possible to state categorically that everyone who receives care and support at the village has an improved quality of life and sense of well-being as a consequence. People clearly do not always have the help they want, exactly when they want it. Opportunities for encouragement do get missed and some people may become isolated. It does appear however that the culture of care at the village is conducive to improved health and well-being for most residents.

3.10. Whilst “support” interviewees for the most part appreciated and praised the care and the majority of staff who provide it, the culture of the care seemed almost an irrelevance – it was taken as read and sat alongside other aspects of village life in contributing to their sense of well-being. There was a sense that they were busy getting on with their lives. As one support resident put it: “There’s more to think about. There’s always something going on. You have choices here.”

What other things have emerged as being important, or at least contributors, to residents’ health and sense of well-being?

Before dealing with individual contributors to – or detractors from – health and well-being, it makes sense to consider why people moved to the village in the first place, so that the following discussions can be seen within the context of people’s motivations and aspirations.

4. MOVING TO REEVE COURT

4.1. Bäumker of the PSSRU outlines two useful models for describing the reasons older people move: the “Push-Pull” model of Lee and Litwak and Longino’s three stage model (Bäumker, PSSRU, November 2007).

4.2. The former involves the negative aspects of a current situation (push factors) and the attractions of the new living environment (pull factors).

4.3. The three stages in the second model are:

- Stage 1: Healthy retirees planning ahead and attracted to certain aspects of the new environment.
- Stage 2: Frailer, less independent people who anticipate a time when they are less able to cope and make a planned move to reduce current difficulties and be closer to sources of help and support, possibly family.
- Stage 3: an involuntary move because current support is inadequate to meet needs.

4.4. Formal interviewees’ motivation for moving will be considered in the context of these models. These are the stories of the “support” interviewees:
• “I had nobody to talk to in my care home. I read about the village and decided to apply. I was very pleased to be offered a flat. It was a solution to my problems. I’m very pleased - my life has improved considerably. I now have two choices. To be on my own or talk to others. I feel safer and protected. I have four rooms instead of one and I feel included instead of excluded.”

• “My husband’s health was declining. We anticipated a time when we could no longer manage the house and garden. Our neighbours were all out at work. The move has given us more freedom, less housework, more security and lots of friends. It is the best thing we could have done.”

• “I lived in a sheltered flat and needed more care. I was a bit upset at the time but I like it now. My health has deteriorated but I’m happier. I feel more relaxed. I have a nasty neighbour but otherwise get on well with people.”

• “I lived in an independent home for vulnerable people with mental health problems. I needed more care than I was getting and didn’t want to move to a nursing home. I was completely institutionalised and had to learn how to live again independently – how to use money, run a home, and pay bills. Since moving here my life has improved dramatically. I used to feel very isolated. I now have friends and better mental health. It came as quite a shock to realise that I was accepted. I have never looked back.”

• “I was on my own in the house. I didn’t have good memories. I’d had a fall and couldn’t manage the stairs, and I wanted to be among people. I don’t regret coming here and my son is glad – he knows I’m safe.”

• “My wife had died and left me on my own. I couldn’t cope with living on my own. I’d had a stroke and couldn’t walk. My children were not happy with me staggering about. I was happy to make the move because I’ve got more people around me to talk to and more help. I have all the help I need. That’s the main thing.”

4.5. Amongst the core group interviewees the following reasons for moving, and their views having made the move, were:

• “My husband was poorly for 18 years. We had our names down to come to the village, but moved to another retirement scheme as he became more disabled. I was happy where I was but he was still keen to move to the village. I was converted when I saw it and we took the opportunity to move. It improved our lives. We were able to go the lounge every night. We loved socialising. We were pleased to have made the move. My husband died several months after moving and I couldn’t have coped. I didn’t feel alone here. People were very kind. Both residents and staff.”

• “I lost my husband 9 years ago. My daughter urged me to move. She saw the ad, came and looked and liked what she saw. I admit I was pushed by my daughter at first. I’d had a number of security incidents at home, and felt insecure and lonely. My life is much better since I moved. The key things for
me are the friendliness, helpfulness and the staff are wonderful. I can't see anything to moan about. I'm very pleased.”

- “We anticipated a time when we would need help. We saw the Extra Care advertising about support services, the welfare nurse on the premises and promises of support services when needed. We've met a lot of nice people but also lost people where we came from. We haven't got a car so have to use a taxi to get back there. The move was right for us in our circumstances. We don't regret it but feel Extra Care did not tell us a proper tale.”

- “We both have severe mobility problems and we wanted to be nearer our son. It's an easier lifestyle. Less travelling. Less work to do. We have a greater feeling of security. We're very happy about having made the move - it's the best thing we did. We would not have been able to cope in our bungalow and would have felt very isolated.”

- “I felt desperate having had a late divorce. I needed to find affordable accommodation and was attracted to the concept of the village. The very first night here I knew I was contented. I have peace of mind, a lot of outside interests, no uncertainty, nice staff and always something to do. Moving here is the finest thing that has happened to me.”

4.6. Amongst the “support” group there were probably more push than pull factors, though both applied. They also fall into the second and third stages in Litwak and Longino’s model, either having anticipated the need for help, support and more manageable properties, or having been compelled to move in order to have more care immediately. (This latter category were in the minority). It is clear that the move has been beneficial for all of them.

4.7. For the two interviewees who came from residential care settings, the pull factors were particularly strong, and they spoke the most highly of the transformation the village had made to their lives. This echoes the findings of Croucher et al (2007). “For those people there was no doubt that the quality of their lives had improved, because of more social and intellectual stimulation.”

4.8. The core group seems to have been motivated more by “pull” than “push” factors, and appears to fit predominantly into second stage of Litwak and Longino’s model with one falling into the first stage – a lifestyle choice.

4.9. In addition, at least five individuals or couples sought an informal interview in order to raise certain concerns. They were almost exclusively people who fitted into stage 1, having made a lifestyle choice. Some of their concerns related to unfulfilled expectations having been attracted to the concept of the village as promoted by the Trust.

4.10. It is safe to assume that all those in the core group – two-thirds of the resident population – fall within the first or second category.

4.11. It is the combination of people from all three categories living at Reeve Court that seems to have triggered dissatisfaction amongst those who fall primarily in to the first stage and “pull” category. This will be discussed at
4.12. With residents’ motivations for moving to Reeve Court as the backdrop, we will look at various aspects of the village which appear to contribute to – or in some instances detract from – residents’ health and well-being.

Two themes predominated in both formal and informal resident interviews as key contributors to well-being: safety and security was the first, and the second related to social interaction and friendships. In the Millionaire survey in which about a third of residents took part, security and companionship came first and second in importance. These will be dealt with first.

5. SAFETY AND SECURITY

5.1. Asked which aspects of the village were “crucial to your happiness and sense of well-being” and “what do you like most about living at the village?”, safety and security formed part of many people’s replies.

- “Being here. Being able to have help when you need it.” (“Support” resident)
- “Safety and security. I feel snug and protected.” (Core resident)
- “Come what may, we can manage here. Security from knowing help is at hand.” (Core resident)

5.2. Even informal interviewees who complained bitterly about the community mix and value for money issues then added that they felt safe and secure at the village.

5.3. Although people didn’t analyse it to this degree, safety and security at the village seemed to encompass two main facets: physical safety and psycho-social sources of security.

5.4. A sense of physical safety derives from the location of the village, the clustering of properties, the door entry system to the main building, progressive privacy and other security devices. People appeared to feel safe enough to leave their front doors unlocked or even wide open whilst out.

5.5. Psychological security comes from the reassurance of having staff on site 24/7 to provide an emergency response service, daily monitoring of residents via the smiley face system, 24/7 care available should it be needed in the long-term, and feeling part of a community where friends and neighbours look out for one another and most faces are recognisable – at least in the non-communal areas of the village.

5.6. Asked about the importance of the “availability of care and support around the clock” every interviewee was very positive about it. The following give a flavour:

- “It’s a massive benefit. I don’t have to worry. I can just use the buzzer.” (“Support” resident)
• “It’s very important. I have so many life-threatening conditions. I was once found unconscious.” (“Support” resident)

• “It’s very important. I have the pendant.” (“Support” resident)

• “It’s very important but at the same time I dread a time when I may need to rely on it.” (Core resident)

• “Very – that’s why we moved in.” (Core resident)

• “It’s important - it contributes to a sense of security.” (Core resident)

• In the context of paying the support charge: “I pulled the cord when my granddaughter took ill. The fact that you can pull the cord and get help is worth paying for - brilliant.” (Core resident)

• “I moved here because I was promised I could live here for the rest of my life.” (Informal interviewee.)

It seems reasonable to conclude that a feeling of safety and security is an important contributory factor to health and well-being at Reeve Court.

6. SOCIAL INTERACTION, FRIENDSHIP AND SOCIAL INCLUSION

6.1. Evans and Vallelley (2007b) found that friendships were important to social well-being and that “the existence of opportunities for social interaction seemed to be vital to the development of friendships”. This evaluation certainly echoed that finding; human companionship, kindness and a sense of inclusion and acceptance were prominent themes.

• “I had nobody to talk to in residential care. They all had dementia. Here I can be on my own or talk to others.” (“Support” resident)

• “I used to be very isolated. Now I’ve got friends around. I think that’s what I like most about living at the village. ...Talking to people – that’s worth getting up for.” (“Support” resident)

• “The main thing is people making you welcome.” (“Support” resident)

• Life improved through moving to the village by “having company” (“Support” resident)

• Interviewer: “Are there aspects of the village which are crucial to your happiness and sense of well-being?

• Core resident: “The whole thing. The friendships and not being alone - they are uplifting for me.”

6.2. Although it is not possible to give quotes from those not interviewed, it was apparent that a significant number of residents took part in and enjoyed a wide range of opportunities for social interaction. It does not seem
unreasonable to conclude that their sense of well-being was enhanced by these opportunities.

6.3. What about residents’ sense of inclusion and belonging to a community? Some of the following quotes illustrate the complex and mixed picture of the community and people’s sense of inclusion.

- “Before, in a wheelchair, I felt excluded but I don’t feel that here. I feel included in everything and that people understand. I do feel part of a community.”
  alongside
  “People who can walk look down on people who can’t.” (*Support* resident)

- “It was a whole year before I told people about my [mental health condition] and it made no difference to them.” …“I feel included and that people understand. People don’t look down on you. They treat you as equals here.”
  alongside
  “People do form cliques and there is intolerance here, though not amongst the staff. They say they wouldn’t have moved here if they’d known there were people with learning difficulties here. I think it’s a terrible way of looking at things.” …“I’d say it’s about 20 people. You can tell that they’re talking about you.” (*Support* Resident)

- “I do feel part of a wider group. I’m welcomed. I have my own network. No-one is ever mean or nasty. Everyone is friendly. I could go and sit with anyone if I wanted to. I am not aware of any cliquiness but there are some disagreeable people who find fault.”

- “I was watching the dancing. One man took a woman in a wheelchair out to dance. She beamed – it was obvious she felt included and really pleased.” (*Support* Resident)

- Asked whether there were things about the village he really didn’t like, one *support* resident replied “I like most things. I just wish my neighbour wouldn’t be nasty to me.”

- Interviewer: “Do you have friends at the village and feel part of a community?”
  Core resident: “Oh I do!”

- “I do feel part of the community but newcomers are not being absorbed.” (Core resident)

- “We’ve no bosom pals but we do feel part of a community.” (Core residents)

- “There are different groups but mostly a united community.” (Core resident)

- “Most people just get on with their lives.” (Rep of the Residents Association)

6.4. Section 5 discusses the mix and balance of the community, and explores tensions between a number of core residents and “support” residents in more
depth. It seems to be true that:

- Despite these groupings most interviewees felt accepted and included – albeit not by every single resident – and considered this to have a really positive impact on them.
- A relatively low proportion of core residents appear to resent disabled people, and an even smaller number who overtly discriminate against them, but the undercurrent of antipathy amongst those involved is real.
- As with most communities, personalities play a significant part – whilst most get along well enough with each other, a small number clash.

6.5. Thus whilst friendships and companionship contribute significantly to the sense of well-being of many residents, some tensions between groupings detract from these benefits for some people.

There are many features of the village which provide opportunities for social interaction and inclusion, including the range of facilities, activities and opportunities for contributing to running the village. Each of these will be considered separately along with other likely contributors to health and well-being.

7. ACTIVITIES

7.1. Current Picture

- The Trust employs an Activities and Volunteers Co-ordinator – this post is being split into two and reconfigured.
- Every week day there are between 4 and 9 regular, organised activities taking place at the village, from morning through to evening. The array is impressive and includes such diverse activities as bible study, line dancing, Tai Chi, yoga, bowls, discussion group, bingo, patchwork and quilting, choir practice, falls prevention and gardening – 28 different weekly activities on the January list (see list in Appendix).
- In addition, specific one-off activities are arranged with or for residents: for example, the Christmas Fayre, or Valentine’s Day celebration, day trips, etc.
- Some activities are run by paid tutors, and others by volunteers, both resident and non-resident.
- Residents are invited to suggest ideas for events and activities.
- An entertainment interest group arranges the Saturday evening entertainment.
- A small charge is made for some activities.
- Some activities are open to non-residents.
- Notice-boards and white boards advertise activities on a daily basis, and a monthly “Village Activity” newsletter is circulated to all residents

7.2. Contribution to health and well-being

7.2.1. Most interviewees took part in some of the activities. Having a range of activities is very important but so is having the choice to take part or not. This is fundamental to residents feeling they have control over
their own lives.

7.2.2. Croucher et al (2007) found that “lack of pressure to take part in social activities if you didn’t want to” was important to residents. Privacy was highly valued and people “felt strongly that it was very much the individual’s choice as to whether to take part and get involved in social activities.”

7.2.3. Activities play a key role in stimulating residents’ interests and providing the opportunity for social interaction and shared participation. They are clearly valued and very beneficial to those taking part. Some of the activities are described as “enriched”. At these additional support is provided to those who need it to take part.

“There’s always something going on. There is so much to do. I no longer have time to do any needlework.” (“Support” resident)

“The activities are very important. Everything I do here is different from what I did in hospital.” (“Support” resident)

7.2.4. Activities and interests contribute to health and well-being for those able to participate, but frailty and ill-health do impede some residents’ ability to join in as they would wish.

“I am not an active sort of person. I enjoy reading and TV. I used to do woodwork but I can’t now. I find it very frustrating.”

7.2.5. The Trust appears to do a fair amount to encourage and support those who find it difficult but a greater number would benefit if they had the staff or volunteers to do still more.

7.2.6. The Trust is to be commended for the range of activities available to residents and also the degree to which residents are encouraged to take charge themselves. Some residents complain that there are not enough cultural and intellectual activities, but to an outsider with experience of many housing with care schemes, the variety of activities at Reeve Court seems very good. One has the impression that if there were sufficient demand for more cerebral activities, ways would be found to arrange them.

7.2.7. One minor negative factor appears to be that the Activities Co-ordinator doesn’t always co-ordinate effectively with the Entertainments Group. As a consequence, there have been occasional clashes of events – something which could easily be avoided.

8. FACILITIES

8.1. The list of communal facilities at the village includes:
- Restaurant
- Bar/lounge
- Village hall
- Shop
- Craft workshop
• Woodwork studio
• Fitness centre/ gym
• Spa
• Well-being room
• IT/TV studio
• Library
• Hair salon
• Laundry
• Enriched activity room
• Greenhouse
• Garden

These are staffed by a combination of paid employees and volunteers from inside and outside the village as necessary.

8.2. What contribution do the facilities make to residents' well-being?

8.2.1. Evans and Valletely (2007b) explored the contribution that a range of communal facilities make to residents' well-being. “These were the focus of social interaction and therefore central to the social life of many residents.” This applies equally to Reeve Court where both formal activities and informal gatherings take place in these facilities.

8.2.2. Virtually every interviewee felt that having a wide range of facilities at the village was important, even if they personally made only limited use of them. Villages and Extra Care schemes can be successful and deliver benefits with fewer specialist facilities, but having a wide range means that there is more likely to be something for everyone.

“The facilities are very important. They contribute to our quality of life.” (“Support resident”)

8.2.3. The lounge and bar are popular for informal gatherings, although the Millionaire resident survey only scored them as satisfactory, so attempts are being made to rejuvenate the facility. A bar host is being employed to inject some “buzz”, while pastries and paninis are being added to the range of refreshments for sale during the day.

“We loved socialising. We would go to the bar lounge every night and he would play the piano.” (Core resident)

8.2.4. The hall is used most days for some activity or other, while smaller scale activities take place in the other rooms.

8.2.5. The restaurant provides another focal point. It is very attractively laid out, although one interviewee commented on the impracticality of linen tablecloths and the incongruity between those and the self-service counter. It appears to be used to a moderate degree – there are always some people having meals, but also usually unoccupied tables. It could certainly be used more. Although used by visitors, the location of the village makes it less than ideal for people to drop in for a meal. The catering service will be discussed in the “Services” sub-section below.
8.2.6. In addition to providing a focus for social contact, the variety of facilities caters to a wide range of interests – woodwork, gardening, keeping fit to name but a few. This helps residents to continue with life-time interests, as well as developing new ones. These can contribute to keeping an active mind and body, giving people a sense of purpose and self-esteem. One staff interviewee suggested allotments would be a valued addition.

8.2.7. The gym is open from 9 a.m. to 9 p.m., with an instructor or volunteer present most of the time. Of 159 members aged 35+, 47 members are residents, the eldest of whom is 85. The Millionaire survey identified aspects of dissatisfaction – the gym’s lack of cleanliness and the apathy of the instructor, which the management has been trying to remedy. One core resident interviewee was a regular user of the gym and clearly derived significant benefit from it. Others said they questioned whether it is worthwhile having it. The instructor said that people with arthritis who used the gym and spa found their joints improved, though numbers actually doing so are low.

8.2.8. Opportunities to keep physically fit and active are core to the Trust’s ethos. In addition, the gym benefits residents who use it and brings the wider community into the village. On balance therefore, the gym seems a valuable facility. A cost/benefit analysis, however, could reach a different conclusion.

8.2.9. The spa appears to be used even less than the gym. It is perhaps less worth the effort and expense involved in maintaining it and ensuring compliance with health and safety requirements.

8.2.10. Some facilities promote the independence of people who might otherwise have to rely on external help. This applies particularly to the laundry, hairdresser and shop.

8.2.11. One resident in a wheelchair who relies quite heavily on the shop made a plea for wire baskets to be available for shoppers.

8.2.12. The hairdresser was found to be very good and the salon is obviously very well used.

8.2.13. One resident interviewee identified the need for a more suitable venue for worship – a chapel – rather than using the village hall.

8.2.14. The same people appear to be using the various facilities, giving the impression that some residents rarely venture into the village centre. It is not possible to gauge whether this is simply a reflection of people exercising their right to choose which aspects of the village they use, and which they don’t, or whether some feel excluded. An interviewee couple in a bungalow who admit to making fairly limited use of the facilities – library, hairdresser and restaurant on occasions – gave no sense at all of feeling excluded. They simply exercised their right to choose.

“we have the best of both worlds. We have the security provided by the village but also some distance if we want it.” (Bungalow Residents)
8.2.15. Given the size of the village, many facilities seemed under-used, particularly the more specialised ones such as the woodwork studio.

8.2.16. Residents did not seem to feel that this was an issue. As one put it, “New things tend to be better utilised, and drop off after a while. It’s the way these things work.”

8.2.17. There seem to be two possible ways of trying to increase usage of the facilities, if this is felt necessary:

8.2.18. Encouraging greater use amongst residents and encouraging more people from the wider community to come to the village.

- The former may require a comprehensive survey into which facilities residents use, and their reasons for minimal usage where this is the case. Providing people do not feel excluded, overly pushy encouragement could be interpreted as interfering with freedom of choice, so must be done carefully.

- Bringing people into the village from the wider community appears to work well in the gym, increasing its usage and revenue for the village, and helping to give some vibrancy to the village street. Encouraging wider membership of “Friends of Reeve Court” and greater external use of facilities such as the restaurant and hobby rooms could serve to enhance these beneficial effects, embed the village even more firmly into the wider community, and perhaps dilute some of the community tensions. However, there appears to be some resistance to this on the part of residents, with some even objecting to grandchildren and pets. Tea-dances which were popular with non-residents no longer take place. Another activity had external people paying to participate. They were then excluded from going on an outing with the group by resident members. The village manager was in the process of exploring with groups the pros and cons of such an embargo.

Nevertheless, there is no doubt that the range of facilities in the village makes an important contribution to the health and well-being of residents.

9. OPPORTUNITIES FOR INVOLVEMENT AND HAVING A SAY

There are several ways in which residents can become involved in more formal aspects of village life and running of the village, and also making their views on issues known.

9.1. Volunteering and Interest Groups

9.1.1. A number of staff and residents have commented on the pivotal role played by volunteers in running the village. Volunteers answer the phone, staff the reception, work in the kitchen, bar and coffee bar, befriend lonely residents, run the shop and library, lead a range of activities, and act as well-being ambassadors.

9.1.2. There were around 130 volunteers at the time of the evaluation of which 50% were residents and the remaining 50% non-residents. The
co-ordinator is trying to get more, mainly to befriend some of the “support” residents.

9.1.3. Volunteers are recruited, supervised and supported by the Volunteers Co-ordinator. All have CRB checks, and if they are not known in the village have to provide two references.

“We have parties for the volunteers. The village could not function without them.” ECCT Staff member

“Villagers do get a lot out of it. It gives them something to do. It’s more of a social thing.” ECCT Staff member

9.1.4. Volunteering not only enables the village to function and thrive. It also brings in people from the wider community, preventing Reeve Court being cut off from the outside world. Those who participate clearly make a valuable contribution while gaining a sense of purpose and self-esteem. This is apparent on the faces of the volunteers bustling around the village. Out of 91 people who answered the question in the Millionaire survey, over 70% agreed that “volunteering is a way of improving your own and other people’s lives”, with only 11% disagreeing.

9.1.5. There is concern amongst some residents that Arena and the Trust are not allocating sufficient vacated properties to potential volunteers. This will be explored elsewhere in this report.

9.1.6. In addition to individual volunteers, there are a number of specific interest groups. Apart from the Entertainments Group already mentioned, there is one for the coffee bar, the shop, the library and the art class. Their purpose seems to be to co-ordinate and shape their particular activity or provision.

9.2. Residents’ Association

9.2.1. The Residents' Association (RA) was instigated by residents themselves in response to concerns about costs and lack of clarity. Arena Options warmly welcomed the development and contributes £250 to its running costs. The Association meets regularly with Arena and the Trust – separately “as there are different issues with each”.

“Our aim is to work with the people who run this place, not against.”
(Residents’ Association Representative)

9.2.2. The committee probably comprises mostly self-funders, and at present does not have any “support” residents as members, though it does include people with disabilities. The constitution aims to have a representative mix of committee members in terms of geography and gender. They have never had to have an election. The committee meets monthly and has general meetings. Minutes are put on the notice boards and in the library.

9.2.3. An off-shoot of the Residents’ Association is the service charge panel comprising four members of the RA. It meets quarterly with Arena
Options and the Trust to discuss service charge accounts and initiatives.

9.2.4. There are also other formal panels in which RA representatives meet with managers at various levels from Arena and the Trust.

9.2.5. The Association appears to be an effective vehicle for channelling and following up issues of concern to residents, especially financial ones. It would not be appropriate for all communication to be channelled through it.

9.3. Street Meetings

9.3.1. Street meetings are held monthly and attended by the Arena’s Village Services Manager and the Trust’s Village Manager. These are meetings with residents in particular streets to listen to concerns and convey information. Most resident interviewees said that they attended these some of the time, but disagreed as to whether they were listened to or not. One “support” resident stopped going because “they don’t tend to take much notice of you” whereas another said she felt residents were listened to.

9.3.2. It is said that many of the same issues come up time after time and are not dealt with quickly enough. “Streetwise” is produced as a brief summary of proceedings at these meetings.

9.4. Surveys and other opportunities

9.4.1. Both Arena and the Trust have separately undertaken surveys to ascertain residents’ views. For example, Arena conducted a customer satisfaction survey at Ryfields and Reeve Court in 2006 and the Trust undertook the Millionaire game survey into residents’ views in August 2007.

9.4.2. It is understood that all three partners have complaints and compliments procedures and invitations for suggestions, but these have not been investigated by the researcher, nor commented upon by any of the interviewees.

9.5. Conclusion

9.5.1. Most interviewees felt they had enough say in the life of the village and the decisions that affected them. Most also felt that having such opportunities was important. There is less certainty that residents are consistently listened to.

9.5.2. It appears that “support” residents may be heard less than those more actively involved in volunteering and forums. However, the village manager is aware of this issue and constantly seeks to redress the balance by encouraging more involvement amongst the “support” group.

9.5.3. Generally, the village seems to provide excellent opportunities for participation and involvement. These are seen as valuable by
residents, benefiting both those who contribute and those at the receiving end. It seems reasonable to conclude that these opportunities make a positive contribution to the well-being of the community as a whole.

10. SCALE, LAYOUT AND DESIGN

The Village as a Whole

10.1. Staff and Resident Association committee members were asked: “What features of the village are essential to making it a success?” Not one volunteered “scale”. Yet it could be argued that the number of properties is key to making the range of facilities, and full-time activities and volunteer co-ordinators affordable, and such a variety of activities sustainable. It enables some economies of scale and provides a large pool of people amongst whom to find common ground, companionship and friendship (community mix issues aside).

10.2. In “Comparative Evaluation of Housing with Care”, Croucher et al (2007) state: “The size of schemes does not appear to influence the range of care services that can be offered; however, it does influence the variety and range of facilities and amenities available to residents.”

10.3. At Reeve Court, the sheer diversity of facilities, activities and opportunities for volunteering certainly appear important to promoting choice and fulfilment. That is not to say that smaller scale housing with care models are not also successful. Each has advantages and disadvantages.

10.4. When asked about the scale of the village, resident interviewees’ views ranged from indifference for the majority, to one person who described it as “ideal because we have a bit of land on all four sides and we fit snugly into it” (core resident).

10.5. Evans and Vallelley (2007b) explore the contribution of progressive privacy to well-being. “This promotes feelings of safety among tenants, by for example, allowing tenants to leave their front doors open during the day.” This benefit certainly applies at Reeve Court where residents greatly value those aspects which contribute to their sense of safety and security.

10.6. Evans and Vallelley (2007b) also explore the indoor street design: “By providing a safe, dry and level environment it maximises accessibility and increases the opportunity for tenants to move around the scheme and meet each other for both formal and informal social activities”…“However, this style of design needs to be sensitively implemented in order to aid orientation, particularly for tenants with cognitive impairment”.

10.7. The scale at Reeve Court, combined with the overall layout and design of the village, is probably better suited to people who are not at risk of isolation or disorientation caused by physical frailty or cognitive impairment. It is easy to get lost, although the opportunity to personalise the front-door area of each apartment may help
recognition.

10.8. Distances also increase the risk of becoming isolated. They are problematic for people with impaired mobility and probably account for the proliferation of wheelchairs “even when people are perfectly capable of walking” (core resident).

10.9. This issue of distance is exacerbated because the entrance and reception area are “in the wrong place”. Residents entering the village are compelled to walk all the way along the main village street to reach the lifts or stairs to their apartments. A village entrance at the other end of the main street could have retained progressive privacy without this additional distance.

“I don't need to use the gym. It's a ten-mile hike to get to my flat.” (Core resident)

10.10. Although streets are wide enough to comfortably accommodate wheelchairs, there could be more seating areas so that people able to walk with rest-stops have that option. One staff interviewee suggested a design for future schemes in which streets are shorter. This may or may not be feasible.

10.11. It seems fair to say, therefore, that although the range of facilities and wheelchair accessibility across the village promote well-being, the scale and distances may detract from some residents’ independence and well-being. As the Trust recognises this makes the village less suited to people with dementia.

10.12. Apart from these issues, interviewees were mostly satisfied with the layout of the village.

10.13. In terms of interior design, the village generally seems a good example of disability-friendly design which promotes independence – wheelchair accessibility, level access, adequate signage etc. These design features arguably contribute to residents’ well-being.

10.14. Some additional comments and suggestions made by interviewees are worth noting. Some are relevant for future developments, while others could be considered for Reeve Court:

- There should be a launderette on each floor to reduce clutter.
- The laundry room doors are spring-loaded the wrong way for wheelchair access.
- There should be more recycling facilities.
- There should be a wheelchair-height cash point.
- The “quiet lounge is like a goldfish bowl” – and used as a thoroughfare.
- There should be pathways all around the building and outer edge of the gardens for wheelchair users.
- There should be lifts at both ends of the building.
- There should be some alternative to the lifts for occasions when both are out of commission.
• Renewable energy sources such as solar panels should be introduced.

**Individual Properties**

10.15. In terms of individual properties, interviewees echoed the high levels of satisfaction evident from the Millionaire survey, in which 92% of respondents rated their property satisfactory (18%), very good (41%) or excellent (32%), and Arena’s survey in which the only property-related issue to score less than 85% satisfaction was storage space.

“it’s marvellous – I love it.” (“Support” resident)

“I now have four rooms instead of just one.” (“Support” resident)

10.16. Wheelchair accessibility and level access showers almost certainly enable greater independence.

10.17. The only adverse comments, apart from the issue of storage space, related to the lip between lounge and balcony, and the partition walls of the bungalows not being adequately sound-proofed.

10.18. The design of the properties, allowing independent living, safety and security, clearly contribute to residents’ health and well-being.

**11. STAFF**

11.1. Staff attitudes can have a profound effect on retirement communities: promoting tolerance or allowing intolerance to go unchallenged; smoothing neighbour disputes or fuelling them; creating a culture of dependence or independence; encouraging suggestions or resenting them; encouraging activities or hiding away in the office.

11.2. At Reeve Court, staff generally have a positive impact on village life. In the Millionaire survey nearly three-quarters of respondents agreed that Trust staff are “friendly, approachable and easy to talk to”. There were similarly high levels of satisfaction with staff in the Arena survey.

11.3. Staff appear to be hard-working. They seem very committed to the values of their organisations and to delivering a good service to residents. Resident interviewees described them variously as “very good”, “splendid - they check on me if my card’s not out”, “friendly and helpful”, “all very, very helpful”, “alright, no complaints”.

11.4. Glitches are related to issues not always being followed through or promises kept, the time taken to get things done, and communication failures. These are discussed in Section 7 of this report. Otherwise, as purveyors of attitudes and services, staff may be said to make a positive contribution to residents’ well-being.

**12. SERVICES**

Care and housing-related support services are covered elsewhere in this
report. Other services which may contribute to improvements in health and well-being will be briefly considered.

12.1. **Well-being Service**

- This is a service about health promotion and prevention.
- A trained nurse is employed to undertake individual health and well-being checks. It is not a clinical treatment role.
- He also runs well-being sessions which include falls prevention, light exercise, healthy eating, Tai Chi, hand waxing and yoga.
- Well-being ambassadors – volunteers – promote the service, support the well-being nurse and undertake “express” assessments.
- Every year all residents have a full assessment covering a wide range of health and well-being measures and domains – for example, blood pressure, breathing, diet, mobility, senses, sleep, psychological and spiritual well-being, etc.
- Advice is given, an action plan agreed upon and referrals made on any problems as appropriate.
- The nurse provides regular drop-in sessions when people call about a range of health concerns (e.g. for blood pressure checks) but also to lend a listening ear.

12.1.1. In 2007, the Trust undertook a survey of the well-being service at Reeve Court and Ryfields. Of 80 questionnaires distributed, 49 were returned. Of these:

- 81% found the assessment and talking to the advisor to be useful.
- Half the responders found the result of their assessment to be a surprise, including picking up unknown conditions or presenting a healthier outcome than anticipated.
- Of the 36 residents who followed their action plan, 29 (80%) reported that the plan had improved their well-being. 62% said it had helped them a great deal or a lot.

12.1.2. Other data provided by the Trust has shown that between April 2005 and March 2007:

- Three cancers were detected in one month
- In the pilot study which was a forerunner to the development of the well-being service, 122 previously undiagnosed conditions had been identified

12.1.3. In the Millionaires survey, 81% of respondents (out of a total of 79) rated the well-being service satisfactory (24%), very good (28%) or excellent (29%)

This service undoubtedly complements others to promote health and well-being; assisting in early diagnosis, promoting good health through well-being groups, helping to prevent ill-health, and listening to and supporting residents.

12.2. **Enriched Opportunities Programme (EOP)**

12.2.1. This service forms part of a three year research study being undertaken by the University of Bradford. The research is looking at
the impact of the programme using 10 housing schemes, 5 of which have staff trained to deliver the enriched programme and five of which have only extra staffing. Reeve Court is one of the sites where all staff (not only care staff) have received training in person-centred care.

12.2.2. There are five elements:

- Specialist expertise: “Locksmiths” – in-house specialists trained to unlock the potential of each individual.
- Individualised assessment and casework with individuals to enable living in a state of optimal well-being. Close liaison with mental health teams.
- Activity and occupation that is varied, and integrates the person into the community.
- Staff training to ensure that all staff have the necessary skills to support the programme.
- Management and leadership both at an organisational level and at scheme level.

12.2.3. The service is targeted at people with specific vulnerabilities: confusion, with or without a diagnosis of dementia; people with communication difficulties; socially isolated residents; people who lack confidence within groups; challenging behaviours; low mood.

12.2.4. There are 26 people on the programme at Reeve Court, which is possibly more than ideal. The locksmith works with them individually and in group settings.

12.2.5. She aims to spend one-to-one quality time with people as well as dealing with particular issues. For example, if someone refuses care, she will get involved and try to gain the individual’s confidence and find a way round the problem, putting forward approaches for inclusion in the care plan. She encourages people to take part in activities by collecting them, staying with them, making sure they enjoy the session and assessing mood. Certain activities have been designated “enriched activities”.

12.2.6. Encouragingly, the locksmith gets a lot of help from non-“support” residents, who now appear to be becoming more understanding. Families and carers are encouraged to join in as well. A group recently went to Calvert for a weekend break which was very successful.

“It takes a lot of pressure off the managers and staff because they know that if they can't deal with problems, the locksmith can. It most definitely improves people's well-being.” (Trust staff member)

The EOP sounds like a very valuable additional support service. It is to the Trust's credit that it is investing in something intended to further enrich the lives of some of their most vulnerable residents. It is not possible to assess its effectiveness since the findings of the formal research have not yet been published. Also, St Helen’s staff undertaking service reviews do not have any information about what is being provided to an individual under the EOP.
12.3. Catering

12.3.1. Resident interviewees had mixed views about the catering at the village, ranging from "very good", "marvellous food", to "not high quality cuisine but it's adequate" and "could be improved - the food is not always hot enough or fresh enough".

12.3.2. The Millionaire survey highlighted similar areas of dissatisfaction with meals in the restaurant. The Trust has taken these criticisms on board. Some residents take their lunch in the restaurant every day so it is important that they enjoy their meal.

12.3.3. Providing a financially self-sufficient catering service on a pay-as-you-go basis in housing with care schemes is notoriously challenging. Apparently the catering service at Reeve Court is still working towards covering costs. The catering staff appear extremely hard-working and dedicated. In addition to the midday meal, they provide a carvery one evening a week, and snacks such as sandwiches and baked potatoes at tea-time. They also provide breakfast and other refreshments to order. Whilst there may still be room for improvement, the fact that the Trust manages to provide a good, responsive service at a reasonable price is to their credit. It certainly contributes to the social life of the village and probably to residents’ nutritional status, and therefore the health and well-being of those who use the service.

12.4. Housing management, repairs and “handyperson” service

12.4.1. As described elsewhere in this report, most interviewees did not distinguish between housing management undertaken by Arena and village management undertaken by the Trust, but there were certainly no criticisms of the housing management service as such.

12.4.2. Residents Association representatives have a much better understanding of the role differences than other residents. One representative described Arena as “a good landlord. They have excellent people working for them and are keen to provide a world class service”. Arena is seen as approachable and transparent in its dealings with residents.

12.4.3. Whilst interviewees seemed generally satisfied with the repairs service, there seems to be some dissatisfaction with the time taken to resolve some maintenance and repair issues. In Arena’s own survey, most satisfaction scores were in the 80s and 90s, but a lower proportion (69%) felt the time they waited for repairs to be done was acceptable. The Millionaire’s survey apparently identified this as an area needing improvement although it is not apparent from the slide how the mean score of 2.1 was calculated.

12.4.4. The issues appear to have been compounded by original faults with the building. One resident said: “The quality of the Reeve Court building leaves a lot to be desired, it looks good but the interior build quality is shabby with poor workmanship. For a development as new as this, an
awful lot has gone wrong. It is so infuriating and frustrating.” Despite this, residents appear grateful that repairs are carried out.

12.4.5. One resident observed that as residents didn’t ring Arena for repairs “you were never sure who to blame.” There does seem to be some lack of clarity as to the role of Arena staff when repairs are needed or require chasing up.

12.4.6. A service that came in for considerable praise from residents was Arena’s Site Supervisor’s role, described by residents as a “handyperson” service. He co-ordinates maintenance on site and carries out small jobs that do not need a contractor. One interviewee had been unaware of this service, possibly because she tended to call on her son if she needed small jobs done. It did, however, raise the question – how were residents notified of this new service?

12.4.7. Having ready access to an on-site Arena manager, not having to worry about getting repairs done – as long as they don’t prove too protracted – and having access to the “handyperson” service all appear to contribute to residents’ peace of mind and well-being.

13. WIDER COMMUNITY

13.1. Is the village part of the wider community, what interaction is there between villagers and the outside world, and does it matter?

13.2. Evans and Vallelley (2007b) found that “Those residents who were not able to access the [wider] community because of lack of mobility or ill-health suggested that this affected their general sense of well-being, largely because they felt restricted and missed doing activities they had enjoyed in the past.”

13.3. The location of Reeve Court, a few miles from St Helen’s town centre and surrounded by a “bit of land on all four sides”, gives the village a very pleasant ambience, but has disadvantages for those without cars. There are few shops and other facilities within easy walking or buggy-travelling distance.

13.4. Many residents do have cars and make regular use of them, so their lives are not focused exclusively on the village.

13.5. The Trust contributes £1,000 a year to a mini-bus which goes into St Helen’s three times a day. Some residents use it regularly. “I go out every morning and have coffee in Patricia’s coffee bar.” Others complain that it runs too infrequently and that the time constraints placed on them make it inconvenient. Those with impaired mobility, particularly wheelchair users, are unable to use it.

13.6. There are buses which pass the entry road to the village, but that distance is too far for many residents to walk, and the buses are said to be less frequent than those which go along Rainhill Road. The view was expressed that buses should come into the village to enable frailer residents to make use of them and – with the benefit of hindsight – if the road into the village had come off the Rainhill Road
rather than Elton Head Road there would have been more buses accessible to villagers. This may of course not have been feasible.

13.7. Many residents rely on taxis or families to take them out and some people rarely manage to go out, making the village facilities and people coming in from the wider community all the more important. Sometimes special buses or coaches which can accommodate wheelchairs enable these residents to go out. They would welcome more of these opportunities. “I do miss going out.” (Support resident)

13.8. The recently introduced Friday fresh “fruit ’n veg” van has been very welcome to residents, who buy the produce and use shopping trolleys to convey it to their properties.

13.9. Volunteers, gym users, friends, families, and other visitors to the village all help to prevent the village from becoming a ghetto. As explored when discussing facilities, greater use of the village facilities by people outside the village would enhance this effect, but may not be universally welcomed by villagers.

14. THE CONCEPT OF THE VILLAGE

14.1. All housing with care developments have their own character, deriving from their unique combination of key features, as well as the personalities who live and work there.

14.2. Providers stamp their own distinctive brands on their developments. The following extracts from the Millionaire survey questions give a flavour of ECCT’s active ageing and holistic ethos:

- Our mission is to give residents the time of their life – on a scale of 1 – 5 how well do you think we are doing?
- Inside every older person is a younger person at heart
- With support and encouragement, elderly people can remain healthy and active
- Age and frailty are no absolute barrier to continuing to achieve
- “Going 4 Gold” has encouraged me to take part in activities
- ExtraCare staff help residents achieve ambitious goals
- ExtraCare staff work as one big team of residents, staff and volunteers

14.3. As part of this evaluation, resident interviewees were asked a series of questions including whether, “if they had their time again”, they would “come here or prefer to live in a different environment”. The majority were unequivocal in their view that they would come to the village again. “Definitely come here again”, “I’d choose to come here again every time”, with a couple being less enthusiastic: “It’s as good a place as any”, and one preferring “the same set-up in the private sector”.

“The whole idea of villages is brilliant. The whole concept is great. The advantages outweigh the disadvantages. We do enjoy living here. We feel safe.” (Informal interviewee)
14.4. Staff interviewees were asked whether they thought the concept of a retirement village was a good idea and works well at Reeve Court. Most replied in the affirmative to both those questions, some with a considerable degree of enthusiasm, but went on to qualify this with “but I wouldn’t like it” or “it’s not for everyone.”

14.5. Reeve Court is age-restricted, and in some ways an artificial community which offers many opportunities and benefits, but is also a life-style not suited to everyone.

14.6. There were clearly a few residents – not amongst the interviewees – who were disillusioned, with one resident in particular extremely angry that her expectations had not been fulfilled. She spent as much time away from the village as possible and refused to take part in village life.

14.7. A breakdown of moves away from the village since it opened reveals the following:

- Out of 52 properties being vacated, the occupants of 19 moved elsewhere.
- Of these 4 moved on to more intensive care leaving 15 who moved away to alternative housing
- 4 of these returned to their former accommodation.

It is reasonable to assume that, for whatever reason, Reeve Court did not suit them. Anecdotal evidence suggests that some of this may be related to expense, and some to unfulfilled expectations or not liking what they found. One resident interviewee felt that the active ageing ethos of the Trust was “pushed down your throat a bit” and that some people moved on because they found the adjustment too great.

14.8. Section 5 outlines some people for whom the village is not ideal – people with dementia, those who lack confidence in large groups, and people whose physical condition makes it difficult for them to participate even with help and support, thus becoming isolated.

14.9. As one staff interviewee put it: “It is not utopia. It can’t be. What it does, it does extremely well, but it’s not for everybody.”

15. CONCLUSION – SYNERGY

15.1. It seems reasonable to conclude that the village promotes the health and well-being of people who enjoy living there and feel able to take part in the many opportunities for enjoyment, health improvement, fulfilment, involvement, choice and control that exist. However, there have been – and will continue to be – some whose health and sense of well-being may not benefit from living at the village.

15.2. There is some evidence to suggest that the health and well-being of some residents needing “support” benefit more from being at the village than if they lived in alternative settings.
15.3. For the purposes of analysis, different features of the village have been itemised and their possible benefit to residents explored. However, it is clear that no single aspect is responsible for promoting health and well-being. It is the unique synergy of a wide range of factors which combine to have an effect greater than any of them on their own. The extent of the contribution of different elements will vary from person to person and cannot be disaggregated. Different people gave different answers to the question of what was crucial to their happiness and sense of well-being, and to the question “which features are fundamental to the viability and success of the village”.

15.4. Safety, security and opportunities for companionship, friendship and social interaction appear to be particularly important. These in turn are made possible by the range of activities, facilities and services at the village, as well as the physical environment.

15.5. As one resident put it when asked what she most liked at the village:

“I like everything – design, safety, activities, companionship and staff – brilliant!”

and another asked about health and well being:

“It does improve people’s health and well-being. The opportunity it presents for continued activity – physical, mental and social, and the way it enables you to get levels of care you wouldn’t get in your own home – on tap at the pull of a cord…well-being nurse, maintenance of properties…put it together in a pot and it has the desired effect”

15.6. The importance of the whole – the synergy – needs to be remembered when this report considers the way in which care and support are commissioned and delivered. Transparency and clarity around what different funding sources cover are important but must not be allowed to fragment the service.
SECTION 4
COMMISSIONING ARRANGEMENTS FOR “SUPPORT”

Core question: What are the advantages and disadvantages of the way in which the care and housing-related support are commissioned and delivered?

1. COMMISSIONING ARRANGEMENTS FOR “SUPPORT”

1.1. OBJECTIVES

1.1.1. The “Partnership Agreement for the Provision of Personal Care” between St Helen’s Council and the Extra Care Charitable Trust sets out the following objectives:

- To maximise the service user’s capacity for independence and self-care
- To minimise the physical, psychological, emotional, social and environmental causes of dependence
- To improve and maintain the service user’s quality of life and capacity for self-fulfilment
- To assist with personal and domiciliary care tasks as necessary
- To support service users’ involvement in their social networks and local community
- To maximise the service user’s capacity for self-determination and control over their own life
- To promote positive attitudes to old age

1.1.2. St Helen’s specification requires amongst others “a range of preventative services to preserve health and well-being” (p22 c), “flexible, responsive services” enabling “service users to exercise control over timing and type of assistance as far as practicable” (p22 d), and various services to improve and maintain quality of life (p23, 4.10). These include a “wide range of daytime activities” and support to make use of facilities outside the scheme, to maintain family and social networks, to develop new social contacts, to help one another and to contribute to the life of the scheme – whilst respecting the service user’s right to choose.

1.2. THE COMMISSIONING MODEL

- St Helen’s has a block contract with ECCT to provide care for 65 service users at a given cost, with the facility to spot purchase care for an additional 5 people.
- The block is divided into 5 bands, band 1 catering for those with the lowest care needs and band 5 including an element of nursing care.
- The cost of each band is pre-determined, and there is an agreed number of people in each band.
- Even if a service user changes from one band to another, St Helen’s continues to pay the Trust the agreed total for the block – although the contract allows for adjustments to be made.

7 “Support” in quotation marks mean the care and support provided by the on site Support team under St Helen’s block contract.
When spare capacity within the block arises, an attempt is made to fill it with someone who will shift actual distribution back towards the block distribution, not another person in the same band – if the actual distribution is out of kilter with the block.

Capacity may be filled by someone new moving in to the village or by someone already resident at the village who needs care.

Separate from ASSD annual reviews, The Trust reviews service users at given intervals or if circumstances change, and contacts care managers if a band level needs changing.

Virtually all residents needing care get it at present through the Social Services block contract.

At St Helen’s, moderate, substantial and critical FACS thresholds apply.

It is a partnership model of commissioning, based upon mutual trust.

The following analysis is based mainly upon information and interviews from a range of staff from St Helen’s council and the ECCT and knowledge of the wider housing with care world.

What are the advantages and disadvantages of this model to Social Services and the Trust?

1.2.1. Advantages

- Use of bands offers a balance between a fixed price approach irrespective of the amount of care delivered at one end of the spectrum, and commissioning based on numbers of hours in care plans at the other extreme. The former provides certainty to commissioner and provider, with the fee paid for those needing less care subsidising those who need more, thereby probably being cost-effective overall, but is a blunt instrument which mimics residential care. On the other hand, commissioning based narrowly on hours can result in inflexible service provision and high levels of bureaucracy.

- The range within bands allows for a person-centred, flexible and responsive service without bureaucratic constraints. Bands facilitate the provision of a service which fulfils the specified service objectives. Service provision does not have to be expressed in outputs of hours and tasks, but in outcomes. In line with the specification, the support extends beyond narrowly defined personal care and can be delivered in an integrated way.

- The synergistic effect of care commissioned and delivered in this way, combined with other aspects of village life, appear to promote the health and well-being of “support” residents (See Section 3), arguably prolonging independence and fulfilling a preventative function.

- The process for movement of service users between bands ensures that significant changes in need are officially recorded and endorsed by Social Services, and the distribution within the block can be addressed when vacancies arise. Smaller changes do not necessitate an ASSD review and change of care plan.

- The fact that the Trust is paid the same irrespective of whether someone needs more or less care provides an incentive to deliver the “support” in...
an independence-enhancing manner, enabling service users to move down bands.

- Having a fixed block provides certainty and stability to the Trust, enabling them to plan staffing levels based upon it.

- Both the fixed block and the fact that payments are not having to be varied in line with band levels provides certainty and stability for St Helen’s Council. These also create savings for St Helen’s in two respects: on administration involved in dealing with variations; and care management time in formally re-assessing every time a different care plan is needed. In the traditional domiciliary care model relatively small scale changes trigger a requirement for re-assessments and subsequent care plan adjustments. These are time and resource-intensive.

- The relationship between the Trust and St Helen’s is one of a trusting partnership rather than the old purchaser/provider split. It is characterised by give-and-take and has proved mutually beneficial. It is the case that whilst the number of people receiving “support” over the last year has hovered around 70 rather than 65, the Trust has absorbed this work within the agreed price for the block rather than charging St Helen’s the spot price, since there have been more people in the lower bands than the block specifies – a quid-pro-quo that is only likely to happen in this sort of partnership.

- The fact that St Helen’s includes those in moderate FACS levels and supports people in band 1 means that people with relatively low levels of need can receive a service which is likely to prolong8 independent functioning at that level rather than escalating towards greater dependency (and therefore costing the council more). It also means that when people do improve, a lower band exists that they can move to, so they will not be artificially included in a higher band.

- The fact that care is removed when it is no longer needed fosters independence rather than dependence and ensures care is targeted where it is needed.

- This commissioning approach accords with the direction of travel of national social policy – partnerships and facilitating individually tailored, outcome-focused service provision. This topic will be returned to when discussing the issue of self-directed support and personal budgets.

1.2.2. Disadvantages

- Relative inflexibility of numbers in the block contract. The maximum number of people who can receive care from the Trust at any one time is 70 – there have been 72 temporarily on the odd occasion. Since everyone within the village needing care must form part of the block, from Social Services’ perspective this potentially impacts on the number of people with care needs who can move to the scheme from the wider community.

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8 This is largely a matter of supposition. Health and well-being data lend support to this assertion but do not prove it.
• Everybody has to come through St Helen’s at present to access care from the Trust. If it is only for a small amount of care, and likely to be short-term, this is arguably a waste of assessment and care management resources, and potentially expensive to a full-cost payer.

• Value for money to individuals will be dealt with separately below under “Charging Arrangements”, but value for money or not, it is a disadvantage that individuals cannot access care directly from the Trust without going through St Helen’s. The facility to do so, rather than having to go to an outside provider or have a formal assessment, would be of great value to people who need only small amounts of care on a temporary basis.

• At face value it might be argued that a model in which the council is not reimbursed any savings made from band changes does not make financial sense. Since this risk (i.e. bands can go up as well as down) can go either way, and other savings and benefits accrue from this approach as described above, this is not accepted as a disadvantage of the model.

• There is some imprecision about what the cost of each band covers. This may be seen as the flip side of a service which is flexible, responsive, outcome-focused and seamless – one of the advantages of this model – so long as it can be demonstrated that the service delivers specified individual outcomes, meets St Helen’s objectives, and provides value for money. A requirement for absolute precision in what is provided, when and to whom, can result in a rigid and fragmented service. However greater clarity and transparency will be needed, to a degree, with the advent of personal budgets (to be discussed later in this section).

• The complexity of band definition means that an assessor needs to have quite a lot of skill and experience to match service-user to band. To achieve consistency or standardisation, assessments are best done by the same person. This does not make for transparency or ease of auditing.

• Will the dependency profile within the 65, either within each band, or by people moving up bands, increase over a period of time to the point where overall staffing levels need to be increased? This is possible, though not necessarily a disadvantage of the model. This is a slightly different question from the community mix/balance one which applies to the whole community, not just the “support” group. These issues will be considered in Section 5.
VALUE FOR MONEY TO ST HELEN’S COUNCIL

1.3. “Support” Service Levels

1.3.1. Documents describing the different band levels differ slightly from one another. The mobility and ADL scores and care hours recorded here are to give an idea of the differences between bands, and should not be seen as the defining criteria for band inclusion. Documents describe the type and intensity of input that an individual in a particular band may require.

- **Level 1 (Assistance)**
  - 10 in block at a cost of £85.23 per person per week
  - Likely to have a mobility plus ADL score between 2 to 16 and up to five hours personal care per week

- **Level 2 (Assistance and Reminders)**
  - 20 in block at £175.45 per person per week
  - Mobility plus ADL score between 17 & 35 or personal care of 6 to 15 hours a week

- **Level 3 (Personal Support and Assistance)**
  - 10 in block at cost of £195.26 per person per week
  - Mobility plus ADL score of 27 – 49 or 16 – 21 hours personal care

- **Level 4 (High levels of personal care, support and assistance)**
  - 10 in block at £245.64 per person per week
  - Mobility plus ADL level of over 35 or 22 hours to residential care levels of personal care

- **Level 5 (High levels of personal care, support and assistance advised and led by domiciliary nurse)**
  - 15 in block at £359.65 per person per week plus £68.25 per person per week contribution from St Helen’s PCT
  - Mobility plus ADL level of over 45 and 22 hours to residential/NH level of care and health needs requiring plan of care to be supervised by a domiciliary nurse

1.4. Introduction

1.4.1. In exploring whether the block contract provides value for money to St Helen’s it is essential to see this question in the context of the health and well-being benefits discussed in section 3.

1.4.2. Furthermore this cannot be an exact science. Every attempt has been made to reflect the position realistically but it cannot be guaranteed to be totally accurate:

- Comparisons are being made where one of the scenarios is hypothetical so estimates have to be made based on available data.
- Some data have not been available (e.g. costs of care packages prior to moving to the scheme, whether they met all the identified needs, whether circumstances changed to necessitate greater
input and what the charges to service users were). To undertake this depth of analysis would have been too complex and time-consuming for a study of this scale.

- In addition one or two devices, which are not intended to be taken at face value, will be used to illustrate points; for example crudely calculated unit costs in Table 6. They are being used for illustrative purposes only and should not be taken out of context.

1.5. Cost based on actual numbers within bands

1.5.1. The HH1 form for the Department of Health recorded the actual number of care hours delivered to residents in Reeve Court during a week in November 2007. These figures were used to calculate the average number of care hours delivered to residents by band.

1.5.2. A calculation was undertaken of the position that would have applied the week that the HH1 form was completed, had St Helen’s paid the Trust on the basis of actual band distribution rather than on the basis of the block contract.

1.5.3. This shows that during that particular week Social Services would have saved £498.94 in total, losing on some bands and gaining on others. This is just a snapshot of one week and will probably have looked different in the weeks when 70 people were being supported, for example. It is questionable whether this amount of saving would justify the administrative workload on both St Helen’s and the Trust of adjusting payments.

1.5.4. The argument could be made that such adjustments could be made on a quarterly, six-monthly or annual basis thereby reducing the administrative costs, but this is unlikely to reflect the variations up and down bands without the task of re-calculating the costs every time there was a change. If an element of risk to either party is to be allowed, the current arrangement seems reasonable and provides valuable certainty for both St Helen’s and the Trust which may be worth more than the small amounts saved for either party.

1.5.5. An issue that the HH1 snapshot highlighted is the non-alignment between the number of people in each band as defined by the block and the actual numbers; in particular, double the quantity of people in band 1 and only just above half the number in band 3 than the block defines. Some of this is accounted for because a number of people have started at a higher band and then moved down. Other people move in to band 1 temporarily following a crisis such as a hospital admission and then revert to having no care. Because there is fluidity between bands, that particular snapshot may not be representative, and the council would need to look at the pattern over a period of time to assess whether the distribution between bands within the block accurately reflects demand.

1.6. Reeve Court compared to costs in the wider Community

1.6.1. A calculation was done, taking the average hours of care per band from the HH1 form and comparing the cost of “support” at Reeve Court with what it would be for domiciliary care in the wider
1.6.2. Based purely on domiciliary care and no expenditure by Social Services on any other services in the wider community, this table shows that St Helen’s is paying less at Reeve Court than they would in the wider community for the top three bands and more for the lowest two. Taking the block as a whole St Helen’s is £46K per annum better off.

1.6.3. Data provided by St Helen’s on the distribution of domiciliary care hours in the community. This was used to calculate an average number of hours within each band range. Using these figures, the pattern described above within each band applies to an even greater degree, with the overall difference coming out as £70K.

1.6.4. These are the gross rather than net costs, but given that under the current non-residential charging policy individuals are less subsidised at Reeve Court than in the wider community, a net comparison is likely to demonstrate further financial benefits to the council.

1.6.5. St Helen’s provided information on the take-up of meals on wheels and day care amongst a sample of 908 service users in the wider community between April and September, who also receive domiciliary care. These proportions have been applied to the Reeve Court block and a cost to St Helen’s calculated based on unit costs for those services (net of service user contribution since this is fixed and standard). A small number of people in the wider community were receiving night support services (a provision not widely available) and this proportion too has been applied to the Reeve block and six month usage assumed. It is valid to include these costs when doing a comparison with Social Services expenditure in the wider community since a parallel service at Reeve Court is included in the price of the band. It was not possible to distribute these sums between bands but taking all bands together, the following picture emerges.

1.6.6. This calculation shows that with the additional costs added in, rather than £46K more, St Helen’s Social Services would have to pay £70K more for domiciliary care in the wider community.

1.6.7. If one were to take the actual night-time care hours delivered in Reeve Court during the HH1 week, and apply the community unit cost to it, the difference would go up to £148,611.

1.6.8. The Supporting People subsidy has not been included in these calculations since it has not proved possible to get an estimate of the cost and number of people in receipt of this service living in the wider community.

1.6.9. **So what does all this tell us?**

1.6.10. Taking the block as a whole, a simple comparison with likely domiciliary care costs indicates that St Helen’s is getting value for money and indeed, is likely to be saving it.

1.6.11. One needs to bear in mind the following:
• These figures were based on a total of 65 people. The annual amount paid by St Helen’s to the Trust actually met the needs of 68 – 70 most of the last year.
• One is not comparing like-with-like and it could be argued that residents of Reeve Court get much more for the council’s money than they would in the wider community. The council is specifically paying for:
  o A person-centred personal care / “support” service that can be much more flexible and responsive
  o Availability of planned and emergency care at night

1.6.12. In addition there are added value benefits from other aspects of living at Reeve Court. It is not unreasonable to say that Social Services makes a contribution to the cost of some of these, for example activities and volunteering opportunities, since they are included in the service specification, while some are funded from other sources:

• A sense of safety and security deriving both from the 24/7 care and support and the security features of the building
• Access to a wide range of activities and opportunities for “citizenship”
• An integrated support service that can be provided as and when it is needed
• Access to a range of services which ASSD does not pay for but which benefit the resident, for example the well-being service, Enriched Opportunities Programme
• Access to a range of facilities which ASSD does not pay for but which have the potential to improve well-being and provide the back-drop to social interaction e.g. bar, coffee lounge, restaurant and gym
• Purpose-built wheelchair accessible properties which ASSD does not pay for but which have the potential to enhance quality of life

1.6.13. It is interesting to note that in the interviews with residents in receipt of “support”, they did not single out the care service as being responsible for their sense of, and improvements in, well-being. Generally it was a combination of all of the above to varying degrees.

1.6.14. Not only is the council getting more for its money. The section on health and well-being suggests that the outcomes for “support” residents of living at Reeve Court are generally positive, with evidence of improvements in levels of functioning and greater independence amongst some. Whilst Reeve Court may not be ideal for every resident receiving “support”, for many Reeve Court seems a very positive environment for optimising choice, self-determination and a sense of well-being. So arguably the council is getting better value for money too.

1.6.15. One Social Services interviewee suggested that the council gets added value from the contract with the Trust, because living at Reeve Court, “people stay well for longer”, so delaying the need for more intensive and expensive services, and in this sense fulfilling a preventative function. Without a large scale, long-term study with a comparator group, this assertion is difficult to prove but may well be the case.
1.6.16. Thus, taking the block as a whole, St Helen’s Social Services does appear to be getting good value for its investment.

1.7. Value for money of separate bands

1.7.1. What is less certain, is whether all bands represent equal value for money.

1.7.2. Taking bands 1 and 2 and the average number of care hours in each from the HH1 Form – 5.3 and 12.8 respectively – the council would have paid around £27K less per annum if the external independent sector unit costs applied.

1.7.3. What would the hourly unit costs in Reeve Court be if one did a very crude calculation based on care hours? These were calculated using the hours from the HH1 form, the wider community profile average mentioned in 2.4.3, and the notional number of hours at the top and bottom of each band.

1.7.4. Such calculations ignore completely the fact that people in the wider community may be receiving other services at extra expense to the council, and that the band cost covers additional services in Reeve Court. However it is probably true to say that people in bands 1 and 2 make less use of some of the extra services specifically covered by the payment than those in the higher bands. For example, taking night care during the snapshot week, only residents in bands 4 and 5 received planned care at night. It is not clear from the data what has been recorded for the lower three bands: visits or hours of care delivered at night. Assuming the former, 16 visits were made to four residents in band one, 26 to 5 residents in band 2, and 9 visits to one resident in band 3, compared to combined planned and emergency input at night to people in band 4 of 93 hours for all 12 residents, and 169 hours for all 14 residents in band 5. Those in the higher bands also make greater use of the pull cord.

1.7.5. Clearly therefore, people in the lower bands have benefited from the availability of emergency care at night but do not use the resource as extensively as those in the higher bands.

1.7.6. On the other hand, people in the lower bands have probably gained as much in terms of the added value and wider benefits outlined in 2.4.11 as those in the top three bands.

1.7.7. Looking at Band 1, whilst the unit cost for those at the top of the band may be argued to provide value for money to the council, for those at the bottom of the band this could not be argued. In reality there are not likely to be many people in receipt of such low levels of “support”. Across the band or the block as a whole it may be acceptable to the council to have the occasional low level service user, particularly because extra people have been slotted in at the total block price.

1.7.8. Within level 2, the band payment for people at the top of the band unarguably represents value for money, but evidence for someone at the bottom of the band is less compelling.
1.7.9. In the other three bands the notional unit cost comes out at less than the wider community domiciliary care unit cost, with added value delivered for the price.

1.7.10. What these crude calculations demonstrate is that broadly speaking, the unit costs go down as band levels go up, when one might argue that if anything, the unit cost should be slightly higher in the upper bands. It seems likely that the lower two bands subsidise the top bands. In a range of Extra Care commissioning models, it is the mix of need levels that makes the cost of the care provision deliver value-for-money overall. Spread across all residents, the collective expenditure is cost-effective. This approach contributes to enabling a balanced, vibrant community for the greater good.

1.7.11. While this makes sense from Social Services perspective – indeed may even be financially advantageous – and also ensures that the provider’s costs are covered, there are a number of reasons why it would be preferable for each band to be more financially self-sufficient and to relate as clearly and transparently as possible to the costs of services being provided within that band:

- The cost to self-funders within St Helen’s charging policy
- The advent of personal budgets

1.7.12. Individuals are not averages, and self-funders will be concerned with what they individually get for their money, not the collective value to Social Services.

1.7.13. Before going on to discuss these issues, a comparison will be done with care home costs on the basis that these may be alternative settings for some residents in bands 4 and 5, and have a bearing on the value-for-money aspects of individual bands to St Helen’s.

1.8. Reeve Court “support” costs compared to care home costs

1.8.1. This is not the place to discuss the extent to which bands 4 & 5 are equivalent to residential and nursing homes respectively. There is little doubt that if Reeve Court were not available, at least some of the people in bands 4 and 5 would be in residential or nursing homes.

1.8.2. Calculations show that the gross cost to Social Services for bands 4 and 5 in Reeve Court is less than the cost for the same number of people in residential homes (band 4) and nursing homes (band 5), the difference being approximately £64K for band 4 and £11K for band 5. These figures do not take into account that were these people to be in residential or nursing homes, the proceeds from the sale of their property (if they own one) would contribute to Social Services care charges, whereas in Reeve Court capital bound up in the property is not available to Social Services.

1.8.3. Even where people don’t have capital assets, the council is guaranteed a minimum income of £98.60 per week towards residential care charges through the benefit system. Comparing the net cost to Social Services, the department pays around £12.5K p.a. less for the 10 residents in band 4 than they would pay in residential care, but
£66K p.a. more for the 15 people in band 5 than if they were in nursing homes at the indicative price.

1.8.4. Here again, one needs to look at the whole picture, not just a simple cost comparison. The discussion of the benefits and added value explored in 2.4.11 in the context of comparisons with social care services in the wider community applies equally here. The points will not be made again.

1.8.5. What does bear spelling out is that people living in residential or nursing homes do not have a property with several rooms that they can call home. They do not have a tenancy or lease which affords security of tenure and certain rights such as deciding who can cross their threshold. It is possible, but unlikely, that the range of activities and social stimulation in most care homes is comparable to that at Reeve Court. It is possible, but unlikely, that care to people in residential care is delivered in an independence enhancing way. Indeed, the lack of facilities militates against that: would someone in residential care be given the opportunity to make a cup of tea or a sandwich? Unlikely.

1.8.6. Another hugely significant benefit of Reeve Court over residential care is that it houses couples where only one may need “support”. Carers can be supported in their caring role and both the cared for and carer can participate in the wide range of activities and opportunities for involvement as far as they wish to.

1.8.7. Value for money to the council for people in band 5 compared to the nursing home alternative is therefore less compelling than compared to likely domiciliary care costs, but in the context of the extra gains at Reeve Court can be argued to be money well spent.

1.8.8. Realignment of costs with services within each band will alter the picture regarding the cost-effectiveness to St Helen’s of the block as a whole, and each band. The outcome cannot be predicted.

1.8.9. What about value for money to the PCT?

1.8.10. The PCT contributes a weekly amount per person for the 15 people in level 5, to cover the cost of the nursing input. Unlike in a nursing home, this amount is paid in a lump sum to the Trust via Social Services, so one person can receive more intensive care and another less.

1.8.11. By definition, people are only in this band if their health needs are such that they require care led and supervised by a nurse. If the individual was in a nursing home instead, the PCT would contribute £101 per week. If on the other hand the individual was at home and required similar levels of nursing input, it would have to be provided by the district nurse. In terms of time spent travelling to-and-fro, level 5 offers economies of scale.

1.8.12. The PCT interviewee indicated that the PCT had recently looked at their contribution and had reached the conclusion that it did provide value for money to the PCT. What also emerged from interviews with
staff and a number of residents who were, or had been, on level 5 was the excellent quality of the service.

1.8.13. Residents could not speak highly enough of the calibre of staff. One resident who had long-standing lesions on her legs when she came to Reeve Court attributed her recovery to the skill of the Reeve Court nurses. In the same way as care and general support is delivered in an integrated, seamless way, so too the nursing input. Similarly, the nursing input is flexible and responsive at Reeve Court. Residents can ring the handset and someone will go back and see them. A resident who has a minor fall and needs a dressing doesn’t have to wait until the district nurse arrives for the scheduled visit or call a doctor. It can be attended to promptly by an on-site nurse. There is continuity of care with the same three nurses who know what is going on with all residents in the band.

1.8.14. It is claimed that the number of hospital admissions for people in Level 5 is low, and often GPs do not have to come out but can give advice over the phone because they are talking to medically qualified staff. This claim, whilst difficult to quantify, seems likely to be true.

1.8.15. So it seems reasonable to conclude that the PCT is getting value for money. As one of the interviewees said, “it’s a win-win situation.”

2. CHARGING ARRANGEMENTS – VALUE FOR MONEY TO SERVICE USERS

2.1. Introduction

2.1.1. There is considerable variation in the charging arrangements for the care element in Extra Care schemes across the country. They vary from a single fixed charge irrespective of the amount of care received at one end of the spectrum to total alignment with the domiciliary care charging policy – usually an hourly charge following a fairer charging assessment – at the other. There are pros and cons to these different approaches which are beyond the scope of this evaluation.

2.1.2. The arrangements at St Helen’s are as follows:
- St Helen’s, not the Trust, charges for the “support”
- Service users undergo a Fairer Charging assessment
- The maximum they can be charged is the charge to St Helen’s for the band which they are in
- This is different from the domiciliary care charging policy where the maximum charge is a proportion of the full cost
- The charge is adjusted if the service user changes bands

2.2. Advantages of this approach

2.2.1. It is not as blunt an instrument as a charge which is fixed irrespective of the level of care, but the arrangement at St Helen’s still allows considerable variation in care provision before a re-assessment and revision of charge is triggered unlike the traditional domiciliary care approach.
2.2.2. It supports more flexible, responsive and person-centred service delivery.

2.2.3. It reflects the additional range of services and benefits within an extra care environment compared to services provided for individuals at home in the wider community.

2.2.4. The contract for “support” remains with St Helen’s rather than with the housing provider’s agent, underlining that care is not a condition of tenancy or lease.

2.2.5. The charge is based on a Fairer Charging assessment.

2.2.6. From the Trust’s perspective, St Helen’s rather than they have the administrative responsibility for this, and also the bad debt risk.

2.2.7. The value of the service user’s house (if they own one) is not included in a Fairer Charging assessment, whereas it would be if s/he were in residential care.

2.3. Disadvantages

2.3.1. It is said that at present there are relatively few people at Reeve Court paying the full cost for their care. This may not always be the case: 50% of residents own or part-own their property, may require “support” in the future, and may have an income which puts them into the full-cost bracket.

2.3.2. Whilst it has been argued in this report that overall, the block contract delivers value for money to St Helen’s, it may not always be the case that it delivers value for money – or be perceived to deliver value for money – to the individual full-cost payer, particularly in the lower bands, and band 1 in particular. For example someone requiring 2 or 3 hours of care a week, and no planned care at night, could get that care at less than half the price by going to an external provider. Whilst St Helen’s will be looking at the long-term benefits and savings derived from living in that environment, as well as the overall benefit to the entire group of service users, an individual is more likely to take the view that they gain those additional benefits (apart from planned night care) anyway, and shouldn’t be expected to pay extra for them. These issues will be brought into much sharper focus when considered within the context of direct payments and personal budgets.

2.3.3. In addition, it could be argued that whilst it is reasonable to expect service users to pay more for services in an extra care setting than in their own homes in the wider community since they derive many more benefits including access to night care (both planned and in an emergency), it is not necessarily fair that self-funders should be expected to pay the full cost in extra care whilst their care is subsidised in the wider community. This makes the discrepancy between what they pay for band 1 and externally provided care all the greater. Also, any extra that they pay needs to appear proportionate and reasonable.
2.3.4. It is inevitable that in a system which uses bands, while the approach has significant advantages as already outlined, those at the top of a given band in terms of care hours will be likely to see it as better value for money than someone at the bottom of that band. Looking again at Table 6 it is probably fair to say that for an individual, the bottom of band 1 does not offer value for money. It may be significant to note however, that whilst the notional range of care hours in band 1 is up to 5 hours, the average in the HH1 week was 5.3 hours. At this level the case could just about be made to an individual that their charge of £85.23 per week represents value for money, but they may take some convincing. The same applies at the bottom of band 2 – whereas for bands 3, 4 and 5 value for money to the individual appears clear.

2.4. Financial Winners and Losers in Care scenarios

2.4.1. The following grid summarises the winners and losers in different care scenarios

<table>
<thead>
<tr>
<th></th>
<th>DOMICILIARY CARE</th>
<th>REEVE COURT - BANDS</th>
<th>CARE HOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>People reliant on benefits</td>
<td>Charge for care unlikely to be very different from that in Reeve Court, but only get standard domiciliary care, not the flexible service, nor the overnight cover. More disposable income than in residential care.</td>
<td>Arguably get a much better service for the amount they contribute More disposable income than in residential care.</td>
<td>Pay a higher amount but covered by benefits. However, left with less disposable income, as well as arguably poorer quality of life for many people.</td>
</tr>
<tr>
<td>Self-funding owners</td>
<td>Retain capital tied up in house. If high income marginally better off because not charged the full gross cost of domiciliary care.</td>
<td>Retain capital tied up in house. Total cost of care could be higher or lower than in either of the other two settings, depending on level of care.</td>
<td>Once income/savings used up, proceeds from property would have to contribute to fees. May pay less overall than in EC but see 6.2 and 6.3.</td>
</tr>
<tr>
<td>Self-funding renters</td>
<td>No home to count as an asset.</td>
<td>No home to count as an asset.</td>
<td>Don’t have anything to sell.</td>
</tr>
<tr>
<td>Social Services</td>
<td>Much less certainty and predictability in uptake and therefore costs. Variations administratively expensive. Beyond that can’t generalise because depends on level of care and individual’s financial circumstances.</td>
<td>Don’t get proceeds from the sale of the property that they would get if person in residential care. SSD does benefit if self-funder in Reeve Court has a level of care that takes the cost above what SSD could charge in the wider community at £8.17 per hour.</td>
<td>Get a higher guaranteed minimum income in this scenario compared to the others. Would also “benefit” from contribution to charges from sale of property of home owners. Beyond that depends on comparative levels of care etc.</td>
</tr>
</tbody>
</table>

Whether definitions of bands, their price, or St Helen’s charging policy should be adjusted, and in what way, will be explored in the discussion.
section below, following consideration of the issues relating to self-directed support and personal budgets in the context of extra care housing.

Other aspects of comparative costs and value for money – for example the overall cost to the state and individual in different settings and scenarios will be considered further in Section 6 of this report.

3. SELF-DIRECTED SUPPORT – PERSONAL BUDGETS AND DIRECT PAYMENTS

3.1. Introduction

3.1.1. An analysis of all the implications of self-directed support is beyond the scope of this study. The focus here will be primarily upon its implications for commissioning round-the-clock care in extra care schemes – a service which is arguably a defining feature of extra care – and in particular for St Helen’s and The Extra Care Charitable Trust in the context of Reeve Court and the current commissioning model.

3.1.2. “Self-directed support is the name given to the way of re-designing the social care system so that the people who get services can take much greater control over them.” (CSIP briefing February 2007) The term encompasses self-assessment, direct payments and individual or personal budgets. In the context of commissioning care in an extra care setting, it is with the last two that we are primarily concerned. They are intended to bring together a number of funding streams – of particular relevance here, LA community care budgets, Supporting People Programme, and possibly ILF, integrated community equipment services, and Disabled Facilities Grants.

3.1.3. The distinction between direct payments and personal or individual budgets is that in the former, the individual is given the money to spend. In the latter, they are told how much is available to spend and can decide what services to buy, from whom, but don’t have to take responsibility for book-keeping. The thinking behind these is that the individual takes on the role of commissioner and stays in control of the services they receive.

3.1.4. The decision has been taken to roll out personal budgets even before the pilot studies are complete, and a ring-fenced budget under “Putting People First” has been given to local authorities to implement them.

3.1.5. The following extracts from Section 3 “A Personalised Adult Social Care System” from “Putting People First: A Shared Vision and Commitment to the Transformation of Adult Social Care” concordat make clear the direction of travel and requirements on local authorities:

- “Person centred planning and self-directed support to become mainstream and define individually tailored support packages.

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9 The term “personal budgets” tends to be used to apply to ASSD money while “individual budgets” may incorporate other funding streams such as Supporting People.
• “Personal budgets for everyone eligible for publicly funded social care support other than circumstances where people require emergency access to provision. Lord Darzi’s recent NHS next stage review report suggested that in the future personal budgets for people with long-term conditions could include NHS resources.

• “Agreed and shared outcomes which should ensure people, irrespective of illness or disability are supported to:
  o Live independently
  o Stay healthy and recover quickly from illness
  o Exercise maximum control over their own life
  o Participate as active and equal citizens, both economically and socially”

• “The overall aim would be to enable existing resources to be allocated and services delivered in ways that personalise responses to need, and give people choice over how their needs are met.” CSIP Briefing

3.1.6. The “wholesale” development of personal budgets is still in the formative stages, and it is not clear what precisely will be prescribed or expected, and how much flexibility will be allowed in the roll-out in localities. Therefore the following thoughts must be seen as just that. It would be unwise to make firm recommendations without having greater clarity on national and local implementation.

3.2. The Housing with Care Context and Reeve Court

3.2.1. One cannot argue with the aims and objectives of self-directed support, but personal budgets and direct payments are not the only route to achieving them and may not be the best way in every context.

3.2.2. This evaluation will conclude that the current care commissioning and delivery arrangements at Reeve Court, combined with the availability of other services, facilities and opportunities, fulfil the objectives of self-directed support described above to a significant degree for most people. Depending on how it is implemented, the introduction of micro-commissioning at Reeve Court, as in other Extra Care settings, risks undermining these outcomes, rather than improving on them.

3.2.3. As an interviewee from St Helen’s Social Services put it, “Personal budgets are about empowerment of the individual, not about a shift in budgets. We are in danger of destabilising the market”

3.2.4. The current situation in most good, publicly subsidised Extra Care housing is that local Social Services Departments block contract the care – and often housing-related support – from a single provider on site. Generally speaking this offers specific benefits:
  • The care and support provision can be delivered in a person-centred, flexible and responsive way.
  • It enables 24/7 care and support provision to be justified and cost-effective, since the on-site provider delivers packages of care and responds to fluctuations in need and emergency calls day and night, minimising overlap or gaps.
This enables people who may otherwise be in residential care to live independently for longer.

It provides safety, security and continuity because there are not numerous providers all sending different people in to deliver care.

It enables a co-ordinated, holistic service to be delivered.

It delivers economies of scale.

People have the right to choose direct payments but may not be specifically encouraged to do so.

Commissioners can commission the service in a block in the knowledge that most service users will choose it.

Providers have the certainty necessary to recruit and train staff and build up a cohesive staff team.

A range of activities are available for individuals to choose; they can participate in these or enjoy individual pursuits with the support of staff.

3.2.5. If service users are encouraged to have a personal budget, and local authorities are fearful therefore of block contracting the care and support services, providers may unwilling to take the risk of setting up an on-site “support” team. This could result in:

- The loss of availability of planned care at night. This would mean people who needed care at night would be precluded from moving to extra care or remaining in extra care once they needed this type of support, unless it was available to spot-purchase externally.

- The loss of on-site emergency cover round the clock.

OR

- A situation where it is possible only to deliver round the clock emergency cover of housing-related support tasks, not care.

OR

- Separation out of emergency cover and care packages which is likely to be less cost-effective and cohesive.

- Rigidity of care and support provision to an individual if the chosen provider is not on site to deliver care in a responsive way or respond to emergencies.

- Lack of co-ordination, to be replaced by a fragmented care and support service, with each individual having chosen their own provider but deriving none of the benefits from a provider on site who can dovetail the needs and wishes of different services users, vary provision from day to day, and ensure effective communication on site.

- Loss of economies of scale and potentially less, rather than more value for money.

- The scheme feeling less secure because of the potentially multiple providers coming in and out.

- An inability to provide the full range of services currently delivered and described in Section 3, leading to a disruption of the service synergy which appears to be significant in promoting health, well-being and independent living.

- Individuals becoming isolated if lots of personal budgets are not brought together to generate group activities in which individuals may wish to participate. There may be no organisation and co-ordination of these activities. It is not clear what mechanisms would be in place to facilitate this collaboration. It cannot be assumed that individual service users would have the wherewithal to do this.
3.2.6. Personal budgets only make sense if there is a range of quality provision to choose from. The incentive for commissioners and providers to develop such services is lost without some degree of certainty. Arguably, block contracts or a grant from commissioners may still be needed to build capacity, creating incentives for providers to develop and maintain quality social care services.

3.2.7. The description in 4.2.6 may be seen as the worst case scenario. It may not happen if
- the on-site service can be shown to offer value for money, not just to Social Services but to the individual service user
- service users in Extra Care see the benefits of receiving support from the on-site provider
- they recognise some of the softer, less tangible benefits of the services and are willing to use the budget to pay for these
- the personal budget calculated for an individual matches the costs within Extra Care
- Social Services are willing to invest in development of services.

3.2.8. This is where the arrangement at Reeve Court and other Extra Care schemes using a banding system face a particular challenge. This has already been outlined in the section discussing the charging arrangements and value for money to self-funders. Personal budgets in effect introduce many more self-funders. Whilst a banding system enables an outcome-focused, person-centred, responsive, flexible and integrated provision of support, the fact that it is a bit more opaque, with the service not clearly defined and quantified, may be perceived as not providing value for money to a given individual.

3.2.9. A service user could in theory be offered a personal budget which would cover the cost of care and housing-related support at Reeve Court, and once there, could opt to purchase support from an outside provider. This is likely to apply particularly to someone needing care at the lower end of bands 1 and 2 who doesn’t need planned care at night.

3.2.10. One or two people going off site for their care and support would not be problematic. Many doing so would be, for the reasons outlined in 4.2.6 – in particular, resulting in fragmentation, and loss of synergy and co-ordination and ultimately undermining the viability of the “support” service both from the Trust’s and Social Services perspective. The Trust’s holistic approach to meeting service users’ needs would be under threat along with the flexible, responsive service – both to those who had gone off site and to the remainder.

3.2.11. A possible approach would be for the Trust to charge one price per band for the whole package, or offer the alternative of selling individual components at a premium. However, a menu-based approach does not strike as compatible with the integrated, holistic service delivery which is the hallmark of the ECCT’s ethos. Whilst preferable to extensive use of off-site providers, it would still destroy many of the features which are the strengths of the current provision; indeed those very aspects which produce the person-centred, self-
3.2.12. Another alternative may be to say that the service user is exercising his or her choice by deciding to move to Reeve Court and an intrinsic element of that choice involves using ECCT’s “support” services. While some local authorities and providers currently take this approach, it is inadvisable to do so as it is likely to be seen in a court of law as a condition of lease or tenancy, and therefore “accommodation provided together with personal care” and liable to registration as a care home. Some might argue that the existence of a separate contract with the on-site care provider would get round this problem, but this seems unlikely because living there is still being made conditional upon using the on-site provider.

3.3. So where to from here?

3.3.1. We need to assume that extra care will not be exempt from personal budget targets, but how vigorously St Helen’s chooses to pursue them in extra care settings, and what they will mean in practice locally can make all the difference.

3.3.2. One might argue that in the best case scenario:

- St Helen’s will maintain its block contract or give ECCT a lump sum to maintain the service.
- Individuals will be able to have a direct payment or personal budget, or simply opt to remain within the Social Services block.
- The method for calculating the value of a personal budget will allow for an individual’s budget to equate to the appropriate Extra Care band. If St Helen’s opts to jointly commission care and housing-related support, this should include the support charge. This means not paring off assumed “efficiency savings” or calculating it crudely on the basis of assumed care hours.
- The figure will reflect the additional outcomes met (e.g. improved safety and security; improved sense of well-being through opportunities for community involvement and social interaction) and/or the additional services provided (e.g. facilitating activities and volunteering, access to round the clock care and support etc).
- ECCT will ensure that the service they offer is more attractive than the alternatives.
- The Trust will ensure transparency in what each band offers and the price of bands will be more closely aligned to the cost and level of service provision within each.
- The implications of different choices will be made clear to all service users, including the individual and collective benefits of using the on-site provider.

3.3.3. An alternative may be that St Helen’s and the Trust agree to share the risk for example by:

- St Helen’s paying enough grant to ensure the costs for round-the-clock cover and management of the service are covered
- Leaving individual packages of “support” to be bought from the Trust (or wherever) following an outcome-based assessment and
determination of the personal budget.

It seems unlikely that this approach could accommodate bands, but the outcomes approach to commissioning should ensure holistic – but possibly less flexible – provision.

The relationship between the service pre-purchased by St Helen’s and the component determined on an individual basis could be complicated to work out. Which elements of the package would be pre-paid as part of St Helen’s block and which paid out of the individual budget? Round-the-clock care and support that simply responds to emergencies, with individual packages being separate, is unlikely to be very economical.

3.3.4. Another option worth exploring may be to assist those receiving “support” through personal budgets to form a purchasing consortium to block contract the “support” services from the Trust.

3.3.5. Whatever approach is taken, St Helen’s and the Trust will need to work very closely together to achieve a satisfactory arrangement. Looking at the trusting, and mutually beneficial relationship St Helen’s and the Trust have had up till now, this should be possible.

4. DISCUSSION ON COMMISSIONING OF CARE

What then are the implications of all of these issues for the way forward?

4.1. The overall commissioning approach based on partnership and trust accords with the direction of travel of national policy – partnership working and facilitating individually tailored, outcome-focused provision. Having a system of bands supports the benefits to all stakeholders.

4.2. But there are also some issues and challenges arising from the commissioning arrangements at Reeve Court. These include:

- The unavailability of care from the Trust without going through the council
- The questionable value for money to individual service users at the lower levels of bands 1 and 2
- The question of whether the number in each band should be altered to more closely match the actual need, assuming a block contract continues to be drawn up in the same way
- With the advent of personal budgets, the fact that
  - bands do not lend themselves to disaggregation into clear component parts
  - that the costs cover components individuals may not appreciate the value of, may not want, or may believe they will receive anyway
  - there is an absence of obvious alignment between the price of the bands and the services being provided
  - not all bands appear to be financially self-sufficient
- Whether the charging policy for Extra Care as currently constituted is counter-productive – particularly with the advent of personal budgets – and may be perceived to be unfair
4.3. In exploring any alterations to current arrangements there are a range of outcomes to be achieved, not all of which are complementary:

- Meeting the demand/need for care in St Helen’s
- Meeting service users’ aspirations
- Meeting the aspirations of the resident group as a whole
- Achieving a system which embraces “Putting People First”, while avoiding potential negative impacts
- Delivering value for money to St Helen’s
- Delivering value for money to self-funders and individual budget holders
- Ensuring financial viability for the Trust
- Achieving sufficient certainty to enable forward planning, stability and continuity
- Retaining the quality, integrity and flexibility of the service
- Minimising bureaucracy
- Achieving a mix of age and ability that supports a vibrant community and attracts fit and able people as well as those with “support” needs
- Building in a contingency for a day if/when the rate of decline of the resident population outstrips the supply of care within the block

4.4. The following exploration of options takes as its baseline that St Helen’s will continue to have a block contract with the Extra Care Charitable Trust.

4.5. Could the Trust make low levels of care on a temporary basis available for purchase at an hourly rate?

**Benefits of this approach**
- People would not have to go through the block or purchase care from outside agencies.

**Challenges**
- The Trust would need to build in additional capacity.

4.6. Should band 1 be dispensed with altogether, with people needing fewer than 5 hours of care and no care at night either purchasing the care directly from the Trust or using a personal budget to do so at an hourly rate?

**Benefit of this approach**
- Residents would not have to go through St Helen’s for low levels of care.
- Care would remain in-house.
- Value for money would be more obvious as a band charge of £83 is not levied.

**Challenges and Disadvantages**
- Would make moving down a band from level 2 to what used to be level 1 more complex.
• There would be more people on an hourly rate than in the previous suggestion, which may be more difficult for the Trust to plan for and accommodate.

• There are a significant number of people in this band so it does seem legitimate to continue having it, and if the HH1 week is typical, the average level of care is near the top of the band rather than the bottom.

• If it were to be dispensed with altogether, other bands would need to have their price raised to compensate, since it is likely that this band subsidises the higher bands. This may be necessary anyway to achieve self-sufficiency within each band.

• It does not seem to be a good idea for a service obtained through St Helen’s, albeit via an individual budget to have different purchasing or charging arrangements within the same setting.

• It is desirable to continue to have people with low level needs at Reeve Court. They help to reduce the polarisation between the core residents and “support” residents because there is a continuum.

4.7. **Should the definitions for bands 1 and 2 change so that, for example, level 1 begins at 4 hours with any care below that being charged privately by the Trust on an hourly basis, or spot purchased by St Helen’s, and going up to 7 or 8 hours, with band 2 starting at 8 or 9 and going up to a notional 15 hours?**

**Benefits**
- This may reflect the reality of the needs within moderate, substantial and critical FACS criteria better.
- It may be that this could be done within the current price for bands 1 and 2, with the prices for bands 3, 4 and 5 being uplifted slightly to compensate. This would have the added benefit of realigning service and price but would need careful financial modelling to ensure fairness and reasonableness to all.

**Challenges**
- Since these band levels are based on much more than notional hours, they would require careful re-definition. Adjustments would be needed to the assessment which would take time to get used to.

4.8. **Should the band definitions be left as they are?**

**Benefits**
- Simplicity.
- There is considerable fluidity anyway.
- The council gets value for money.
- There may be other ways of addressing the value for money issue for self-funders such as a change to St Helen’s charging policy.

**Challenges**
- It would still be an advantage for temporary low level care to be available directly from the Trust.
- With the advent of personal budgets it may still be necessary to look at the alignment between prices and service levels.
4.9. In the context of personal budgets, should St Helen’s and the Trust abandon bands altogether as being too imprecise?

**Benefits**
- Such an approach could be argued to deliver maximum flexibility and linkage between budget and service level IF the following applied:
  - If the bands were replaced by true and detailed outcome-based commissioning at an individual level with an individual budget to match AND
  - St Helen’s gave ECCT a lump sum to enable them to employ staff and run the service AND
  - The lump sum equalled the cost of delivering the service and the composite of all the personal budgets AND
  - There were flexible review arrangements which didn’t involve the council in constant reviews and individual budget adjustments (like bands?)

**Challenges**
- The above are very big “IFs” and as argued in this evaluation, the bands approach is probably the optimum arrangement for providing an outcome-focused, flexible and personalised service to the individual, balanced with certainty to the council and Trust.
- Perhaps partners need to see how the calculation of personal budgets develops in St Helen’s. Dispensing with bands could see a return to task-driven services, financial uncertainty and excessive bureaucracy.
- If the service user spent the personal budget elsewhere, the council would in effect be paying twice

4.10. Should the price for each band be re-negotiated to align it more clearly with the level of service provision?

**Benefits**
- This would make value for money to self-funders and individual budget holders much clearer

**Challenges**
- It might be that in doing so the obvious cost-effectiveness of the higher bands will be reduced

4.11. Should the number of people within each band be revised?

**Benefits**
- It may make sense if it is quite clear that there is more need for capacity in one band and less in another. This would require further investigation.

**Challenges**
- It remains important to retain a mix and spectrum. Any decisions about changing numbers in bands has to be considered in the context of the overall community mix, and its impact on the core residents. Any such discussions would need to involve Arena Options. Residents should be consulted if any major changes are being considered.
4.12. Should the number in the block be increased now - or in the future?
   - No – not now. For discussion of this issue see Section 5.
   - Decisions about the future should be taken in the future in the context of prevailing circumstances.

4.13. Should the number in the block be decreased to build in contingency for the future?
   - This is a decision that needs to be taken by St Helen’s in discussion with ECCT and Arena Options in the context of levels of demand and new developments in the pipeline. On balance, probably not.

4.14. Should St Helen’s alter its charging policy for Extra Care so that it is more equitable with its other non-residential charging policies, for example making the maximum charge within each band two-thirds of the cost of that band?

   **Benefits**
   - At present, most service users are not full-payers anyway, so at the moment it will probably not make a huge difference to the council’s coffers.
   - It would not be unreasonable for St Helen’s to subsidise services which deliver health and well-being benefits and may result in savings compared to alternatives in the longer term. Charging policies in extra care schemes vary. For example, there are some in which planned care is charged but the availability of round the clock care and support is not.
   - A maximum charge of two-thirds of the band creates a charging policy which is still tied into the distinctive features of extra care, still allows the fluidity and flexibility of service, but will be seen to be more equitable than the current arrangement.
   - The lower the charge, the lower the incentive to seek cheaper alternatives outside, except where in-house services genuinely don’t meet a given individual’s needs and preferences.
   - With the advent of personal budgets, this adjustment would help to ensure the viability of the block contract assuming that continues to be the agreed approach.

   **Challenges**
   - It will reduce the level of income brought in by charges to St Helen’s.
   - It is not in line with residential care charges – but given that extra care housing provides care in people’s own homes, albeit with important differences, it is the domiciliary care policy rather than the residential one that should be the point of comparison.
   - It would not make sense to review the charging policy until the future commissioning arrangements between St Helen’s and the Trust have been agreed.
SECTION 5
RANGE AND LEVEL OF NEEDS AND COMMUNITY MIX

The core questions that section 5 sets out to address are:

- **What level and range of needs can be met by living at the village?**
- **To what extent does the mix and balance of ages and abilities contribute to the well-being of the village community as a whole, can this be maintained over time, and what are the implications if the rate of deterioration outstrips the vacancy rate?**

This section will:

- Address the first question in the context of the one-third of residents who have "support" needs
- Look at the wider question of the mix and balance between those who have care needs and those who do not
- Consider the implications of conclusions on community balance for the size of the St Helen’s block contract, and access to Reeve Court for people with care needs in the wider community, over time

SECTION 5 A
RANGE AND LEVEL OF NEEDS WITHIN THE “SUPPORT” GROUP

“What level and range of needs can be met by living at the village?”

In particular, answers were sought to the following:

- **Does the village support people who would otherwise be in residential care?**
- **Does the village support people who need more nursing care than could be provided by peripatetic staff in the wider community?**
- **Does the village support people who would otherwise require nursing home care?**

Throughout this discussion it is important to distinguish between the type and levels of need at the point at which people move to the village, and the “support” service’s capacity to continue meeting needs of existing residents as they change and grow.

1. CURRENT POSITION

1.1. From the documents provided, there do not appear to be specific care-related eligibility criteria in terms of need domains, or levels of care needs which would make a move to Reeve Court unsuitable. Instead the Allocations Information says “If you have care needs, you will be assessed by someone from the Care Team. The assessment for care will be agreed with you and you will be awarded a priority for Extra Care housing.” It then goes on to spell out priority based on three different risks levels.

1.2. Appended to St Helen’s “Extra Care and Support Service Referral Policy and Procedure” is a description of the level and type of service input that can be expected at different bands, but no description of the need domains or levels...
of need that Extra Care housing can be expected to cater for – in other words it is expressed largely in service rather than need terms.

2. TYPES AND LEVELS OF NEED

2.1. Eligibility Criteria

2.1.1. There are pros and cons to an approach which is imprecise in the needs it is seeking to cater for.

2.1.2. On the one hand it enables flexibility and professional judgement on a case by case basis.

2.1.3. On the other hand it is not very transparent or informative to anyone other than those directly involved.

2.1.4. It relies on assessments being done by people who have an implicit rather than explicit understanding of the services and context of the village, and how they suit the needs and aspirations of the individual being assessed.

2.1.5. Where only a handful of people undertake these assessments, as at Reeve Court, standardisation can be achieved and this works well. In a system where assessments are undertaken by a number of care managers, it would not. It might be better to combine more explicit care eligibility criteria with a small number of skilled assessors doing the assessment.

2.2. Range and Level of Need at Point of Entry

In terms of need domains, what type of needs can be met at Reeve Court, at point of entry?

2.2.1. People have successfully moved into the village with a range of physical disabilities and medical conditions, learning disabilities (4 people), mental health problems and multiple needs. So far, no people have moved to the village who are bed-ridden, despite popular misconceptions to the contrary, but the manager of the Support Team said she would not completely rule this out. It would depend on circumstances.

2.2.2. No-one from the Trust has spelt it out in the following way, but in all cases, the limit to inclusion at point of entry might be:
   • Whether the individual is likely to be able to benefit from some of the distinctive features of the village, in particular:
     • having their own self-contained accommodation;
     • a tenancy or lease and control over who crosses their threshold;
     • the capacity to exercise choice, albeit with support and in small things;
     • the opportunities for social interaction, taking part in activities, access to the facilities.
   • These may be determined by:
     • the severity of their condition
• whether the levels of care and support available and their method of delivery are suited to the individual’s needs
• what impact offering them a place is likely to have on their neighbours and wider community

2.2.3. In addition the following need to be taken into account:
• the balance within the “support” group and the wider village community
• suitability of the scale and layout of the village for that individual
• whether the lifestyle suits and appeals to the individual

2.2.4. The village does not normally aim to cater for people with dementia, although there are 7 people with the condition living there (3 diagnosed and 4 undiagnosed). There are circumstances where people with dementia may not be excluded, one such being when they are one of a couple. This is very important since it enables couples to stay together with support who may otherwise have to separate.

2.2.5. Pivotal in all this is a skilled holistic assessment and ensuring assessors and applicants have a good understanding of what is on offer. “On paper, people who appear unsuitable have been offered places and done very well. It’s a fine judgement” (Trust staff member)

2.2.6. The fact that the ECCT seeks to limit the entry of people with dementia “causes social services commissioners a headache”, but seems a sound policy.  
• The village scale and layout appear less than ideal for people with dementia to move to because:
  • Distances are great
  • Orientation is difficult
• The apartments are not arranged in small clusters with access to a nearby communal lounge, which would enable staff to keep an eye on the people with dementia whilst not involved in activities – and this pre-supposes that they all lived in the same cluster which brings its own issues, since people with dementia and learning disabilities tend to be stigmatised
• People with dementia risk loneliness and isolation as their condition worsens, unless they are already very much part of the community, or if staff are able to devote the time to encourage and enable participation

2.3. Levels of Need Once Living at Reeve Court

2.3.1. Once people are living at Reeve Court, the Trust appears to have made a commitment to enable them to live there for life. This is not deliverable in all cases and some “support” residents have had to move elsewhere, not necessarily from choice but because their needs could no longer be met – 3 people. This has applied to people whose dementia meant that the environment was no longer safe and to those who needed specialist dementia care. As with point of entry, the need to move elsewhere will depend on individual circumstances.

2.3.2. Since it opened, 19 people have continued living at the village until death; of these it is not known how many died in hospital and how
many died at the village. It is certainly the case that terminal care is provided in some cases. At the time of interview with the Manager of the Support Team a lady in Band 5 who was dying was being nursed at Reeve Court.

2.3.3. The Enriched Opportunities Programme is likely to prolong the ability of very vulnerable residents to continue living at Reeve Court and derive benefit from doing so. It remains to be seen whether any of them will need to move to more specialist care or whether they will live out their days at the village.

2.4. Couples

2.4.1. The village is particularly suitable for couples where one has care needs. The availability of two-bedroomed properties enables care to be delivered at night while the carer sleeps. The carer can receive support in his/her caring role and both can participate in the life of the village. There are a number of couples at Reeve Court to whom this applies, and it is interesting to note that some carers are active volunteers.

3. RESIDENTIAL CARE

3.1. Current Position

3.1.1. Band 4 is the one most closely equivalent to residential care. It is described slightly differently in the care contract and St Helen’s Extra Care & Support Service Referral Policy and Procedure. The following is extracted from both:

- Level 4 (High Levels of personal care, support and assistance)
- Minimum 22 hours and maximum hours equivalent or comparable to Residential Personal Care per week.
- Mobility plus ADL score of over 35
- For service users who need frequent assistance or supervision throughout the day to monitor their safety and well-being
- Support staff will interact with the service user between 4 & 10 times per day with activities requiring significant staff involvement on 3 or 4 occasions
- Hourly monitoring
- Assistance with the use of the hoist or assistance by more than 1 member of staff (There is some inconsistency in these definitions since the detailed breakdown in 4 refers only to moving and handling with a hoist and cites two to transfer as one of the extras in Band 5)

4. Does the village support people who would otherwise be in residential care?

4.1. There is absolutely no doubt that the village can and does support people who would otherwise be in residential care. Indeed, it houses 21 people who moved to it from care home settings.

4.2. Of the two people interviewed who had moved from residential care, one had lived in residential care for eight years and had been at the point of moving
into a nursing home because of complex health needs. The other had been in residential care for many years following a stroke. Not only was the village more than capable of meeting their needs; as explored in Section 3, their sense of well-being, choice and control has been transforming. (See quotes S3 page 8)

4.3. As described in Section 4, allocation to bands is not based solely on the amount of personal care needed. Levels of guidance, supervision and tendency to use the pull cord also come into play, so it is not possible to quantify from the HH1 form how many of the people in Band 4 would otherwise be in residential care. It is clear that 7 of the 12 in that band had planned care at night and additional unscheduled calls took place. Thus the likelihood is that they would be in a care home if they were not in Reeve Court. Also, some people who came to the village from residential care may be in other bands, having either regained some independence or now needing nursing care.

4.4. Whether Reeve Court could be a complete replacement for residential care is a different question. As a Social Services interviewee put it who has experience of both residential care and Reeve Court: “My Mum has dementia and is in a residential home. She couldn’t cope here. Some of the ladies at her home couldn’t cope here. They couldn’t cope with the size; the forceful characters. Because of that they might become more socially isolated. This way of living is not for everyone”

4.5. So what are some of the criteria for differentiating between potential residential care candidates who would thrive in the village from those who would not?

4.6. Again, this has not been specifically spelt out by the Trust or St Helen’s, but some of the factors may be:

- The motivation to live as independently as possible, and the likelihood of benefiting from a setting which promotes this
- Being stimulated rather than daunted by the scale of the village, the range of facilities and the activities
- Being attracted to, or at least being able to hold their own – albeit with support – within a fairly large, heterogeneous and at times quite lively community
- Being attracted to the lifestyle in general
- Not needing close round the clock supervision
- Not having a dementia or other conditions which may result in becoming isolated or having difficulty orientating
- Being capable of summoning help if needed

4.7. In conclusion, then, Reeve Court does support people who would otherwise be in a care home, but it is not a complete replacement for residential care, or smaller/different models of housing with care.

5. NURSING CARE

5.1. The current position

5.1.1. Level 5 caters for people who need a high level of personal care, support and assistance, advised and led by a domiciliary nurse
5.1.2. A minimum of 22 hours and maximum hours equivalent or comparable to nursing and personal care per week led by a domiciliary nurse.

5.1.3. Mobility plus ADL score of over 45 and health needs requiring the care plan to be advised and led by a domiciliary nurse.

5.1.4. In addition to the tasks outlined for band 4, level 5 might include:
- Daily assistance with eating of a special diet by one-to-one feeding and monitoring nutrition and fluid intake
- Artificial feeding supervision
- Two-person transfer
- Assistance with waterflow and tissue viability and the use of appropriate equipment
- Wound care management as required
- Organisation of speech and physiotherapy as required
- Intervention for diabetes management
- Palliative care as appropriate
- 3-monthly well-being checks

5.1.5. There are three qualified nurses who work on a rota basis during the day.

5.1.6. They provide the professional supervision and nursing care while the residential support workers deliver the personal care.

5.1.7. Nursing staff are not on site overnight but are available on-call.

5.2. Does the village support people who need more nursing care than could be provided by peripatetic staff in the wider community?

5.2.1. The answer to this question is almost certainly “yes”, but lies more in the way the care can be delivered than in the total amount of care. As described when considering value for money to the PCT, exactly the same tasks can be covered but in a more flexible, responsive way.

5.2.2. Nurses are on site to respond to calls on their handsets. They can see someone several times a day if necessary without travelling as a district nurse would have to do. Sessions can be shorter but more frequent if that is needed, with additional ones being slotted in as necessary. Minor changes in someone’s condition will register with this pattern of service delivery, and treatment can be varied accordingly very promptly.

5.2.3. With the best will in the world, a district nursing service could not be as flexible, responsive and cost-effective.

5.3. Does the village support people who would otherwise require nursing home care?

5.3.1. The staffing of band 5 would not fulfil the requirements for a nursing home and the Trust does not see Band 5 as a substitute for nursing homes.

5.3.2. That said, there are people being cared for within the band who would in all likelihood be in a nursing home, and, as described when considering value for money, they are arguably better off at Reeve Court than in a nursing home. They have their own self-contained property and all the opportunities for social interaction and participation that Reeve Court offers. The fact that somebody might
otherwise be in a nursing home for health care reasons does not necessarily mean they are incapable of using and enjoying the facilities at Reeve Court.

5.3.3. Exactly how many residents would otherwise be in a nursing home is not clear.

5.3.4. The HH1 form indicates that every resident in level 5 receives planned care at night, and most have used the care call system day or night – a few quite frequently.

5.3.5. A Social Services interviewee familiar with some of the residents said she could “think of at least two who would have to go to a nursing home but benefit more from being here. They are better off here than in a nursing home or their own home in the wider community”. The same staff member praised one of the nurses particularly, saying: “She looks at the person holistically. She knows everything about them. There is such a relationship of trust. That’s the sort of care I would want for myself.”

5.3.6. The “Support” team manager was asked to look at the people in Level 5 and say which ones in her opinion would be in a nursing home. Her list contains 12 names. Whilst that is her sincerely held professional opinion there may be a degree of subjectivity in that estimate. Such assessments are not an exact science. The figure is somewhere between 2 and 12.

5.3.7. Band 5 appears to deliver a particularly good and valued service for people who need intensive help with nursing care and supervision. But, as with residential care, band 5 cannot be seen as a complete substitute for nursing home care, and it has its limitations:
- It is not suitable for people who need intensive 24 hour nursing care
- Someone who is bed-bound or house-bound at point of entry with no prospect of that position changing at Reeve Court may be better off in a nursing home. People can become quite isolated in a large village if they can’t get out
- It is probably not suitable for people with extreme challenging behaviours and severe mental health problems that are not liable to improve in this setting or be managed by treatment

5.3.8. The skill of the assessor mentioned at the beginning of this section is particularly critical when considering applicants to band 5.

5.3.9. Some people are nursed at Reeve Court until they die, but no-one has been assessed for continuing health care at the village.

5.3.10. As a Trust interviewee put it:

“Although there are people here who would be in nursing homes, there are people in nursing homes for whom this is not suitable”
SECTION 5 B

COMMUNITY MIX AND EXPECTATIONS

To what extent does the mix and balance of ages and abilities contribute to the well-being of the village community as a whole?

1. CURRENT PROFILE

Number of Residents

- On 12th December 2007 there were 260 residents

Age profile

- The age profile for 254 of those residents was:

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<th>NUMBER</th>
<th>PERCENTAGE</th>
<th>TARGET PROPORTIONS</th>
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<tr>
<td>55 - 64</td>
<td>24</td>
<td>9.45</td>
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<tr>
<td>65 - 74</td>
<td>77</td>
<td>30.31</td>
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</tr>
<tr>
<td>75 - 84</td>
<td>97</td>
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<td>28%</td>
</tr>
<tr>
<td>85 - 94</td>
<td>53</td>
<td>20.87</td>
<td>30%</td>
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<tr>
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<td>3</td>
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<td>10%</td>
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</table>

254 98.82 100%

Social grouping

- 54 couples
- 2 sets of siblings
- A family of three
- 1 mother and daughter
- 108 single women
- 35 men

Gender

- 167 women
- 90 men
- Remaining 3 not known

Tenure

<table>
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<tr>
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<td></td>
<td></td>
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<tr>
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<td>52</td>
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<tr>
<td>Shared owner 75%</td>
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<tr>
<td>Shared owner 50%</td>
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</table>

Number of volunteers

- Approximately 65 residents
- Approximately 65 non-residents
Support Group Bands November 2007

<table>
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<th>Actual no:</th>
<th>Block</th>
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</tr>
<tr>
<td>Band 3</td>
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</tr>
<tr>
<td>Total</td>
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2. INTRODUCTION

2.1. The following discussion links in to Section 3 on Health and Well-being, in particular Paragraph 6.3 on residents’ sense of inclusion and belonging to a community (S3 p12).

2.2. The aim of the retirement village is to have a mix of ages, backgrounds, needs and abilities. In the information which goes out with the application forms it is described thus:

“The village aim is to have a spread of age ranges and care needs, from those with no needs to those with very high ones, and it aims to reflect the diverse population of St Helen’s.”

2.3. The original Lettings Policy says: “The village will cater for all levels of physical ability from the fully able to the very frail. It will offer a home for life by providing facilities that transcend disability backed up with a flexible service which adapts to individual need.”…“The aim is to promote a balanced community, which will reflect both age profiles and the abilities of individuals.”

3. DISCUSSION

These are noble aspirations. Do they work? The picture is very complex.

3.1. Retirement village or nursing home?

Of the half-dozen or so residents who specifically requested informal interviews, most had done so to air their views about the community mix (and /or value for money issues which will be dealt with elsewhere). The thrust of their concerns were as follows:

3.1.1. They had been misled as to what to expect, or not given a full picture.

- One of the strands of this argument was that the term “retirement” implies a) people who have been working and b) that they have stopped working recently. Thus they did not expect such a significant number of older, frailer residents or people who had never worked owing to disabilities.
- Furthermore, they were not told that there would be people with learning disabilities and dementia. They drew attention to
someone with learning disabilities who was “creating havoc” for his/her neighbours, and they viewed people with dementia as being unsuitably placed and at risk of going out and getting lost.

- It had not been brought to their attention that those in the youngest age bracket, i.e. 55 – 60s would not be fit and able but would have disabilities.
- Promise of a home for life. As one resident put it, “I was told I could be here until my dying day. I chose to come here because I was promised I would be looked after for the rest of my life and I really don’t want to end up in a nursing home. I was not told that I would have to pay extra for my care if I needed it.”
- Most claimed to be unaware of the block contract with Social Services – either that it existed, or that it was limited to 70 people at the most. They were also therefore unaware of how it potentially benefits them in that they can access care (not just hands-off support) in an emergency. They did understand that they would be able to have care if they needed it but not the process for getting a care package.
- At presentations before Reeve Court opened, people gained the distinct impression that this was a private development, not an environment where “welfare cases” would be living.

3.1.2. There were too many people with care and support needs, and too many people using wheelchairs and electric buggies in the village, putting off visitors and potential applicants. “We’re virtually falling over them” and “There is a widely held view amongst those who do become more actively involved that St Helen’s uses it as a dumping ground”

3.1.3. People were coming in to the village who already needed residential or nursing home care when they arrived.

- There is a perception that people who are sick and bed-ridden, even in hospital beds move in to the village, some of whom die soon afterwards. Whilst it was accepted that villagers may progress to this level of need, those expressing this view felt that people should not be coming to the village at this stage

3.1.4. The population was growing older and not enough younger fit people were coming to the village.

“we don’t seem to be getting young retired couples. This started off as a retirement village and it’s turning into a hospital”

3.1.5. One person suggested that Arena and ECCT should select applicants on the basis of their willingness to participate and volunteer.

“I don’t think they’ve got their selection procedures right. They don’t seem to get people in who want to volunteer.”
3.2. Analysis

3.2.1. Were they misled?

3.2.2. This question is hugely difficult to judge and the answer may be yes and no.

- The Powerpoint presentation from when the village was being promoted prior to opening says under the heading “Provision of Care and Support” – “The Village is geared to provide care and support for up to 1/3 of its residents. The provision will range from help around the home for some, to the equivalent of full nursing care for others.”
- There is no doubt that there is truth in what the Trust representatives say about the initial process for raising awareness of the village – that an enormous amount of effort was put into informing people what to expect realistically, especially at question and answer sessions. Rumours were tackled head on. It was pointed out that one-third of the community would be on “support” and that, for example, some people using the restaurant may need feeding.
- However, it is also very likely that the range of disabilities encompassed under the notion of those with “support needs” including those with mental health problems and learning disabilities would not have been made explicit. Written information seems to refer only to people with physical disabilities.
- Not everybody will have attended these sessions.
- It is possible too, that the need to balance giving a realistic picture with marketing the properties may have resulted in gloss or exaggerated claims being made in some areas while others may have been played down.
- It is also true that people listen selectively and hear what they want to hear. Whilst not all the written material used at the time has been made available for this research, it is possible that it provided less information than was actually presented verbally, and that some details necessary for enabling an informed choice were not included.
- The wording of the lettings policy around “home for life” certainly comes across as a promise, not a determined aspiration which is all it can be in reality.

3.2.3. Is their perception about community mix correct?

- The age profile outlined above shows that there are fewer people in the older age groups than the original target groups and more in the younger age groups. This has not however, been tied in to which of the younger cohort are part of the “support” group. Nevertheless purely in terms of age, perception and reality do not tally.
- Is there an increasing number of people receiving support, and of these are there more in the higher need levels? The reality is that the number of people in the “support” group has remained fairly
constant rising to a maximum of 72 for a brief period. There are a greater number of people in the lower 2 levels of need than the block contract prescribes (36 instead of 30) and fewer in the upper 3 levels (32 rather than 35).

- Is there a growing number of wheelchairs? Probably, although the numbers are not known. Not everyone using a wheelchair has “support”. It would appear that if mobility is limited, some people who can manage short distances using a walking stick or frame, cannot manage the long distances in the village. They then make the choice to buy buggies.

- Are new people joining the village sick and in hospital beds? “Support” staff refute this assertion saying that whilst this would not be ruled out in certain circumstances, it hasn’t happened yet.

3.2.4. So what is going on?

- It is quite likely that those in the “support” group and wheelchairs are particularly visible for a number of reasons. Unlike their fitter fellow-residents many are unable to leave the village without assistance or special transport, and so are restricted to using village facilities and participating in village activities. That is what these exist for.

- Then there is a relatively small group of people who are active as volunteers and in interest groups in the village, and it is a number of these who seem the most vocal regarding the village becoming a “nursing home.”

- Probably the majority of residents get on with their own lives, taking part – or not – in a cross-section of the activities, facilities and services on offer, but are invisible for the rest of the time behind their own front doors or out of the village.

3.2.5. Legitimate concerns or fear and prejudice?

3.2.6. The answer to this question too is quite complex and appears to be a combination of both.

- Volunteering - It is certainly true that the village relies very heavily on volunteers in all sorts of ways, described in the section on “Health and Well-being”. It is also clear that these residents are genuinely concerned about the flow of volunteers, and perhaps feel that they do more than their fair share while others don’t do enough, although this particular gripe was not verbalised. However, on balance it would seem that the concerns expressed have more to do with erroneous perceptions and prejudices than with the flow of volunteers. Firstly, many volunteers come from outside the village. They make an extraordinary contribution and help to dissipate some of the insularity to which a closed community is susceptible. Secondly, the assumption that young, newly retired residents moving in would necessarily contribute to the life of the village in this way may well be flawed. As one of the Resident’s Association representatives put it, “it has nothing to do with age. It is entirely a mind and fitness thing. There are a lot of younger ones who don’t want to do it”.
• The impact on attracting other fit, able residents – This may be a legitimate concern, and depending on how the village population needs-profile changes over time, may become an increasing issue. However, nobody really knows at this stage. At present, “there is a waiting list to fill the village twice over” although their age and ability profile is not known. It is also unclear what impact other developments currently in the pipeline in St Helen’s will have.

3.2.7. So, whilst there may be legitimate concerns, they are undoubtedly mixed with a significant degree of disillusionment deriving from unfulfilled expectations, intolerance, and possibly not wanting to live side-by-side with reminders of their own possible decline in health.

3.2.8. People within the “Support” group are made to feel like second class citizens by some of this vocal group. As one “support” resident put it, “we have a little clique here you know. They tend to take over the place, I’m only the ordinary class, I’m not the elite”... “the ring leader picks on me. She bullies me, but I can give as good as I get.”

3.2.9. A dialogue between two support residents also illustrates the point:

Resident 1: “Does your face fit, YY. Mine doesn’t”
Resident 2: “No mine doesn’t”
Resident 1: “Shall we put masks on then?”

3.2.10. A number of people not involved in either group have commented on the nastiness and intolerance of one or two people.

“I don’t like it when some people are nasty to others. One lady told XX off for wearing slippers in the lounge”.

3.2.11. Croucher et al (2007) found that attitudes towards disability and illness did vary across schemes, and in some places attitudes echoed those at Reeve Court. “The non-disabled people thought the disabled people should be somewhere with more care. Conversely, the disabled people thought the non-disabled people did not need to be in a ‘place like this’” In other schemes where a number of people had moved from care homes, “the integration between fit and frail seemed to work very well”.

3.2.12. Prejudice does not only relate to disability. It has to do with socio-economic status and education as well. A number of people who have disabilities and are in wheelchairs, but do not currently receive “support”, are totally accepted.

“Would you see a doctor and his wife moving here? Intelligent, professional people are deterred from applying because of the bingo type of activities and insufficient cultural ones.”

3.2.13. Allied to this are finance and tenure-triggered tensions amongst some residents. Indeed one interviewee who rented her apartment was quite concerned that her status as a tenant was known to the interviewer.
until it was explained that this was not common knowledge but part of the criteria for inviting her to interview.

3.2.14. Purchasers were seen by some to see themselves as having more rights and "lording it" while purchasers thought renters were better off financially because they were on benefits.

"Some people outside don't want to buy in to the village because they don't want to live alongside renters" were some of the comments made by purchasers. These tensions too are not unusual in mixed tenure developments.

3.2.15. Croucher et al (2007) found that “In those schemes where some residents might be self-funding and others in receipt of means-tested benefits, friction between those receiving benefits and those not were consistently reported.”

3.3. How prevalent are concerns about community mix?

3.3.1. It is interesting that of the 11 formal interviewees, six expressed the view that more younger, fit people were needed in the village to do the volunteering, and that the village was becoming like a nursing home.

3.3.2. Of these six, two were in receipt of "support" and in wheelchairs themselves. The "support" interviewee who dubbed the group a clique and said how disgusted she felt by their views towards people with learning difficulties, also said that the views were expressed by a small number of people. She thought that the clique who were “taking over” numbered no more than 20 people.

3.3.3. Those residents who felt that the balance of the community was about right, reinforced the point that these views were manifest amongst a small proportion of residents, not the majority. The interviewees from the Residents’ Association shared this perception.

3.3.4. It is not possible, without surveying every resident, to state with certainty how widespread these feelings and concerns are. It certainly came across as a strongly held, if not statistically significant, view and some people in the “support” group certainly felt “picked upon” by a handful of people.

3.3.5. The situation can probably be characterised as: a visible “support” group, a strident minority, and a silent, invisible majority who don’t feel affected and have little interest in the issue either way.

3.4. How is it being handled?

3.4.1. The manager and other staff members appear to do their best to deal with issues as they arise, try to clarify where perceptions are not valid, and to engender a sense of understanding and tolerance amongst the chief complainants.

3.4.2. They also work hard to support and encourage “support” residents to participate in opportunities to have their say, emphasising to them that
they have just as much right to contribute and be listened to as other residents.

3.4.3. Not many “support” residents participated in the Millionaire’s game in which villagers were asked their views of the services they receive. The manager therefore arranged to meet with groups of support residents to obtain their views and encourage participation in future opportunities.

3.4.4. One professional interviewee outside the Trust commented that the staff dealt with the tensions quite well.

3.4.5. One or two people expressed the view that some of the niggles were allowed to drag on for too long before they were tackled or resolved. It is an ongoing process, and as one staff member said, “you will never achieve the perfect village.”

3.5. Conclusion

3.5.1. With one exception only, even the most vocal critics of the community mix (and financial matters to be addressed later) derived benefit from being there and did not regret moving to Reeve Court.

3.5.2. The answer to the following question is not clear: Is the notion of a balanced village community which reflects a mix of backgrounds and abilities a microcosm of any community, anywhere (bar the age element), or is it a construct and ideal of well-intentioned professionals?

3.5.3. In the context of selection criteria, Croucher et al (2007) make the point that within the schemes they reviewed “none of the schemes could meet all the needs or preferences of the various people we met across different settings. Those schemes that would only accept people with clearly defined care needs were unable to accommodate those people who were seeking to plan for the future, or were primarily seeking somewhere to live. Other schemes required residents to be independent at least at the point of entry, thus the very frail would be unlikely to be accepted. Others required residents to have certain levels of income.”

3.5.4. Reeve Court is quite unusual, not only because it is trying to accommodate all these differences, but also because it is doing so within an integrated model, with people of different needs, backgrounds and tenures scattered across the village. It appears to work, but not without community tensions.
SECTION 5C
CHANGING NEEDS OVER TIME

• Can the mix and balance of ages and abilities be maintained over time?
• What are the implications if the rate of deterioration outstrips the vacancy rate?

1. CURRENT POSITION

1.1. There are a number of aspects to these questions. Movement into and out of the block contract for care, and movement in and out of the village.

1.2. Of the last 25 people to form part of the block contract, 14 were already resident at the village and 11 moved in from the wider community.

1.3. When the village opened, the people within the “support” contract accounted for 53 rentals and 17 sales. 19 of the rental units have been vacated since, and have been let to 10 people with care needs and 9 without. Of the 4 units that have become available for sale, 3 have been taken by non-care applicants, and one is in the process of being sold. None of the 27 general voids which have arisen has gone to “support” applicants.

1.4. In other words 12 of the original care spaces in the block had been filled by existing residents, so reducing the number of “support” incomers to the village by 12.

2. DISCUSSION

2.1. These figures demonstrate that the village is fulfilling its purpose in providing for the care needs of villagers as they arise. Out of the 14 village “admissions” to the block, most were to level 1. Five of these had care for a short period following an acute episode such as fall and hospital admission, and then became self-supporting again. One of the 14 was to a level 5 – a gentleman at the village who had a heart attack and stroke followed by a fall.

2.2. What these figures also show is that over the three years the village has been open, some of the residents have required care, making that care capacity unavailable to new referrals from the community.

2.3. Availability of Properties for Applicants with “Support” Needs

2.3.1. In order to maintain the overall two-thirds/one-third balance, that is as it should be. The balance is helpful in maintaining a vibrant community, particularly so in the ECCT model of retirement village. This report has described the strength of feeling amongst residents in relation to the importance of fit, able people moving to the village from the wider community to take over from those becoming frailer. The implications of this may be that over time, all new properties end up being offered to people who do not have care needs.

2.3.2. It is difficult to predict with any certainty when or whether this will happen, but there seem to be only two solutions to this particular dilemma at Reeve Court – to increase the overall number receiving “support” thus shifting the balance, or for St Helen’s to accept that
whilst fewer new applicants with care needs can move in to the village, they are enabling people to continue living independently in their own homes.

2.4. Rate of Decline Within the Village

2.4.1. It goes without saying that existing residents will grow older. It is also true that people stay fit for longer – particularly in an environment like Reeve Court. Will the rate of decline be matched by the number who die or move away? If not this can impact the village in three ways:

- The needs profile within the block can alter. This may require an alteration of the number in each band and additional staffing, but would not necessarily affect the two-thirds /one-thirds ratio. Tweaking arrangements in relation to Level 1, and access to low levels of care on a temporary basis, is likely to create a bit of room for manoeuvre within the block.

- The number of properties becoming available for “younger” fitter people to move in could be affected, thereby upsetting the balance and potentially reducing the attractiveness of the village to the very people it would be seeking to attract. (The emphasis here should arguably be on fitness rather than age. “The age where people consider themselves old is getting later and later. It therefore may be unrealistic to expect people in their 60s to want to move”)

- More than 70 people living at the village could come to require care. Some interviewees saw this as inevitable, and just a matter of time – though what length of time is not clear. Others said that this was not inevitable. ECCT staff pointed to Berry Hill which has been open for 10 years and where the age profile and care to core ratio has remained fairly constant.

2.4.2. There appears to be little research evidence on this topic.

2.4.3. A study was undertaken at Berry Hill between 2001 and 2003 (Bernard et al 2004). The timing of the “waves” is not absolutely clear from the report but it appears that in snapshots taken over a two year period, the proportion of residents receiving “support” went from 28% through 34% to 31%.

2.4.4. At Hartrigg Oaks village, which has been going for ten years “the number of households requiring domiciliary support has remained relatively stable over time” (JRF representative). Whilst data is available on the changes in levels of domiciliary support to the households, the specific circumstances in relation to the pattern would make a comparison invalid. What their data does show is that the health issues at point of entry affect the amount of care needed later on.

2.4.5. So there is no absolute certainty that at some point in the future, more than 70 households will need ongoing “support”. If that point does come, there appear to be only two possible solutions:

- Increase the number receiving care - whether through the block or some other means, that would still alter the ratio, or
- Agree criteria for asking people to move from the village
2.4.6. It is to be hoped that this situation won’t have to be faced, but if it is partners will have to agree what approach to take. Given the commitment to providing a home for life and the fact that leases and tenancies offer security of tenure, people could not be forced to move out. Perhaps the former option would have to be the way forward. It is likely that at that point, the view of the critical residents will be different because it is they who need the help.

2.5. Implications for Future Developments

2.5.1. What are the implications of all of these issues for future developments? The current issue is bound up quite closely with the ethos of this particular model of retirement village. Possibilities for future developments may be:
- Larger developments (commensurate with sufficient demand to justify the size) so that the proportion on “support” starts off smaller and has room to grow over time if necessary
- Starting off with fewer in the higher bands and more in the lower bands
- Developments the same size or smaller, but where less emphasis is placed on the actual ratio, and more emphasis placed on people coming in from outside to do the volunteering
- A different ethos which encourages active ageing and participation but lays less emphasis on attracting a totally fit cohort, so that the range is between very high and low care and support needs rather than none
- Continuing along similar lines in the knowledge that no model is perfect and the dilemma around the size of the block has not so far had to be faced – and may not be

2.5.2. All models have their pros and cons. This model is very good at what it does, but because people’s needs and preferences differ, it makes sense anyway to have a diversity of models and provision from which to choose.
SECTION 6
CONCLUSIONS

1. Overall, Reeve Court provides a really good service to most of the people who live there. In assessing its performance against the White Paper and DCLG outcomes it would be fair to say that it:

- Succeeds in optimising health and emotional well-being for many of the people who live there, with some evidence to suggest that well-being outcomes may better for those in receipt of “support” at Reeve Court than might be expected from domiciliary care in the wider community. Such benefits are attributable to the synergistic effect of the all aspects of living at the village, not just the “support” service.
- Appears to improve the quality of life for many residents, giving a wide range of opportunities to achieve and enjoy, and supporting vulnerable residents to do so.
- Gives exceptional opportunities for residents to make a positive contribution.
- Largely optimises choice and control – in relation to daily life and in terms of service delivery where care and support are involved – with the possible exception of self-payers of the support charge, who, given a choice may opt out of paying the charge and risk the associated loss of entitlement to service.
- Protects people as far as possible from discrimination and harassment though it does not totally succeed in this.
- Upholds personal dignity and respect in the way services are delivered and staff relate to residents.
- Contributes greatly to residents’ safety and security, both physically and psychologically.

2. The picture in relation to economic well-being is less clear. On balance, Reeve Court appears to provide value for money both to those on benefits and to self-funders, but with a few caveats regarding the latter. If the partners ensure that access to benefits advice is clear to all, that costs are kept to a minimum and made transparent, and surpluses are fed back in to the scheme, then they are doing as much as can reasonably be expected to promote economic well-being.

3. The current arrangements for commissioning “support” are an important contributory factor in the delivery of a flexible, person-centred service in which residents feel they exercise choice and control. The predictability of the commissioning arrangements also make it easier for the Trust to deliver the wide range of services which contribute to residents’ well-being whilst providing value for money to St Helen’s Council compared with care in alternative settings.

4. Individual budgets will need to be introduced with a great deal of care and thought in order to ensure that the current benefits to residents do not get undermined by fragmentation of services or inadequate funding levels.

5. Value for money to residents who are assessed to pay for their own care in the lower two bands is less clear than to those in the upper bands, and the bands need re-definition to make their costs align more closely and transparently with the range and level of services provided. This is particularly important with the advent of individual budgets.
6. Reeve Court accommodates people with an unusually wide range of abilities, from those who are completely fit and independent at one end of the spectrum, to those with nursing needs at the other. Some people who live there would almost certainly be in residential or nursing homes if Reeve Court didn’t exist, and they derive many benefits which would not be available in most care homes.

7. It also caters for people from a variety of backgrounds and socio-economic statuses. This diverse range of people are housed within an integrated model. There are community tensions but these are probably not atypical. They are tackled appropriately by staff and are outweighed by goodwill and the sense of a thriving, active community.

8. Over the years that Reeve Court has been open, fewer people with care needs have moved in to Reeve Court than have vacated properties. This has enabled care to be provided to existing residents without increasing the size of St Helen’s block contract. There does not appear to be sufficient evidence to draw conclusions as to what might happen in the more distant future, although evidence in Trust villages so far suggests that the rate at which residents decline and need care does not outstrip the rate at which others fall out of the block contract, enabling the ratio to remain the same.

9. Priorities for action include:
   • Jointly developing a commissioning approach compatible with “Putting People First” which maintains or strengthens the current good record on personalisation, well-being, choice and control outcomes. Assuming bands continue to apply, this needs to include re-alignment of band costs with services.
   • Continuing work to promote inclusion and tolerance within the community.
   • Jointly developing written information on Reeve Court for applicants and residents.
   • A number of practical measures: seating areas along streets, and wire shopping baskets.

Reeve Court is not for everyone, and the positive outcomes will not apply in every case. It is a life-style choice and potential applicants need to understand what that lifestyle involves. Certain aspects of the village – the age profile, its scale and design, the emphasis on participation and activity – are better suited to the needs and preferences of some people than others. But for those that it suits, it provides safety, security, friendships, community life, excellent facilities, tailored accommodation, and access to a wide range of services, all of which effectively combine to support and promote health and well-being, probably prolonging independent living.
LIMITATIONS OF THIS STUDY

It was the purpose of this evaluation to provide sound and useful information to the stakeholders and others in improving current services and shaping future ones. The methodology was chosen to suit the resource and time frame of the study. It is fit for purpose but has some limitations:

- Use of second-hand data sources has meant that some of the material turned out to be different from what was expected and not always sufficient or complete. For example, hard data on health and well-being outcomes turned out to be narrower in focus than originally anticipated.
- It has not always been easy to obtain the information needed for this study, and some has simply not been obtained, reducing the level of certainty in some areas.
- Formal tools have not been used to measure a range of parameters.
- Only a sample of residents’ voices has been heard directly – some self-selected. Whilst a range of staff and resident interviews and surveys have captured many perspectives either first or second-hand, without interviewing every single resident, it has not been possible to ensure that a comprehensive picture has been gained.
- In addition to defined issues, open-ended questions were used to identify further themes and concerns. Time and resource constraints have restricted the depth to which some of them could be further investigated.
- Within the current uncertainty around how personal budgets will be implemented nationally and locally, making cast iron recommendations has not been possible.
## GLOSSARY OF TERMS

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Arena</td>
<td>Arena Options is a subsidiary of, and managing agent for the Arena Housing Group. Arena Options incorporates what used to be St Helen’s Housing Association. The term “Arena” will be used where it is not necessary to distinguish between the Group and its subsidiary.</td>
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<tr>
<td>ARSC</td>
<td>Accommodation-related service charge</td>
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<tr>
<td>Care</td>
<td>Personal care which forms a significant part of St Helen’s block contract with the ECCT</td>
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<tr>
<td>Core group</td>
<td>Those residents who do not receive “support”</td>
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<tr>
<td>Extra Care and Housing with Care</td>
<td>Terms used interchangeably to refer to housing schemes which provide on-site round the clock care and support</td>
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<tr>
<td>Housing-Related support</td>
<td>Those aspects of support eligible for funding by Supporting People</td>
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<tr>
<td>Support</td>
<td>Generic term for any form of general support</td>
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<tr>
<td>“Support”</td>
<td>When used in the context of St Helen’s care contract, it is used to refer to whole service commissioned by St Helen’s and denotes the more holistic approach contained within the contract. It is the term used by the Trust in preference to “care”. When used as a description of the service provided by the “Support Team” it covers all the support provided to residents by that team including care, housing-related support, more general support and encouragement.</td>
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<tr>
<td>“Support” group</td>
<td>Those residents receiving “support” as part of St Helen’s block contract</td>
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<tr>
<td>The Trust</td>
<td>The Extra Care Charitable Trust</td>
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