Contact Consulting

Outline feasibility study and draft business plan for the future development of Protheroe House Sheltered Housing scheme

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v6.0

1 Overview and introduction

The provision of specialised housing for older people has a long history that may be traced back to the provision of almshouses from the Medieval period onward. In many ways the specifications have changed very little: modest in size, accessible, grouped together to provide some level of communal life and affordable.

In the twentieth century the most prolific form of specialised housing for older people has been sheltered housing.

The model that we now recognise as conventional sheltered housing began to emerge shortly after the Second World War. Growth during the 1950s was relatively slow, with perhaps 28,000 people living in sheltered housing by 1960. Most of the accommodation, in flats and self-contained bungalows, came from local authorities.

The first priority of post-war housing policy had been the clearance of damaged or unfit housing and the building of family accommodation. By 1960 the lack of balance in existing programmes was beginning to be recognised and greater emphasis was placed on providing accommodation for older people.

Official government policy began to encourage housing departments to build "accommodation mid-way between self-contained dwelling and hostels providing care." (Ministry of Housing and Local Government design bulletin (1958). The design guidance – accommodation for a warden, alarm system and a communal sitting room – reflected this 'hybrid' concept.

This guidance set the tone for the next thirty years. It suggested a model of housing which combines self-contained accommodation with communal facilities. Further, it advocated a particular model of community care which ensured that people move along a continuum of built provision as their need for care increases: moving from general housing to sheltered housing, on to residential care when care needs became more pronounced and, for some, on to nursing care, whether in a Nursing Home or in a long-stay hospital setting.

Two cornerstones of the vocabulary of sheltered housing were provided by the Ministry of Housing and Local Government circular 82/69 that set the pattern for the continuing rapid growth in provision in the 1970s.

This circular introduced the distinction between Category 1 schemes for more active elderly people and Category 2 schemes for the less active. This distinction still influences current designs and language. Category 1 schemes were seen as grouped self-contained housing designed especially for older people. Category 2 schemes included communal facilities, warden accommodation and office, an alarm system, a guest room, laundry facilities and a common room. It is this style of provision that we have referred to as "conventional sheltered housing".

These are the influences and assumptions that shaped the design, facilities and expectations of Protheroe House.

As tenant populations grew older, and the age for first admission to sheltered housing increased, providers began to recognise that the needs of their tenants could not be met within a conventional sheltered housing scheme with a traditional warden service. Whilst a traditional warden service and peer support among tenants could cope over a long period with one or two frail tenants in a scheme, or a slightly larger number for short periods, a situation in which a significant proportion of tenants needed care services posed difficulties.

Care often seemed to come into the scheme in an uncoordinated, almost haphazard way and the warden was left to cover the care gaps. From the early 1980s some providers began to develop schemes in which more coherent arrangements for care were negotiated with social service authorities and some additional facilities were introduced into schemes. Some experimented with the provision of meals, most looked to provide facilities for assisted bathing, treatment rooms and other specialised facilities.

These were known by a variety of titles including the ludicrous jargon of "category two and a half", placing them somewhere between conventional, category two, sheltered housing and residential care or Part Three homes. These schemes, some new build and others by the conversion of existing sheltered schemes, provided the first examples of Very Sheltered Housing.

As the need to respond to the needs of an ageing and frail population moved up the public agenda and the search for less institutional settings for care gathered pace, in the early 1990s Very Sheltered Housing began to attract attention.

The rising popularity of very sheltered housing coincided with a growing awareness among providers that conventional sheltered housing was beginning to run into difficulties. After two decades in which demand had consistently outstripped supply they began to encounter a fall off in demand for some of their schemes. The reasons for this fall off in demand were self-evident; many schemes were old, unattractive, in areas where local shops and other facilities had disappeared and access to transport was no longer easy. Many schemes offered very small, bedsitter accommodation. Some had shared bathrooms, a few even shared toilets. A number, especially those in the ownership of local authorities, lacked lifts and were generally inaccessible to potential tenants considering a move into sheltered housing at a later stage in their lives than had generally been the case in the 1960s and 1970s.

Through the 1990s policy and investment decisions at national and local levels began to be influenced by the general perception that in most parts of the country there was a sufficient supply of conventional sheltered housing but that opportunities existed to add to the stock of Very Sheltered Housing. This was substantiated in McCafferty's 1994 study for the Department of the Environment[1] that concluded that there was "a significant unmet need for very sheltered housing and a potential over-provision of ordinary sheltered housing".

[1] McCafferty P 1994 Living Independently: a Study of the Housing Needs of Elderly and Disabled People, HMSO

It was against this background that the model now generally referred to as Extra Care Housing has emerged.

Extra Care Housing aspires to offer more than accommodation and the prospect of access to care services: it looks to provide a positive lifestyle in old age. It will thus generally include imaginative communal facilities: exercise suite, hairdressing facilities, possibly a shop, art and craft rooms, a restaurant, a bar, internet connection and so on. This is will be provided within a culture of activity, learning and participation by those who live in the scheme.

Whilst there is no single definition of what constitutes Extra Care, the consensus view of most commissioners and leading providers is that it must provide:

- A basis of occupation that comprises ownership or tenancy.
- High standards of accessibility in individual dwellings, in common parts and in the outdoor areas of the development.
- The availability of care services, operated flexibly under a domiciliary care arrangement and offering the capability for 24/7 cover.
- Social, recreational, craft and cultural facilities and activities that offer opportunities for a stimulating lifestyle in old age
- The creation and maintenance of a balance in care needs among the population of occupants.

The Department of Health has been particularly active in promoting this style of provision, supporting a programme of capital subsidy that has encouraged the spread Extra Care Housing across England.

The size of Extra Care developments varies and whilst there is general agreement about the minimum number required to achieve viability in the provision of facilities and services some have developed “retirement villages” on the Extra Care pattern of more than three hundred units. Whilst most developments completed to date have been predominantly on a social rented basis the trend has been toward mixed tenure developments that reflect the diversity of tenure to be found within the older population.

2 Description of the alternative forms that might be developed

There can be never a direct correlation between a level of physical disability or capacity for self care of an individual and a particular model of housing with care. Experience suggests that some of the most disabled of individuals have continued to live and cope happily in their own homes without any inputs of formal care, as this was their choice and in many cases their determination. It follows that the appropriateness of the particular model of sheltered housing for an individual is as much influenced by the choice of the older person, their emotional commitment to that choice, their subjective assessment of its fit to their sense of wellbeing as any specific characteristics of the accommodation or care on offer.

Terms such as enhanced sheltered housing, very sheltered housing and extra care are used by some as interchangeable. Similarly there are many models of what could be called conventional sheltered housing, and people's understanding is coloured by the variant closest to their direct experience. We would maintain that there are significant differences in the capacities of so called conventional schemes dependent upon the configuration of the accommodation, the nature of call systems employed, the existence of resident or peripatetic wardens, cover arrangements and the integration or otherwise of warden services with a wider whole system of health and care.

<u>Conventional Sheltered Housing</u>

Itself not one model but many, as we argue above but currently the largest volume of housing with care in the UK. Just as bedsit schemes over recent years become increasingly difficult to let, so we believe much of the current conventional stock will not be the accommodation of choice for future generations for older people. The increased expectations of newly retired individuals and couples will not be met by the space standards and institutional design of much of the current stock built in the 1960s and 1970s. The ability of many retired people to stay put often in accommodation that they own is likely to exacerbate the current trend in many areas of the age of first entry to conventional sheltered housing increasing and therefore reducing demand. The increased availability of dispersed call systems and peripatetic support services is likely to further reduce demand. There is we would suggest a limited and shrinking future market for the conventional model which whilst offering increased security and a community of peers of similar age with the occasional input of warden activity as good neighbour does not offer access to future care per se.

However, we would argue that two factors will act to sustain the conventional model in the short to medium term. The first is the volume of tenants already in the system, a majority of whom will be able to stay put for the remainder of their lives with minimal inputs of care. The second is the increasing problems faced by care suppliers to deliver care in sufficient volumes to individuals in dispersed units of accommodation. The scarcity of home care in some areas with the consequent increases of cost of supply will probably leave some authorities to see sheltered housing as a "communal" and most cost effective solution to providing domiciliary care. Thus we would anticipate a greater or but inexorable move from the

conventional model as it assumes more of the characteristics of the enhanced model of sheltered housing.

Whilst the majority of developments that fall within the definition of “conventional sheltered housing” are offered on a rental basis they share many characteristics with the retirement housing developments offered by commercial developers such as McCarthy & Stone.

There is no reason, in our view, why conventional sheltered housing cannot provide a service to substantially disabled older persons provided the warden or scheme manager is seen as an integral part of the whole system and is able to access appropriate care and community health services for tenants. Breakdown is likely to occur where environmental constraints of the flat or scheme can no longer meet the needs of the tenant or where care cannot be delivered in sufficient volume or flexibility to individual tenants.

Enhanced Sheltered Housing

Again there are many variants of this models sometimes referred to as very sheltered housing and, mistakenly in our definition, extra care housing. The variants range from upgraded and adapted conventional sheltered housing with additional warden cover and enhanced access to care services to purpose built schemes with a dedicated but separately managed care team. There are also a wide variety of allocations formulae both for the initial admission of residents or tenants and for adjusting the care input during the period of residence or tenancy. We make the assumption that all will either be single storey or have a lift, and that all areas will be wheelchair accessible allowing ease of access and egress within the scheme. Most enhanced sheltered housing schemes aim for a balanced community and reflect this in their admission policy, often by use of a percentage allocation of low, medium and high care need tenants or residents in the scheme. Therefore these schemes are often extremely sensitive to changes in individual care needs placing pressure on the overall care resources available to the scheme.

Most local authority social services departments funding an enhanced sheltered housing will seek to contain their investment in care for an individual to a ceiling of the cost of alternative provision in residential or nursing home care. This current care cost equate to the provision of up to 23 direct care hours per week to an individual with high needs. In principle there is no reason why a person with the most extreme care needs could not be cared for in enhanced sheltered housing and many are. However, there is tension with the desire to maintain a balanced community, the pressure to contain care costs and the concept of enhanced sheltered housing as a home for life.

Whilst the majority of enhanced sheltered schemes are operated by local authorities and Registered Providers they broadly equate to models emerging in the private sector such as “Assisted Living” developments offered by McCarthy & Stone and Bovis Homes, among others.

Extra Care Housing

Of the three models examined extra care housing is in our view the most realistic alternative to residential care. It is characterised in our definition by being purpose designed to offer accessibility to the most physically disabled of tenants or leaseholders, communal facilities designed to enhance the wellbeing of residents and integration in a single scheme management of both the housing stock and care provision. Extra care housing will also usually encompass a philosophy and practice of utilising the skills and experiences of both staff and residents in the community to focus on enhancing the quality of life. Its focus and philosophy for residents is on enhancing their skills and capacity rather than their deficits.

Whilst many extra care housing schemes will aim to provide a balanced community by prudent management of the admissions policy it would not be normal to determine in advance any ceiling on care needs for an individual once admitted. The integration of management of care and environment allows the scheme manager flexibility in the management care resources. By the deployment of the total staff complement and knowledge of individual residents changing needs the optimum use of the resources allocated for the scheme can utilised. If the care needs of the community as a whole increase then clearly the allocation of resources need to be renegotiated with the care commissioner but generally the flexibility of the care service on offer is greater than in the enhanced sheltered housing model.

Care commissioners may still want to put a ceiling on the cost of care deployed to an individual, or to a scheme as a whole, and on occasions the scheme managers may feel that the amount of individual residents exceed the communities capacity to supply or respond. However, there is in principle no reason why an individual should need to leave extra care housing for residential care. Indeed, in the best examples of extra care housing we have seen that have dedicated input local community health staff it is possible to retain tenant or leaseholders who might otherwise but accommodated in nursing homes.

Care is provided through a domiciliary care team with a working base within the scheme, although their remit may include the delivery of care services into the surrounding neighbourhood. Registration with the Care Quality Commission is as a domiciliary care agency. The design of the service needs to reflect the registration requirements for domiciliary care and to avoid straying into areas that would require registration as a Registered Care Home.

The communal facilities in extra care housing usually exceed those found in conventional or in enhanced sheltered housing scheme and are focussed on the development of capacity rather than recreational. Therefore it is not unusual to see fitness suites, gymnasia, computer and educational facilities provided as well as them being the focus for the promotion of health in the local community. The “need” or “demand” for these facilities tends to drive up the optimum size of schemes. The economies of scale mean that it is highly unlikely that the level of required communal resources can be provided in schemes below the unit size of forty-five dwellings.

3 Illustrative materials

Figures One and Two set down the suggested areas required for the range of communal facilities and service facilities within a typical Extra care housing development.

Figure One – Communal Facilities and tentative space requirements

Facility	**Approximate space requirement**
Main communal lounge	1.5m^2 per resident
Dining area	2.0m^2 per resident
Residents Tea kitchen	10m^2
Exercise Suite	15m^2 minimum
IT suite or internet cafe	12m^2 minimum
Shop	12m^2 minimum
Library	12m^2 minimum
Small lounges or hobby rooms	15m^2 minimum
Communal WCs	4m^2 each
2 Assisted bathrooms (1per 60 units in Extra Care)	12 – 15m^2
Hairdressing and Beauty Therapy	12m^2 minimum
Informal seating spaces	3m^2 pr
Manager's office	12m^2 minimum
Guest room with en suite	20m^2
Laundry	30m^2
Sluice room	5m^2
Main catering kitchen and associated storage and staff facilities	55m^2
Cleaners storage	5m^2 each
General storage	15m^2 minimum
Refuse store	16m^2
Recycling collection point	6m^2
Electrical intake/ Meter room	10m^2
Store for electric pavement scooters with charging facilities	10m^2

Figure Two – Service facilities and tentative space requirements

Facility	**Approximate space requirement**
Care Staff office	15m^2 minimum
Staff overnight with en suite	18m^2 minimum
Staff rest room with kitchenette	15m^2 minimum
Staff locker/change room & WC	10^2

4 Need and demand for the provision

At this stage we have looked only at the potential need and demand for provision of this kind at a Borough level

The Office of National Statistics projects an increase in the population of older people within Haringey which is, compared with many parts of the country, relatively modest. However it is to be noticed that the oldest age group has the highest proportion of increase. It is in this age group that the potential demand for specialised housing and for care and support services is most marked, as is clear from Table 2.

Table 1 Population aged 65 and over, by age, projected to 2030

	2009	2015	2020	2025	2030
People aged 65-69	6,000	6,700	6,600	7,800	9,200
People aged 70-74	5,500	4,900	5,700	5,600	6,600
People aged 75-79	4,300	4,400	4,000	4,600	4,600
People aged 80-84	2,600	3,100	3,200	3,000	3,600
People aged 85 and over	2,300	2,400	2,800	3,200	3,500
Total population 65 and over	20,700	21,500	22,300	24,200	27,500

Figures may not sum due to rounding. Crown copyright 2008[2]

The profile of projected population increase among older people in Haringey is unusual in that the there is projected to be substantial increase in the youngest cohorts of older people (65-69 years), limited increases among those in their seventies and substantial increases for those in advanced old age. The most significant increases are among those in the oldest age group.

Table 2 Population aged 65 and over, by age, projected to 2030 as percentage change

	2009	2015	2020	2025	2030
People aged 65-69	0%	12%	10%	30%	53%
People aged 70-74	0%	-11%	4%	2%	20%
People aged 75-79	0%	2%	-7%	7%	7%
People aged 80-84	0%	19%	23%	15%	38%
People aged 85 and over	0%	4%	22%	39%	52%
Total population 65 and over	0%	4%	8%	17%	33%

Figures may not sum due to rounding. Crown copyright 2008[3]

Whilst in early old age there is no firm connection between chronological age and frailty or ill-health the connection becomes much stronger in later old age: from seventy-five years of age and especially from eighty-five upwards there is a strong

[2] Figures are taken from Office for National Statistics (ONS) sub national population projections by sex and quinary age groups. The latest sub national population projections available for England are based on the 2006 mid year population estimates and project forward the population from 2006 to 2031. Long term population projections are an indication of the future trends in population by age and gender. The projections are derived from assumptions about births, deaths and migration based on trends over the last five years. The projections do not take into account any future policy changes.

[3] As above

correlation between chronological age and the prevalence of various forms of physical and mental frailty, as later tables will demonstrate. A substantial increase in the number of those in the sixty-five to sixty-nine cohort may not have any substantial impact on the demand for appropriate accommodation and a range of care and health services. However the corresponding increase in the number of those eighty-five years of age or older will have a strong and direct impact on demand for these services.

Whilst in the past it has been received wisdom that the age profile of Ethnic Minority communities was younger than the White population and that demand for services related to advanced old age were therefore to be found only in very small numbers, this is no longer the case. Table 3 shows significant proportions of elders within both the Asian and particularly the black communities who are in advanced old age. This offers a challenge both in the provision of ethnically and culturally targeted provision but also in ensuring that all provision is sensitive to these needs.

Table 3 People aged 65 and over by age and ethnic group as a percentage of the total population of that age band, year 2007

	People aged 65-74	People aged 75-84	People aged 85+
White (this includes British, Irish and Other White)	70.08%	79.30%	90.83%
Mixed Ethnicity (this includes White and Black Caribbean; White and Black African; White and Asian; and Other Mixed)	2.00%	1.50%	0.91%
Asian or Asian British (this includes Indian; Pakistani; Bangladeshi; and Other Asian or Asian British)	7.22%	4.88%	2.52%
Black or Black British (this includes Black Caribbean; Black African; and Other Black or Black British)	18.48%	12.92%	5.26%
Chinese or Other Ethnic Group	2.22%	1.39%	0.48%

Figures may not sum due to rounding. Crown copyright 2008[4]

Figures in this table have not been projected forward as the figures would not be reliable.

The capacity for independence in old age is more frequently compromised among those living alone and therefore the increase in elderly single person households is a significant indicator of the need for specialised housing with support.

[4] Figures are taken from Office for National Statistics (ONS) Table PEEGC163, Ethnic group of adults by custom age bandings, mid-2007, and percentage of total population for each age group applied. This table is a commissioned table from the Population Estimates by Ethnic Group. The Estimates, released in April 2009, are experimental statistics. This means that they have not yet been shown to meet the quality criteria for National Statistics, but are being published to involve users in the development of the methodology and to help build quality at an early stage.
The wording used for ethnic groupings are as used by ONS.

Table 4 People aged 65 and over living alone, by age and gender, projected to 2030

	2009	2015	2020	2025	2030
Males aged 65-74 predicted to live alone	1,060	1,040	1,080	1,180	1,460
Males aged 75 and over predicted to live alone	1,258	1,394	1,462	1,598	1,700
Females aged 65-74 predicted to live alone	1,860	1,950	2,040	2,220	2,550
Females aged 75 and over predicted to live alone	3,355	3,416	3,477	3,843	4,087
Total population aged 65-74 predicted to live alone	2,920	2,990	3,120	3,400	4,010
Total population aged 75 and over predicted to live alone	4,613	4,810	4,939	5,441	5,787

Figures may not sum due to rounding. Crown copyright 2008[4]

Table 5 provides the rate for people living alone by gender within two broad age bands.

Table 5 Rates for people living alone are as follows:

Age range	% males	% females
65-74	20	30
75+	34	61

Source ONS Crown copyright 2008[5]

Table 6 provides information about the tenure mix among older people in Haringey but as tenure mix varies from area to area across the Borough we need to pay attention to more local characteristics and in the area of Protheroe House there are very high levels of social rented properties.

[5] Figures are taken from the General Household Survey 2007; table 3.4 Percentage of men and women living alone by age, ONS. The General Household Survey is a continuous survey which has been running since 1971, and is based each year on a sample of the general population resident in private households in Great Britain.
Numbers have been calculated by applying percentages of men and women living alone to projected population figures.

Table 6 Proportion of population aged 65 and over by age and tenure, i.e., owned, rented from council, other social rented, private rented or living rent free, year 2001

	People aged 65-74	People aged 75-84	People aged 85 and over
Owned	57.80%	51.90%	41.35%
Rented from council	23.11%	26.40%	27.81%
Other social rented	9.19%	8.28%	14.00%
Private rented or living rent free	9.90%	13.42%	16.83%

Figures may not sum due to rounding. Crown copyright 2008[6]

Figures in this table have not been projected forward as the figures would not be reliable.

Table 7 provides information about the number of people providing unpaid care in a range of circumstances. Supporting such informal carers through appropriate accommodation and services relieves upward pressure on the growth of formal care services.

Table 7 People aged 65 and over providing unpaid care to a partner, family member or other person, by age, projected to 2030

	2009	2015	2020	2025	2030
People aged 65-74 providing unpaid care to a partner, family member or other person	1,422	1,435	1,521	1,658	1,954
People aged 75-84 providing unpaid care to a partner, family member or other person	619	673	646	682	736
People aged 85 and over providing unpaid care to a partner, family member or other person	85	89	104	119	130
Total population aged 65 and over providing unpaid care to a partner, family member or other person	2,127	2,197	2,272	2,458	2,820

Figures may not sum due to rounding. Crown copyright 2008[7]

[6] Figures are taken from Office for National Statistics (ONS) 2001 Census, Standard Tables, Table S017 Tenure and age by general health and limiting long-term illness.

The terms used to describe tenure are defined as: Owned: either owned outright, owned with a mortgage or loan, or paying part rent and part mortgage (shared ownership). Other social rented: includes rented from Registered Social Landlord, Housing association, Housing Co-operative and Charitable Trust. Private rented: renting from a private landlord or letting agency, employer of a household member, or relative or friend of a household member or other person. Living rent free: could include households that are living in accommodation other than private rented.
The most recent census information is for year 2001 (the next census will be conducted in 2011).

Table 8 People aged 65 and over unable to manage at least one domestic task on their own, by age and gender, projected to 2030.

	2009	2015	2020	2025	2030
Males aged 65-69 unable to manage at least one domestic task on their own	432	480	464	560	704
Males aged 70-74 unable to manage at least one domestic task on their own	546	462	525	504	609
Males aged 75-79 unable to manage at least one domestic task on their own	684	684	612	720	720
Males aged 80-84 unable to manage at least one domestic task on their own	410	533	574	533	615
Males aged 85 and over unable to manage at least one domestic task on their own	544	612	816	952	1,020
Females aged 65-69 unable to manage at least one domestic task on their own	924	1,036	1,008	1,204	1,344
Females aged 70-74 unable to manage at least one domestic task on their own	1,160	1,120	1,280	1,240	1,480
Females aged 75-79 unable to manage at least one domestic task on their own	1,248	1,248	1,196	1,404	1,352
Females aged 80-84 unable to manage at least one domestic task on their own	1,072	1,139	1,206	1,206	1,407
Females aged 85 and over unable to manage at least one domestic task on their own	1,230	1,230	1,312	1,476	1,640
Total population aged 65 and over unable to manage at least one domestic task on their own	8,250	8,544	8,993	9,799	10,891

Tasks include: household shopping, wash and dry dishes, clean windows inside, jobs involving climbing, use a vacuum cleaner to clean floors, wash clothing by hand, open screw tops, deal with personal affairs, do practical activities

Figures may not sum due to rounding.

[7] Figures are taken from Office for National Statistics (ONS) 2001 Census, Standard Tables, Table S025 Sex and age by general health and provision of unpaid care. The most recent census information is for year 2001 (the next census will be conducted in 2011).
The term "unpaid care" covers any unpaid help, looking after or supporting family members, friends, neighbours or others because of long-term physical or mental ill-health or disability or problems related to old age. Numbers have been calculated by applying percentages of people providing unpaid care in 2001 to projected population figures.

Table 8 projects the numbers of older people unable to manage at least one domestic task and the rate at which those numbers will grow in the future. Often these deficits are in small tasks where appropriate support and accessible facilities will mitigate the effect. Some of those who experience these difficulties will currently be allocated to a care home setting where a more appropriate environment could be provided through Extra Care Housing with its flexible patterns of care and support.

Table 9 Rates for men and women unable to manage on their own at least one of the domestic tasks listed are as follows:

Age range	% males	% females
65-69	16	28
70-74	21	40
75-79	36	52
80-84	41	67
85+	68	82

Figures are taken from Living in Britain Survey (2001), table 37.
The prevalence rates have been applied to ONS population projections of the 65 and over population to give estimated numbers predicted to be unable to manage at least one of the domestic tasks listed, to 2030.

Table 10 makes similar projections in relation to difficulties with tasks of self-care where the same inferences may be drawn: accessible facilities and low levels of support, flexibly applied, can maintain the capacity for independence.

Table 10 People aged 65 and over unable to manage at least one self-care activity on their own, by age and gender, projected to 2030.

	2009	2015	2020	2025	2030
Males aged 65-69 unable to manage at least one self-care activity on their own	486	540	522	630	792
Males aged 70-74 unable to manage at least one self-care activity on their own	494	418	475	456	551
Males aged 75-79 unable to manage at least one self-care activity on their own	551	551	493	580	580
Males aged 80-84 unable to manage at least one self-care activity on their own	330	429	462	429	495
Males aged 85 and over unable to manage at least one self-care activity on their own	408	459	612	714	765
Females aged 65-69 unable to manage at least one self-care activity on their own	693	777	756	903	1,008

Females aged 70-74 unable to manage at least one self-care activity on their own	870	840	960	930	1,110
Females aged 75-79 unable to manage at least one self-care activity on their own	936	936	897	1,053	1,014
Females aged 80-84 unable to manage at least one self-care activity on their own	848	901	954	954	1,113
Females aged 85 and over unable to manage at least one self-care activity on their own	1,110	1,110	1,184	1,332	1,480
Total population aged 65 and over unable to manage at least one self-care activity on their own	6,726	6,961	7,315	7,981	8,908

Activities include: bathe, shower or wash all over, dress and undress, wash their face and hands, feed, cut their toenails, take medicines
Figures may not sum due to rounding. Crown copyright 2008

Table 11 Rates for men and women unable to manage on their own at least one of the self care activities listed are as follows:

Age range	% males	% females
65-69	18	21
70-74	19	30
75-79	29	39
80-84	33	53
85+	51	74

Figures are taken from Living in Britain Survey (2001), table 35.
The prevalence rates have been applied to ONS population projections of the 65 and over population to give estimated numbers predicted to be unable to manage at least one of the self-care activities listed, to 2025.

Table 12 projects forward the numbers of older people, by age and gender that may be living with a long-term limiting illness. The impact of such illnesses is often seen in a loss of mobility leading to social isolation. A more accessible and supportive environment can have a major positive impact on the quality of life of those living with long-term illnesses.

Table 12 People aged 65 and over with a limiting long-term illness, by age, projected to 2030

	2009	2015	2020	2025	2030
People aged 65-74 with a limiting long-term illness	5,142	5,186	5,499	5,991	7,064
People aged 75-84 with a limiting long-term illness	3,794	4,123	3,959	4,178	4,508
People aged 85 and over with a limiting long-term illness	1,413	1,474	1,720	1,966	2,150

Total population aged 65 and over with a limiting long-term illness	10,348	10,784	11,178	12,135	13,723

Figures may not sum due to rounding. Crown copyright 2008[8]

Depression has been identified as one of the major conditions to have a negative impact on the quality of life in old age. Living in a community, such as that created by Extra Care Housing, with access to a range of stimulating activities can help mitigate the prevalence of depression.

Table 13 People aged 65 and over predicted to have severe depression, by age, projected to 2030

	2009	2015	2020	2025	2030
People aged 65-69 predicted to have severe depression	150	168	165	195	230
People aged 70-74 predicted to have severe depression	88	78	91	90	106
People aged 75-79 predicted to have severe depression	151	154	140	161	161
People aged 80-84 predicted to have severe depression	78	93	96	90	108
People aged 85 and over predicted to have severe depression	90	94	109	125	137
Total population aged 65 and over predicted to have severe depression	556	587	601	660	741

Figures may not sum due to rounding. Crown copyright 2008

Table 14 Rates for people diagnosed with severe depression are as follows:

Age range	% people
65-69	2.5
70-74	1.6
75-79	3.5
80-84	3
85+	3.9

For source see footnote[9]

[8] Figures are taken from Office for National Statistics (ONS) 2001 Census, Standard Tables, Table S016 Sex and age by general health and limiting long-term illness. The most recent census information is for year 2001 (the next census will be conducted in 2011).
Numbers have been calculated by applying percentages of people with a limiting long-term illness in 2001 to projected population figures.

[9] Figures are taken from McDougall et al, Prevalence of depression in older people in England and Wales: the MRC CFA Study in Psychological Medicine, 2007, 37, 1787-1795.
The prevalence rates have been applied to ONS population projections of the 65 and over population to give estimated numbers predicted to have severe depression, to 2030.

The marked increase in the number of people living into advanced old age carried with it a projection of increases in the numbers of those living with dementia. Whilst Extra Care Housing may not be a suitable environment for all those living with dementia it can be designed to provide a "dementia friendly" environment in which those developing initial symptoms, and others whose behaviours never become extreme or disruptive, can be successfully supported without recourse to placement in a registered care home. There is a strong emerging argument for Extra Care Housing to be augmented with small specialised units of accommodation that will support those with advanced dementias and provide positive options both for those living with dementia but also their spouses, partners and carers.

Table 15 People aged 65 and over predicted to have dementia, by age and gender, projected to 2030

	2009	2015	2020	2025	2030
People aged 65-69 predicted to have dementia	74	82	80	96	114
People aged 70-74 predicted to have dementia	150	135	154	149	179
People aged 75-79 predicted to have dementia	253	253	236	278	271
People aged 80-84 predicted to have dementia	315	359	382	372	432
People aged 85 and over predicted to have dementia	536	555	640	729	800
Total population aged 65 and over predicted to have dementia	1,327	1,384	1,492	1,623	1,796

Figures may not sum due to rounding. Crown copyright 2008

Table 16 Rates for men and women with dementia are as follows:

Age range	% males	% females
65-69	1.5	1
70-74	3.1	2.4
75-79	5.1	6.5
80-84	10.2	13.3
85+	19.7	25.2

For source see footnote[10]

[10] The most recent relevant source of UK data is Dementia UK: A report into the prevalence and cost of dementia prepared by the Personal Social Services Research Unit (PSSRU) at the London School of Economics and the Institute of Psychiatry at King's College London, for the Alzheimer's Society, 2007.

The prevalence rates have been applied to ONS population projections of the 65 and over population to give estimated numbers of people predicted to have dementia to 2030.

To calculate the prevalence rates for the 85+ population, rates from the research for the 85-89, 90-94 and 95+ age groups have been applied to these age groups in the total England population, in order

Table 17 projects the numbers of older people likely to be experiencing difficulties with their mobility. Well designed, spacious and accessible environments, such as that offered in an Extra Care scheme can help mitigate the impact of disabling environments on those who are experiencing mobility challenges.

Table 17 People aged 65 and over unable to manage at least one mobility activity on their own, by age and gender, projected to 2030.

	2009	2015	2020	2025	2030
People aged 65-69 unable to manage at least one activity on their own	513	573	556	667	784
People aged 70-74 unable to manage at least one activity on their own	724	668	762	736	882
People aged 75-79 unable to manage at least one activity on their own	732	732	687	807	786
People aged 80-84 unable to manage at least one activity on their own	644	727	774	756	879
People aged 85 and over unable to manage at least one activity on their own	1,030	1,065	1,220	1,390	1,525
Total population aged 65 and over unable to manage at least one activity on their own	3,643	3,765	3,999	4,356	4,856

Activities include: going out of doors and walking down the road; getting up and down stairs; getting around the house on the level; getting to the toilet; getting in and out of bed
Figures may not sum due to rounding. Crown copyright 2008

Table 18 Rates for those who are unable to manage at least one of the mobility tasks listed are as follows:

Age range	% males	% females
65-69	8	9
70-74	10	16
75-79	12	21
80-84	18	29
85+	35	50

Figures are taken from Living in Britain Survey (2001), table 29.
The prevalence rates have been applied to ONS population projections of the 65 and over population to give estimated numbers predicted to be unable to manage at least one of the mobility tasks listed, to 2030.

to calculate the total numbers in each age group, and then divided into the total 85+ population to establish the predicted prevalence of the 85+ population as a whole.

5 Staffing and management arrangements

Good practice suggests that however services are procured it is preferable that there should be an on-site manager with overall responsibility for the operation of the development. It is this Manager who will co-ordinate the input from a range of partner organisations and contractors and carries the overall accountability for the operation of the development to residents and other stakeholders.

Cleaning staff and support staff will normally come under the direction of this manager.

The key staffing element will be the provision of a domiciliary care service within the scheme able to offer 24/7 cover. The benefit of an on-site team is in the flexibility it provides. It creates the capacity to offer very small interventions: escorting people to social activities for example, which would not be viable for a visiting service.

Whether provided by an in-house provider unit or an external partner the service will need to be financially viable: this is generally calculated to be achieved through the delivery of around four to five hundred hours of care per week. If the demand for care generated within the development is insufficient then the team might provide outreach to people living in the surrounding neighbourhood.

The provision of catering may be arranged through the employment of staff, which would then come under the direction of the manager, or be provided by contractors.

If the Council looks to undertake this development in partnership with another organisation then it may hand over concerns for the provision of services and their management to the partner.

6 Meeting the regulatory requirements

All staff coming into contact with residents will need clearance under the new Vetting and Barring regulations, once they come into force. Although Government is currently reviewing the extent to which the vetting and barring requirements should apply it is likely that any changes to the scheme will be to remove some categories of volunteers, rather than professional staff, from its orbit.

The delivery of care will be regulated by the Care Quality Commission, the organisation providing the service being registered, the manager of the care services being personally registered and the service being open to inspection.

If the development is managed by a partner organisation that is a Registered Provider then that organisation will be regulated by the Tenants Services Authority (TSA) in relation to all areas of its operations, policies and performance.

7 Implementation and time line

We would suggest that there are a number of stages to implementing a vision for the future of Protheroe House:

	Stage or task	By whom	When
1	To accept the option appraisal as the basis for consultation and development.	Project Team / Senior Officers	August
2	To agree re-provision through Extra Care scheme on the Protheroe House site as the preferred option.	Project Team / Senior Officers	August/ September
3	To prepare illustrative materials for use in consultation and to test feasibility of fitting ECH scheme of this scale onto this site.	Consultant	August
4	Consultation with Protheroe House tenants.	RG & Consultant	August
5	Clarify the availability of capital funds.	NP	August
6	Incorporate emerging thinking from Extra Care group led by Adult Social Care.	Consultant (?)	September
7	Review proposal in the light of appraisal of other sheltered scheme(s) under review.	Consultant / Project Team	September
8	Consult with potential RSL partners.	NP / Consultant (?)	October
9	Revise Option Appraisal document to incorporate the results of foregoing steps.	Consultant	September
10	Prepare Committee report	NP & colleagues	September
11	Secure agreement on option to be pursued.	NP with Cabinet Lead / elected members	October / November
12	Engage in public consultation.	Officers	December to February (?)
13	Secure partnership agreement to re-develop the site.	Officers	March
14	Prepare application for planning permission.	?	?
15	Tender for the demolition and building work.	Partners with Officers	?
16	Prepare and implement plan for re-location of remaining tenants, including individual care, support and re-location plans.	Officers	?

17	With partners, appoint contractors.	Partners with Officers	?
18	Start on site		?
19	Build period		? but about 15 months

8 The nature of Protheroe House

Protheroe House represents a classic Category Two sheltered housing scheme of its period. Originally provided with accommodation for a warden to live on site, with a good sized common room and a limited range of other communal facilities it would have been regarded as a good practice design when first opened. The finishes to the corridors and communal; areas give a utilitarian aura to the scheme but this would have been fashionable at the time Protheroe House was designed. Built round a grassed courtyard with a secure perimeter the footprint of the building would have been regarded as best practice for an urban setting. The forty-two one bedroom flats, all of sizes that we would now regard as "modest", are typical of the period.

Whilst still valued by tenants who have lived there for a number of years Protheroe House has, by a number of objective measures, reached the end of its useful life.

Work by the Housing Quality Network that contributed to the Haringey Council Sheltered Housing Options Appraisal completed in August 2009 concluded that:

> "*The scheme is poorly laid out, poorly designed and does not use the space effectively."*
>
> *"The scheme has relatively high costs for refurbishment and would cost an enormous amount of capital resources to improve to a fully modern standard in terms of layout and space."*
>
> *"Running costs are high for Homes for Haringey in terms of repairs and utility costs are both high for residents and are being supported by the remainder of the HRA."*

The scheme is not attractive to new tenants and the level of void properties is likely to rise. New allocations are not currently being made to Protheroe House whilst its future is under review.

Apart from more detailed concerns around accessibility, thermal efficiency and so on Protheroe House presents two major challenges: the individual dwellings are too small and the range of facilities too limited.

Whilst the second of these might be addressed through re-modelling and extension the first cannot. The construction and configuration of the building would be unlikely to offer opportunities for internal re-modelling that would lead to a satisfactory outcome.

The level of expenditure required to effect such changes would not in any event represent value for money as the outcome would be a compromise at best.

9 The opportunities presented by the building and the site

The building has a limited potential for alternative uses: the deficiencies identified in the preceding section suggest that it would only be suitable for short-term occupation and that the costs of maintaining it, let alone bringing it to an adequate standard would be disproportionate.

If Protheroe House is decommissioned as sheltered housing and vacated then it might be used for some other client groups as part of a pathway into permanent housing but could not itself offer a long-term accommodation solution.

The site is roughly rectangular with a total area slightly in excess of three thousand square metres. The current building is of two and three storeys and a new building of three to four storeys would be proportionate to neighbouring development.

The developable area of the site is compromised by the presence of a number of mature trees along one boundary of the site and, depending on the view taken by planners, may reduce the developable area by as much as 20%. On the other hand the trees add to the amenity of the site and a sympathetic development is likely to be enhanced by their retention.

The location of the site has a good deal to recommend it: it is close to a main thoroughfare which provides access to shops, other amenities and to public transport routes. Standing about fifty metres from the main road and adjacent to a major residential development the site may be seen as highly desirable for housing development. The current uses of some nearby premises may lessen the attractiveness and amenity of the site slightly.

Although the current buildings offer limited options for future use the size of the site and its location make it attractive for re-development: re-provision of specialised housing for older people, other specialised social housing development or a small development of social housing would all be possible uses. It is conceivable that a private developer might also have an interest in building housing for open market sale on the site but it may be a little small to attract that interest and the location might not be the first choice within the borough for such a project.

As the current use of the site is for specialist housing for older people we have considered the options for re-provision of housing for older people on the site.

10 Identification of the preferred option

The provision of further conventional sheltered housing within the Borough is not suggested as a priority. Whilst an important and valued part of the offer made to older people conventional sheltered housing addresses the needs of a shrinking proportion of the older population. Older people prefer to stay in general housing for as long as possible and average ages, both on moving to sheltered housing and among the established population of sheltered housing schemes, are rising. With an increased average age comes a higher level of frailty and an increase in the requirements for support and care. The conventional sheltered housing model is not sufficiently robust in supporting a population where significant needs for care and support are more than exceptions to a general level of independence.

The enhanced sheltered model offers a narrower range of facilities and services than Extra Care Housing and is thus slightly less expensive to build. Because its services are viable with smaller numbers the development can be smaller in size and thus less demanding of site size. Against that it does not offer the stimulation and flexibility in support and care of Extra Care.

To meet the aspirations of a rising generation of older people and the flexibility of a model that can deliver care and support to enable older people to "age in place" the Extra Care model has much to recommend it. Estimates of the minimum scale of development to achieve viability in the provision of care services and for a sustainable catering operation have gradually moved upwards and many would now say that around forty-five units, with an implied population of fifty-five to sixty people is required if the development is to be viable.

At this scale and with the range of communal facilities expected of an Extra Care scheme such a development is demanding of space and will require a total floor area in the region of five thousand square metres. If we make the assumptions that the footprint of a new building on the Protheroe House site would not exceed fifty percent of the area of the site (allowing not only for the trees but for open space within the development and the possibility of limited parking spaces), and that development might go to three storeys with some four storey areas then an Extra Care development of forty-five units would just fit on this site.

Whilst one might modify the total floor area required, for example by altering the mix of one and two bed properties (working on the assumption of $55m^2$ for one bed and $65m^2$ for two bed) and kept the communal facilities to a slightly more restricted range then the fit between the size and limitations of the site and the requirements for such a scheme would be moderated.

Re-provision through the development of an Extra Care Housing scheme would offer the best solution if it is achievable: it offers a high quality, stimulating environment to older people in the Borough, it has the flexibility to offer support and care so that occupants may "age in place" and as a model is likely to be sustainable in the longer term.

The value of adding Extra Care Housing to the mix of options available to the older citizens of Haringey has already been recognised by the Council and the provision of

new extra care homes is identified as an investment priority within Haringey's draft Borough Investment Plan with the Homes and Communities Agency (HCA).

We identify a total of ten possible options available to the Authority:

	Option	**In favour of that option**	**Against that option**
1	Maintain Protheroe House in the Council's management as Sheltered Housing	Least disruption for existing tenants. Limited capital investment compared with most other options	Increasing void risk and revenue deficit. Fails to meet decent homes standards. Not a solution for medium and longer term
2	Transfer Protheroe House to the ownership / management of a Registered Provider as sheltered housing.	Minimise disruption for existing tenants. Risk and losses transferred to third party. Possibility of small capital receipt (?)	Unlikely to find a credible partner willing to take on the challenges Protheroe House brings. Loss of control of current and potential provision. May need a dowry to persuade a partner to take it (?)
3	Demolish and re-provide Protheroe House as Sheltered Housing on the same site.	Would provide continuity in style of provision, especially for current tenants who may chose to return. Least expensive of re-provision options in terms of capital.	Conventional sheltered housing for rent already in over-supply. Significant capital investment needed for a style of provision of limited flexibility.
4	Invest to upgrade Protheroe House to Enhanced Sheltered Housing within the current building envelope	Allows continuity for current tenants. Limited capital investment. Provides some additional capacity to cope with more frail tenants.	Fundamental design problems with Protheroe House remain. Internal re-modelling likely to reduce number of units to a point where services are not viable.
5	Demolish and re-provide Protheroe House as Enhanced Sheltered Housing on the same site.	Because footprint of Enhanced Sheltered is less than Extra Care would certainly fir onto site. Would add to capacity to support a more frail tenant population appropriately.	Almost as expensive as re-provision as Extra Care but much less flexible. Difficulty in assembling capital funding package.
6	Demolish and re-provide as an Extra Care Housing Scheme on the current site in partnership with	Would help deliver the Borough's Extra Care aspirations in an area of high need. Would provide a flexible capacity to meet a variety	Ability to fit an Extra Care scheme of a viable scale onto this site dependant on planning constraints. Difficulty in assembling capital funding package.

	an RSL	of needs	
7	To dispose of the property on the open market and re-invest the proceeds in a specific Extra Care development on another site	If the alternative site were already in the Borough's ownership then this receipt would provide a further element in the capital funding package.	Unless the alternative site were nearby would remove capacity to support frail older people from an area of significant need.
8	To dispose of the property on the open market and re-invest the proceeds the Extra Care development programme generally	Would provide flexibility in developing the Borough's Extra Care programme.	Would remove capacity to support frail older people from an area of significant need.
9	Retain Protheroe House in the Council's management but for an alternative client group.	Would re-deploy the asset to meet other needs with limited requirement for investment.	No suggestion that accommodation of this style and scale would be appropriate to an alternative identified client group. Problems in meeting Decent Homes Standard would remain.
10	Transfer Protheroe House to the ownership / management of a Registered Provider but for an alternative client group.	Would re-deploy the asset to meet other needs without the Borough accepting risk or capital investment requirements.	No suggestion that accommodation of this style and scale would be appropriate to an alternative identified client group. Unlikely to find a credible partner willing to take on the challenges Protheroe House brings. May need a dowry to persuade a partner to take it (?)

In summary the options may be presented as:

1. Retain Protheroe House with minimal investment
2. Retain Protheroe House but invest in upgrading and re-modelling
3. Transfer to an RSL for up-grading and re-modelling
4. Demolish and re-provide as Extra Care Housing
5. Demolish and partner with an RSL to provide Extra Care Housing
6. Dispose of site and take a capital receipt

The questions facing the Authority are in three parts:

- What to do with Protheroe House?
- What to put in its place?
- How is that to be achieved?

The elements to be considered in evaluating the principal options are:

- The ability to appropriately meet the current and future needs of older people in that part of the Borough
- The fit to the overall strategic direction for future provision for an ageing population.
- The impact on revenue and capital budgets.
- The impact on the current residents.

	Meeting need	Strategic Fit	Capital and revenue budgets	Impact on current residents
Retain with minimal investment	-	-	-	+
Retain but invest in upgrading and re-modelling	-/+	-/+	-	-/+
Transfer to an RSL for up-grading and re-modelling	-/+	-/+	+	-/+
Demolish and re-provide as Extra Care Housing	+	+	-	-
Demolish and partner with an RSL to provide Extra Care Housing	+	+	+	-
Dispose of site and take a capital receipt	-	-	+	-

11 Conditions necessary to deliver that option

Apart from the political will to proceed with the closure of Protheroe House the principal condition required to deliver a new Extra Care housing development on the Protheroe House site is the availability of the significant amount of capital required. A broad estimate would be in the region of six to seven million pounds and the extent of mortgage borrowing that might be set against that could be serviced from rental income would be unlikely to exceed thirty-five to forty percent or two and a half to three million pounds.

To deliver the development and to operate it the Council will need to develop partnerships, either internally or with external partners: to undertake the re-development of the site, to provide the estate management and support functions, to deliver a catering service, to provide a flexible domiciliary care services, and to support the range of social, cultural and recreational activities within the development.

12 Outcome of consultation

The current tenants of Protheroe Housing have been engaged in a process of consultation about the future of the site. They have now been consulted on the specific matters contained in this draft. Whilst accepting of the fact that Protheroe House was to close they were distrustful of the outcome of re-provision and anxious about the timing of arrangements for their re-settlement. Concerns were voiced about the space standards and facilities that would actually be delivered in a re-provided scheme. Frustration at the slow pace in resolving their immediate concerns about their re-location made it difficult for them to engage with the details of what might be available in a new facility on the site. Whilst they were not hostile to the proposals it would be right to characterise their reaction as sceptical.

As a result of the individual evaluations and discussions with tenants it appears that the over-whelming majority currently aspire to return to Protheroe House when it has been re-built. Some may form attachments to the accommodation to which they move in the interim and change their minds about returning but it seems l;ikely that a significant number will wish to transfer back.

13 Benefits to the organisation and other stakeholders

For the Council the re-provision of Protheroe House with a forty-five unit Extra Care Housing development would replace a potentially expensive sheltered housing scheme that is increasingly hard to let with an attractive and flexible new facility that will offer a sustainable range of options to older people in this part of the Borough.

For the current tenants of course the prospect is mixed: whilst in the medium term they can be offered accommodation on the same site that will be more spacious, attractive and appropriate to their needs they have to face leaving their existing homes and living through a period of displacement. The disruption and uncertainties connected with that process will need considerable sensitivity and support.

For the Council in its adult social care function the existence of a further Extra Care development will offer a more flexible option for supporting the independence of a range of vulnerable older people in an attractive and stimulating environment.

14 Level of fit to strategic objectives

The provision of an Extra care development on this site offers a high degree of fit to the strategic objectives of the Council:

- It will offer a quality option to older people in that part of the Borough.
- It will encourage and facilitate the maintenance of independence in old age.
- Poor quality housing stock will be replaced by high quality stock.
- The thermal efficiency and ecological impact of the new building is likely to be a major improvement over the existing building.
- An additional facility will have been added to the locality and, through access to the communal facilities and activities, the options available to older people in the surrounding area will have been enriched.
- The Council's objective of offering older people in Haringey high quality services and options within the area in which they live will have been facilitated.

The option of developing a forty-five unit Extra care Housing scheme on this site has a high degree of fit to the strategic and policy objectives of Haringey Council.

15 Options for establishing the initiative

The options available to the Council are heavily constrained by the current national and international economic situation and the impact which that will have on the available of public subsidy for new schemes for the next number of years. Whilst the operational costs may be argued as representing value for money when compared with alternative outcomes: an increasing number of older people being supported in residential care homes, finding the capital required is clearly a major challenge.

In theory at least Haringey Council could undertake the development and deliver the services itself, retaining full control over every aspect of the development and its eventual operation. This would of course require the Council to find the whole capital and to carry the whole risk. On both counts this may not be desirable, or even feasible. In the current financial climate it is difficult to avoid the conclusion that this is not a viable option.

The Council may look for a Registered Provider to enter into partnership, perhaps in some form of joint venture into which Haringey Council would contribute the land and some capital and the Registered Provider would raise a mortgage and input the balance of capital, perhaps drawn from other profitable developments that could generate a surplus.

Alternatively Haringey Council could provide the land and some capital, leaving it entirely to the Registered Provider to carry the development and operational risk but retaining some control through the operation of nomination rights.

A partner organisation may be willing to cross-subsidise the new development from schemes elsewhere in their portfolio. If achievable on appropriate terms, that is without compromising the fundamental features of the proposed scheme, this may be an attractive possibility.

In some situations the arrangements might include offering some units for sale on a leasehold basis to recover a proportion of the development cost. An example would be that in a development of forty-five units with an overall development cost of £6.75 million the proportion of cost attributed to each unit would be £150,000. If ten units were sold at, say £200,000 this would contribute £2 million to the development cost. However in this location it seems that the development would most appropriately be offered on a social rented basis.

A further option to get the scheme built would be a partnership with a commercial developer who would provide the development finance and build the scheme. The overall cost is likely to be rather higher by this route by all concerns for funding the initial development costs would sit with the commercial partner. The Authority, or its partner organisations that would provide long-term management, would need to find the capital finance to acquire the completed development.

16 What funds will be required?

In broad outline we would estimate that the build cost for the scheme we have described would be in the range of £6.5 to £7 million, depending on the detail of design and that the other costs (architects and specialist consultants, fees and other on costs) will add a further £1 million.

A more detailed account of the likely capital costs can be provided when the number and mix of units, the scale of communal provision and the assumption that tenure will be wholly social rented have been agreed.

As we have suggested above the likely stream of rental income, after allowing for housing management costs and other items to be set against rent, would be likely to support a mortgage of around two million pounds.

17 Capital Funding in the current climate

Until recently the Authority might have looked to central government to provide a substantial measure of subsidy, either through the Housing Corporation/Homes and Communities Agency or the Department of Health's programme to encourage the development of Extra Care Housing. The prospect of securing the level of funding required from the HCA seems remote in current circumstances and the funding programme from the Department of Health will not be renewed.

Whilst the development of new Extra Care Housing is identified as an investment priority within the draft Borough Investment Plan agreed with the HCA the current reductions in public finance make the availability of substantial capital resource from this direction extremely unlikely.

One option would be to reduce the capital requirement by selling a proportion of the units but it seems unlikely that such an offer would be successful in this part of the Borough and the overwhelming need in the area is for high-quality older person's provision on a social rented basis.

The clear implication is that, apart from any funding that a Registered Provider or other charitable partner might contribute, the scheme will need to be internally funded. Given the vulnerability of the client group, the potential future savings in both capital and revenue budgets when compared with retaining the current Protheroe House this initiative must have a high claim on Haringey Council's limited capital investment programme.

The other major sources to be considered are capital receipts from Section 106 contributions from commercial developers across the Borough (although this would require a policy decision to prioritise this scheme to receive those contributions) and from the disposal of one or more of the other sheltered housing schemes recognised as approaching the end of their useful life.

The challenge of assembling the scale of capital funding needed for a development of this size is considerable. We would identify five principal potential sources of capital that the Council might assemble without reliance upon HCA Grant:

- An allocation from the Borough's Capital Investment Programme
- The contribution of the value of the land at nil cost.
- A mortgage to be serviced from rental income.
- Receipts from Section 106 "off site" contributions by developers.
- Capital receipts from disposal of other premises or land in the Council's ownership.

If re-provision is undertaken in partnership with a Registered Provider then additionally they may contribute:

- Capital from their own reserves.
- Receipts from the disposal of land or premises in their ownership.
- Cross-subsidy from the development of properties by the Registered Provider for sale or rent at a premium.

Whilst unusual the third of these options has been floated by One Housing within a discussion about the ways in which they might work in partnership with the Borough to facilitate the development of further Extra Care schemes.

If the Council is able to clarify its intentions in relation to the site and identify at least some of the potential sources of internal capital funding suggested above then this would provide the basis for conversations with a number of potential Registered Provider partners to see what they might be prepared to bring to the table.

18 Risks and mitigation

This section provides the first draft of a risk register for this initiative. Probability of the risk and estimate of its seriousness are both scored on a scale from 0 to 5.

Risk	Probability	Seriousness	Possible mitigation
Failure to secure political support for the proposal	2	5	Ensure continuity of briefing to members, arrange visits.
Inability to find a willing and competent partner to develop the scheme	1	4	Develop business case and specification in collaboration with potential partner(s)
Detailed plan shows viable size of Extra Care development will not fit on site	2	2	Modify requirements and re-visit alternative uses for site. Consider disposal of site and transfer to alternative site.
Capital funding not available	3	4	Consider scope and timing of scheme
Planning permission refused	2	2	Work with planning colleagues from early stages of proposals.
Public campaign against proposals	3	2	Continue communication programme with residents and local residents.
Escalation in capital costs	3	2	Follow best practice in procurement and contracting. Review all elements of the scheme.
Dependency mix in the scheme too high and peer support and activity programme not sustainable	1	2	Ensure agreed allocation targets and procedures are in place before commissioning
Dependency mix in the scheme too low and care services not viable	1	3	Ensure agreed allocation targets and procedures are in place before commissioning
Catering service not viable	2	3	Achieve supply on basis of low threshold of take-up for viability.
Failure to attract sufficient applications to fill scheme	0	2	Ensure the model and its advantages are well publicised. Ensure affordability of all aspects of the scheme