

**A CARE TEAM FOR SHELTERED/RETIREMENT HOUSING – WORKSHOP**

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**REPORT**

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Extra care, or very, sheltered housing is, today, a preferred mode of providing accommodation for vulnerable older people. In 1994 the McCafferey Report claimed that there was “a significant unmet need for very sheltered housing”, though its claim that there was an over provision of conventional (Category 2) sheltered housing was perhaps coloured by the amount of difficult-to-let housing; potential tenants sought better quality homes but the overall demand for conventional sheltered housing has remained strong.

More recently, in early 2004, the Department of Health provided £87 million as capital funding for 16 new extra care schemes; there were over 200 applications for the awards; a further £60 million is promised for 2006-08.

Typically the extra care scheme has a dedicated care team providing care and support for 24 hours, 7 days a week, funded by Social Services but usually provided by a contracted care agency or provided in-house by the landlord. Rarely, if ever, does an extra care sheltered scheme provide outreach services within the locality. The scheme aspires to be a ‘home for life’, avoiding a later move to accommodation with more intensive care. Recent reports, both by independent researchers (eg: Brooks 2003) and by the landlords’ own satisfaction surveys indicate that extra care sheltered housing is generally successful and that it is popular with its residents.

But extra care sheltered housing still comprises only 5% of the total sheltered housing stock. Where does this leave the remaining conventional schemes - probably numbering well over 2000 and accommodating almost two-thirds of a million residents?

Their residents are ageing, an average of 80+ years is common. Existing residents become more frail as they grow older, new residents are more frail than those of a decade ago, many having chosen (or been allocated to) sheltered housing rather than a residential care home. Scheme managers frequently claim that they have as many frail and vulnerable residents as an extra care scheme. They too aspire to provide a ‘home for life’. But the care and support available within their scheme is highly fragmented and unco-ordinated; too many of their residents are obliged to move on to other accommodation.

This Workshop, the 33rd held by the Sussex Gerontology Network since 1992, sought to examine the manner by which care and support are delivered in conventional sheltered housing schemes and to see whether a move towards a care team approach is possible and feasible. This is not a new issue - many local authorities and RSLs have carried out their own pilot projects some of which have successfully continued, others have failed (for reasons to be suggested below). One obvious factor is the number of stakeholders involved - Social Services, Supporting People Teams, NHS Trusts, the Private Sector Care Agencies, RSL and LA Housing Managements, their sheltered scheme managers and residents. Desire for change by one set is so often frustrated by the problems perceived by others. The participants at the Workshop - 45 in all - represented each of these stakeholder groups. A pre-circulated Briefing Paper attempted to set out the issues to be raised during a day of presentations and dialogue.

## CASE STUDIES

The scene was set with the presentation of two case studies - one of a not-atypical conventional sheltered scheme, the other of a scheme recently upgraded to extra care. Both were selected 'at random' - their scheme managers are associated with SGN - and not because of any qualities displayed by the schemes.

### Daffodil Court (a pseudonym)

Daffodil Court is a small inner urban scheme opened 20 years ago. Today it has 25 residents - 19 women, 6 men - many of whom have spent many years there. Their average age is 80 years - 8 are over 80 years, 8 are under 75 years. Two residents are able to live quite independently, eleven receive support from family members (10) or a friend (1). The remaining 12 receive support by outside agencies, as follows:-

4 as Social Services Clients; \_ 2 receive support from one care agency (1-1 hour 3 times a week; 1-3 hours daily). The other 2 receive support from two different agencies (1-4 times daily). Two residents receive an hour a week from Supporting People project care workers. A Mental Health Team, the District Nurse, MacMillan Nurses. Age Concern, a private agency and a self-employed domestic help each support one resident.

Thus, 11 different agencies support 12 residents. The total weekly support given amounts to about 100 hours. This load is seen by the scheme manager as relatively light - six fairly dependent residents have died within the past nine months. Some of these visiting professionals and care workers will, on occasion, be providing care and support for which they have been professionally trained; but much of their work appears to be of a very general nature.

To any observer it would seem that such fragmentation is costly in terms of travel time; this is exacerbated in a rural area where care workers might be travelling 10 miles or more to visit a single client.

For the scheme manager several issues are regularly articulated:

**Security:** With perhaps over a dozen care workers entering the scheme each day (different workers may make the morning and evening visit) it is impossible to check their credentials. Most don't greet the scheme manager. In recent months bogus callers have claimed to be care workers

**Emergency and Short Term Help:** If any resident falls ill suddenly or needs convalescence, the scheme manager is unable to seek help from any of the care workers visiting the scheme - their contract is with a single client and they have no relationship with the scheme manager. The scheme manager is left providing the help needed or trying to facilitate alternative provision

**Flexibility:** A residents' needs can vary from day to day - but the contract specifies a fixed period of time and stated hours for a visit; this will not be reviewed probably for several months; yet residents frequently report truncated visits or late arrivals though, anxious not to cause trouble, they sign for the full and correct performance of the duty

**Residents Views:** The residents too are concerned by the security issues; their family members are worried by the apparent randomness of care workers visits and decide to provide the help needed themselves, often at a cost to personal relationships

### Croft House (also a pseudonym)

Croft House is a scheme in the centre of a thriving village. It was first built in the early 70's, refurbished in 1990 and upgraded to extra care in 2001. The scheme provides two daily meals, taken by most residents, most of the time. Other facilities include assisted baths, wheel chair store with charge up facilities etc.

Croft House has a little over 40 residents, many of whom have lived there since before the upgrade.

A single care agency provides support for all the residents who need it - whether supported by Social Services or paying privately. The team of 6 care workers, all of whom live in the village and most of whom have worked within the scheme for several years, also support a few residents in the village outside the scheme. The team supervisor works from an office in the neighbouring large town but makes a regular weekly visit to the scheme. The care team provides currently, about 100 hours day support together with 70 hours night sleep-over. The team is funded by Social Services through a block contract.

A very few residents receive specialist support from professional workers over and above that provided by the care team. If a resident becomes so highly dependent as to make "independent living" impossible, or if Social Services will not pay for the full range of services needed, a case conference is held to discuss a move to alternative accommodation.

The team members are, by rota, on-site from early to late morning and in the early evening with one member sleeping over. During the afternoon one of the two scheme managers is on-site and will deal with emergencies; if necessary they can call one of the care team to come in and help; in more difficult situations the supervisor can be contacted and she will if necessary contact Social Services, to ensure that support is immediately available.

The care team members work together closely; they share relevant information about the residents; they can adjust times and duties to suit a resident's needs; they will appraise their supervisor of any change in a care plan which they feel to be beneficial. The team is well known too to all the residents, whether receiving support or not; residents undoubtedly talk among themselves about team members. If they need short term help they will turn to the care team rather than to any other agency. (When the scheme was upgraded one resident chose to opt out of the care team's support, selecting another agency; within a few weeks she returned!)

Residents discuss the work of the care team both informally and formally; they will pass any complaints either directly to the supervisor or through the scheme managers. Scheme managers, their line manager, Social Services and the agency's supervisor hold regular meetings; but more importantly, they have close personal relationships and interact with ease.

### **Comparison**

The two schemes can hardly be more different. Yet the amount of day care provided in each is similar. Croft House shows that one does not have to provide the 300 hours often cited as a lower limit of viability of a care team. The issues of security, provision of emergency cover and flexibility cited in Daffodil Court are absent in Croft House. Workshop participants suggested that, with the close interaction between care team members, residents' rights to confidentiality might be more easily breached. But the care team members are trained to respect confidentiality and to share information only on a need-to-know basis. No such issues have arisen in Croft House in the past 3 years; there could be a greater likelihood of breaches with fragmented provision as in Daffodil Court.

## THE COMMISSIONING AND PURCHASING PROCESS

How has this stark difference in the manner in which care and support are delivered, as illustrated by our two case studies, come about?

The quite obvious answer lies in the processes by which care and support are commissioned, purchased and delivered. So many agencies are involved: Social Services provides care and support through in-house teams in the case of more specialised services and through contracted care agencies, to an increasing extent, in the case of domiciliary care. The NHS provides through its different categories of nursing staff. The private purchaser is free to choose from among private sector agencies, voluntary organisations and the like. Fragmentation seems inevitable. But one still wonders why, within a sheltered housing scheme, each Social Services supported resident receives services from a different agency - a typical if not invariable pattern.

Service provision tends to focus on the individual; today, one is urged to provide what the client really needs - not what the provider can most easily supply. The result in the public sector is spot purchasing/contracts to fulfill an individual care plan.

An alternative focus is upon the community - such as a sheltered scheme, or the locality - a neighbourhood or village. Here 'block purchasing/contracts' may be employed. Thus the dedicated care teams in extra care sheltered housing are funded through block contracts, whether the team is 'integrated' with housing management or 'segregated' as a separate service (see Brooks, 2003).

The block contract facilitates, as we have seen in Croft House, a degree of flexibility in operation, whilst allowing Social Services ultimate control in meeting its statutory obligations.

Social Services are, generally endeavouring to move towards greater provision of services through block contracts and better coordination of service provision. Supporting People, whose projects provide low level support (as distinct from care) enabling individuals to live independently generally, because of the nature of the projects, operates with block contracts.

The fragmentation of service delivery within Social Services is more difficult to overcome. An individual becomes dependent and vulnerable and seeks assessment by Social Services; eligibility is established and a care plan devised. A service provider must then be found - but:

- needs are often met from different funding 'pots'; some bureaucrats will find a way around this, others will be reluctant to do so
- Social Services may have established a list of 'preferred providers' for provision either throughout their whole area, or part of it'; but many contracts were established before this and remain ongoing
- many care agencies provide but a limited range of services; one must be found which matches the care plan
- the contracted care agency might not be able, through lack of care staff, to meet the needs immediately
- Social Services and the care agency might not be able to agree on a price

- selecting a care agency which already provides services within a scheme and could coordinate service delivery, seems, in many cases, a low priority

(In the Workshop the case of a newly established extra care scheme was cited, where none of the tendering care agencies was able to cover the full range of services sought; the scheme established its own in-house team).

Within Social Services one meets many individuals who seek to obviate these problems; but so often their efforts are thwarted either by their own colleagues or by the other stakeholders who raise their own problems and difficulties.

Within Social Services' contract and purchasing units there may be a reluctance to put "all one's eggs in one basket", lest the single agency providing services within a scheme goes out of business, or fails to perform to standard. This does not seem a plausible difficulty - there are many agencies willing to take over.

### **Individual Choice**

Choice is a buzz word today. Within the private and voluntary sector, the individual is free to choose the service provider. Within the statutory sector the individual is given little or no opportunity to exercise a choice. Entry to an extra care scheme, with its block contracted team, assumes acceptance of that team; no opt out mechanism is offered. In arranging a spot contract, the individual is rarely consulted about choice of providing agency.

### **Monitoring**

How does one ensure that, once contracts are entered into, acceptable standards are maintained?

Within Social Services and the NHS in-house units are monitored through internal procedures; user satisfaction surveys are also employed.

In drawing up a list of care agency preferred providers, past performance is rigorously scrutinised; the care agencies are also subject to regular inspection by the Commission for Social Care Inspection.

Supporting People, a new mode of funding, requires all its projects of service provision to be inspected and audited within the first three years.

As we have already noted above, the care plans delivered through spot contracts are relatively inflexible; a regular reassessment takes place only with lengthy intervals - though an acute crisis can trigger an immediate change in the care plan. With the in-house care team considerable flexibility is possible, including an immediate reduction of service provision as a resident regains their abilities.

## **THE CARE AGENCIES**

The several representatives of care agencies attending the Workshop were all supportive of care team service provision - they were, after all, a self selected group. Most came from the larger agencies. The stability offered by block contracts was clearly preferable to the vagaries of spot contracts.

They saw no difficulties in creating care teams:

- in many localities recruitment is more difficult; but for most workers being in a team offers greater job satisfaction; (but some workers, it was alleged, as prefer working on their own - unsupported but also unsupervised!)
- they would have little difficulty in creating a team which covered all (or almost all) the skills and resources required by residents. This might require them to go beyond the range of services currently being offered
- service delivery is spread unevenly through the day; but they are accustomed to recruiting staff with different work preferences - mornings when children are at school v. evenings or nights; reduced/no work in school holidays; willingness to work overtime or to work only when needed etc

A care team certainly reduces travel costs - whether the hours worked include time spent travelling, or the worker receives a higher hourly wage for time spent actually with the client.

Participants saw no difficulty in creating a care team which served both those clients who were publicly supported by Social Services and the NHS, and those paying privately (though using in many cases their Attendance Allowance or Direct Payment) and also those seeking short term provision only. The care team (or those members with own car) could do out-reach work in the locality.

A few sheltered housing schemes are experimenting in using some of their accommodation for short term use, for intermediate care, rehabilitation or respite care, (using perhaps difficult-to-let units). A dedicated care team facilitates this development.

It is possible that two nearby sheltered schemes, managed by different agents, might share the services of a single care team; whilst the care agency would probably seek to provide a uniform service, the two managing agencies might have different procedures and standards to which they expect the care agency to conform.

## **HOUSING MANAGEMENT**

Most sheltered housing is managed by LAs and RSLs together with a large stock of general needs housing. (The exceptions are those schemes managed by the few, albeit large, RSLs specialising in accommodation for older people, and very small RSLs linked to local charities). Sheltered housing has, all too often, been marginalised, the poor relation.

The line managers of the sheltered stock have usually had career paths through general needs housing; their professional qualifications have been in legal and financial issues - but not in care and support provision. They have been unable to promote training or provide specialist support for their scheme managers.

Today we see a change : housing management embraces the creation of a good environment beyond the actual houses, and the provision of care and support to enable the vulnerable tenants to maintain their tenancy. With the latter objective, housing management has entered into dialogue and partnership with Social Services.

The actual role of sheltered housing within overall housing provision often, however, remains unclear.

Should one enter sheltered housing only when one needs care and support? For some people the provision of security is more important. The waiting list for one-bed flats in general needs housing is usually much bigger than for sheltered housing; one can reduce it by directing some applicants to sheltered schemes, even though they do not need care or support. Allocation processes for rented housing generally favour the more frail; yet those buying into leasehold retirement homes often do so well before frailty develops - they see the move as preventative care, they wish to adjust to less space and to communal living whilst they still have the will and ability to do so.

Is sheltered housing an alternative to residential care, mitigating the closure of care homes? Or is it just a new form of residential care albeit providing greater independence?

Such policy issues underlie the enthusiasm, or lack of it, with which LAs and RSLs are, in many areas, seeking to upgrade their sheltered housing stock towards 'extra care':

### **The Scheme Manager**

A much more immediate issue, however, is the role of the scheme manager in the provision of care and support within the scheme. In recent years the overall role has changed considerably from "good neighbour" to "trained professional"; the scheme manager today has more skills, spends less time in the scheme (being away at team meetings, training courses etc) and is possibly non-resident.

The scheme manager, who has for several years been resident in the scheme, inevitably develops close personal relationships with residents. Most will feel very concerned that their residents receive appropriate care and support and will "pull out all the stops" to ensure that no one is, without very good reason, obliged to move to alternative accommodation. They seek to make 'a home for life' a reality.

But this role is not usually fully described in the job description. The degree to which the scheme manager 'monitors' the provision of care is problematic:

- The scheme manager might act as an advocate for a resident, on request taking up cases of poor service provision, facilitating access to statutory bodies or voluntary organisations etc. Or they might play a more proactive role, urging the resident to seek support, perhaps through facilities unknown to the resident
- Monitoring might take the form of casually noting the arrival and departure of care workers; alternatively it could involve recording the exact times of arrival and departure or the regular checking of the log books held by the resident
- If a care team is established within the scheme will it be managed by the scheme manager (integrated model) or a parallel care team leader (segregated model)? If the latter, what is the relationship between the two? What authority does each have over the individual workers in the team? Do the respective line managers ever talk to each other? In practice much is achieved through goodwill - and common sense; but the absence of protocols can lead to friction and ultimate collapse of the project
- Today it is often suggested that a scheme manager might do outreach work - for instance, giving a morning call to older people living alone in the neighbourhood; (in some ongoing projects these

calls are balanced by scheme residents opting out). Such outreach work could be co-ordinated with the services offered by a care team

- Many of the tasks coming to be undertaken by the scheme manager might seem to fall within the remit of Social Services; but is Social Services prepared to transfer some of its budget to Housing, as a contribution towards the scheme manager's salary? What contribution might Supporting People projects make towards the salary?
- Most landlords have a fairly uniform job description for their sheltered scheme managers and a single salary scale. But the introduction of extra care and care teams into some schemes but not in others leads to differences in the skills and workloads, necessitating a grading structure of posts and salaries. As individual scheme managers move upwards through the grades/career ladder, so will they spend less time in any one scheme - yet another significant change to the traditional role. And will a more highly paid scheme manager lead to an increase in the service charge - and will this be tolerated by the residents?

Thus, whilst housing managers might readily espouse collaboration with Social Services in enhancing the provision of care and support within their sheltered schemes, they might not be prepared to entertain the intricate negotiations with their staff necessitated by their policy. They might have opened "the can of worms"!

### **SOME OTHER FACTORS**

#### **Single Assessment**

In April 2004, single assessment of the needs of older people began to be introduced. Hitherto each service provider - Social Services, NHS, Housing etc - had used their own specific forms, and the assessed person was asked the same questions by successive professionals.

The several providers (with Housing often being less involved) have collaborated in devising a single form, or set of forms. An initial section provides basic data and can be completed by whoever starts the assessment process. Subsequently, other professionals complete sections appropriate to their own service. The set of forms is available to all, subject to the consent of the assessed person.

This new process offers two roles to the sheltered scheme manager. Firstly, as the person who initiates the assessment process and completes the initial sections of the forms. And secondly, as the care manager who co-ordinates and monitors the provision of services.

It has for long been the wish of many scheme managers to be involved in the assessment process - they do have a much greater knowledge of their residents than any of the professionals later introduced. However, this new role must be incorporated in their job description and conditions of employment.

#### **Direct Payments**

Direct Payment - a scheme whereby Social Services gave a cash payment to the recipient commensurate with the services detailed in the care plan - was originally available only to physically disabled persons under 65 years. Two years ago it was made available to all persons over 65 years



and is currently being vigorously promoted by the Department of Health.

Take up among the disabled has been low; among older people it is even less. The scheme seeks to give recipients much greater control over service provision through the purchase of those services they feel that they really need.

A person in receipt of Direct Payments must keep a separate bank account. In addition, the recipient must assume all the obligations of an employer - in making PAYE and NI deductions and payment and in observing all Health and Safety regulations. Many disabled people have received considerable help from local disability associations in surmounting these bureaucratic obstacles. They create a strong disincentive for older people with declining mental faculties. An original ruling that the recipient could not employ family members or close friends, has now been rescinded. But there seems, at present, to be no indication that the bureaucratic hurdles will be removed. With older people there is seen to be a potential danger if they employ unscrupulous individuals.

If residents in a sheltered housing scheme were to apply for Direct Payments, it could lead to even greater fragmentation of service delivery than exists at present.

However, an alternative has been suggested. Encourage residents (and others in the locality) to claim Direct Payments and, collectively employ a care team. The team might be managed by a committee of residents and housing staff; far less onerous would be to contract a care agency to provide the team. The agency would bear the bureaucratic responsibilities; but control would be with the residents in selecting an agency, drawing up the contract and monitoring performance.

### **Scheme Design**

In the Workshop we focussed almost exclusively on the provision of care and support to sheltered housing residents, possibly through dedicated care teams. We were however reminded that care provision would be irrelevant if the design of the scheme was inadequate for the more frail older person:

Access : no steps, lift to upper floors, corridor rails or aids for those with sensory impairment

Facilities : eg. no assisted baths, battery charging for wheelchairs, a daily meal and fully equipped kitchen

A care team will need a room for use as an office and for relaxation to promote interaction between members. A room will be required for sleep over staff.

The use of the scheme as a resource centre for the neighbourhood may be enhanced by:

- accommodation for peripatetic professionals (eg: hairdresser, chiropodist, GP consulting room)
- facilities to enable the scheme to act as a day centre
- accommodation for short term use for intermediate care, respite care and rehabilitation

### **Pay-As You-Go or Insurance Premium**

In most of the discussion about flexibility of service provision and delivery - in meeting emergency or short term needs, or in adjusting to daily variation in delivery - it was assumed that services provided would be paid for directly; private clients would pay for the services received; Social Services would reimburse the contracted care agencies.

But the costs of sheltered housing do incorporate an insurance premium; the service charge paid by residents contributes towards the scheme manager's salary. However, residents do not all receive the same amount of support - some receive more than others, some will become heavily dependent on their scheme manager whilst others will remain virtually independent. (Again, all make National Insurance contributions, but some will receive far more benefits than others).

In some types of accommodation for older people a lump sum paid on entry, guarantees the care and support that one might later need.

Thus it seems possible that the service charge might include an element of insurance premium - to cover, for example, an hour or two a day for two or three weeks, in cases of brief sickness or convalescence.

### **THE WAY FORWARD**

At the end of the day, the Workshop participants seemed unanimous in feeling that the provision of increased care, via care teams, in conventional sheltered housing was both desirable and feasible.

Most, however, had come to the Workshop with the intention of supporting such a policy! Similar views have been expressed many times in recent years, yet so few projects have been initiated and of those hopefully launched, many have collapsed. Wherein lie the difficulties?

The establishment of a care team involves a large number of stakeholders, many of whom have not, in the past, been accustomed to talking to each other. Today there is much closer liaison between Social Services and NHS/Health, but Housing has often remained on the margins. Problems of collaboration are much greater in two-tier local authorities - where Housing is a District function and Social Services a County function - than in unitary authorities where the two services are often closely linked. In the two-tier authorities ultimate decisions are made by two sets of councillors, sometimes politically antagonistic.

The ultimate goal, achieved in a few local authorities, would be to establish a strategic partnership board to plan the accommodation and care of older people in all its forms. The partnership would then have an agreed joint commissioning process, to implement the plan.

Many of those who have launched projects have spoken at the length of time needed to establish relationships of trust. Thus Social Services staff need to feel sure that sheltered scheme managers will not direct care to residents who are not eligible for public support. Ideological support for partnership and personal goodwill between staff are not enough. Clear protocols for action must be established; the design of single assessment forms is, currently, a good example of the issues raised.

In the course of the Workshop a number of potential hurdles were identified - most arising from the participants' own experiences.

- Senior professionals who are empowered to make decisions are often too immersed in everyday administration and change to take a lead in new initiatives
- Those keen to initiate were not supported by colleagues who preferred to use long established procedures
- A change in commissioning procedures, made for good reasons, may

- frustrate plans for care team development
- Capital funding might be available but not the recurrent expenditure to maintain it; (an RSL was willing to install a hoist - but Social Services could not bear the costs of its use)
- A care agency awarded a contract for a care team might fail
- Transfers of budgets are revoked; eg: Social Services refuses to contribute towards the scheme manager's role in care delivery

Each major shareholder has a role to play in initiating the development of care teams.

Social Services and other Commissioners should:-

- place locality high on the list of criteria in awarding spot contracts
- be willing to award block contracts
- be prepared to work with other stakeholders in the commissioning process

Care Agencies could:-

- be more proactive in demonstrating their ability to create a care team and a large enough clientele - eg: with Social Services and private clients within and beyond a sheltered scheme
- demonstrate their ability to cover a wide range of services, embracing domiciliary care, low level support and some more specialist services

Housing Management should:-

- in expousing the principles of providing enhanced care within the sheltered housing, develop a clear strategy about the purpose or role of sheltered housing
- be aware of consequential changes in the roles of scheme Manager and include them in all discussions of policy change

Conventional sheltered housing (Category 2) and extra care sheltered housing (Category 2½ or 2.9 in everyday parlance) are often seen as two distinct types of housing. Most extra care schemes are new-built and have all the facilities associated with the category.

But we have been discussing the development, or upgrading, of facilities within the conventional sheltered scheme. There seems no reason why such development should not proceed incrementally; eg:-

- ensure that all publicly supported residents within a scheme are served by the same providing agency
- establish a care team which is on-site for part of each day - mornings and early evenings, but on-call at other times
- introduce night cover

- introduce a daily meal service

Each step in the upgrading process must be congruent with the design and facilities in the building and with the agreed roles of scheme staff.

### **Implementation**

Upgrading is agreed; the new developments and protocols are in place. How does one implement the change in a pre-existing scheme? Clearly the residents cannot be confronted with "Tomorrow you will have a care team; your existing carers will no longer help you". The change over looks potentially traumatic; one participant gave a case study of a scheme where she had worked.

Residents were fully consulted in the discussions leading to the decision to upgrade. They participated in the decision to award the care team contract to the agency which already served the majority of the residents (though this was not the landlord's initial preference). For a transitional period residents' existing care workers worked in tandem with the new care team. Within a short period all those residents accepted the new care team. Though the loss of a careworker of long standing was a personal wrench, this was outweighed by the advantages of the new care team; the services available could delay or prevent the need to move on to a residential care or nursing home - the most frightening threat hanging over many older people!

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So it can be done - with goodwill and with the awareness of all the hurdles to surmount.

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