The Institute of Public Care

Very Sheltered Housing in South Gloucestershire

Draft Report

May 1 2003

Executive Summary

1. Introduction

In January 2003 the Institute of Public Care (IPC) was invited to submit a proposal concerning the development of very sheltered housing in South Gloucestershire. The Institute was specifically asked to report on:

- A Literature review
- Visits to other very sheltered housing schemes.
- A survey of a sample of older persons recently admitted to residential accommodation.

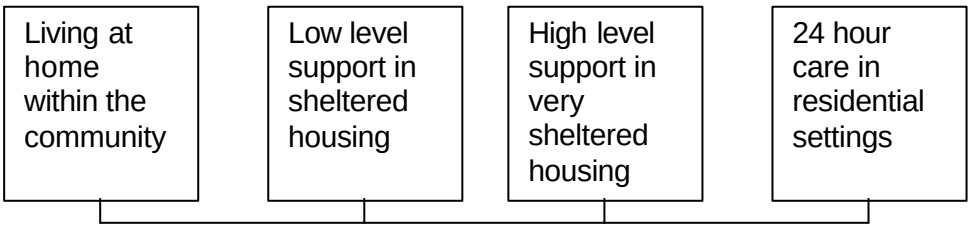
The intention is that his work forms part of a wider commissioning strategy for the authority designed to develop appropriate very sheltered housing (VSH) to consider the role of ordinary sheltered housing (OSH) and to explore the potentiality of VSH to act as an alternative to residential care.

2. Background

'Home Alone' the Audit Commission's review of the role of housing in the community noted that 'Although not typically associated with care in the community housing service are, in fact, a core component in making the approach work. Suitable housing provides a base for independent living and affords access to other services such as health and social care, education and training.'

An extended role for housing in supporting community care has already been recognised through the governments 'Supporting People' initiative. However, defining exactly what role housing should play and how and whether people should progress from one form of provision to another is not as easy to agree or define how and when such transfers may take place. For example there is a divergence of whether; community, OSH, VSH and residential should represent a continuum of care provision through which people pass or whether different levels of care should be provided within a single housing provision to offer a home for life.

Therefore the easy assumption to make is that there is a linear progression of care as the diagram below represents:



However, the real picture is not as simple, neither is there necessarily a linear progression, as our work and that of others reveals. Many people live in the community for a long time often with very high levels of support provided by friends and relatives. Consequently, they are already at the intensive end of the continuum when any future placement decision is made. Equally there are some people who enter residential care with a low level of dependency and need, frequently self financing, who remain in that provision when local authorities become responsible for funding the placement. Residential care may not always mean 24 hour care as often people can be left in care homes for long periods of the day without physical care being provided.

3. Factors which result in a move to residential care for older people and their implications for the provision of Very Sheltered Housing in South Gloucestershire.

Precipitating factors	Delaying factors
• Need for safety and security • Perception of risk • Carer's perception of risk • Deteriorating health • Medical emergency • Difficulty with stairs • Falls • Medical attitudes	• Being married • Living in accessible housing • The availability of immediate assistance in an emergency

Commentary on factors which influence choice of housing

3.1 The policy of enabling people to live at home with the help of home care packages means that most service users are located within the community and hence it predicts that the majority of the population in residential care are likely to have high dependency needs. Therefore, it is of little surprise that in our survey all but one of the service users studied was very frail. For most of these people home care, even the most intensive packages, might meet the physical needs of service users but not the emotional needs. Some service users were alone at night and often most of the day, and ultimately most simply 'lost their nerve' – especially if they suffered frequent falls.

3.2 Loneliness was a key factor in the move for 36% of all cases and as a precipitating factor this is not currently resolved through OSH as half of this amount already lived in sheltered housing.

3.3 Seventy-eight per cent of service users in our sample moved into residential care following a crisis, and 39% of these crises involved a fall. In over three quarters of cases studied, more support at home would have been unlikely to have made a difference to the decision to move into residential care, and in five cases where the social worker suggested it, the client and family refused.

3.4 The Literature Review suggested that fear of crime, and a perception of risk among clients and carers, were major factors in the decision to apply for residential care. However, South Gloucestershire is a relatively prosperous area and, in the questionnaire survey, fear of crime did not feature highly in peoples' list of worries.

3.5 Many older people do not make plans to move from their existing accommodation, which means that the decision to move is often made hurriedly, following an emergency.

3.6 Informal carers play a major role in the decision to move to residential care. One study found that medical professionals were the first to suggest residential care in well over half of the cases, and in over a third this professional was a doctor working in a hospital.

3.7 People being cared for by a spouse remain at home for longer than those being cared for by other relatives. Apart from peoples personal commitments to each other this may also reflect the absence of accommodation for married couples in residential homes.

3.8 Older people who are already tenants of local authorities or housing associations are more likely to be aware of the local options for supported housing than are owner occupiers.

3.9 Eighty-six percent of our sample had already moved from the family home, some several times, prior to admission to residential care. Many of the housing solutions they had adopted turned out to be unsuitable – for example buying a mobile home, or moving from an accessible property to the inaccessible house of a son or daughter. It is at this stage of decision-making that older people need information about housing choices, and help with financial planning.

3.10 From our discussions with service users and their relatives who had moved to residential care from OSH we gained the impression that wardens are operating in a culture of a 'continuum of care' ie, making the assumption that tenants who become frail will move geographically to a different sort of provision such as residential or nursing care. Indeed, we even found some evidence that suggested that tenants of OSH can be fast-tracked into residential care by wardens who are familiar with referral procedures and care pathways.

3.11 There was evidence that home care encouraged dependency in the same way that residential care often does. There seemed to be no expectation that home care, once in place, would diminish. In VSH on the other hand, volumes of care can change from day to day, and the emphasis on rehabilitation ensures that the volume can diminish as well as rise.

3.12 Some groups are under represented in VSH schemes. These include owner occupiers on middling incomes, people who are mentally frail, and people from ethnic minorities.

3.13 The conversion of existing sheltered housing schemes into very sheltered can be difficult if the accommodation units are inferior. It may not always be possible to convert property to the standard required and so this may limit gaining appropriate tenants thereby creating voids. Poor accommodation may also help to create isolation by limiting tenants capacity to move around the scheme and thereby meet other people. Older people who are used to good quality housing may well prefer to remain at home with domiciliary care, rather than move to a bedsit or flat which is cramped or not fully accessible.

4. Potential characteristics of VSH for South Gloucestershire

4.1 **Tenancy arrangements.** South Gloucestershire has a high number of owner occupiers. As stated above older people who are already tenants of local authorities or housing associations are more likely to be aware of the local options for supported housing than are owner occupiers. If VSH is to reach all its potential target audience then it will be important to enable and encourage owner occupiers to take advantage of VSH, and this may mean making some properties available for sale. In addition potential tenants or leaseholders will need financial advice. The Department of Health Commissioning Strategy gives reference to approaches to different types of tenancies (Appleton and Porteus).

4.2 **Location.** An important factor in the choice of residential home by clients and relatives in our survey was location. A major benefit of VSH is that relatives –

particularly spouses – may continue caring if they wish to do so, and receive more support than current community provision offers. We found that those clients living at home who received the greatest input from home care services, also received a substantial input from relatives. The value of that input is considerable. The implication is that VSH schemes in South Gloucester should be entrenched in local communities.

Whilst we felt that there was a minimum size below which the number of dwellings in a scheme should not fall – perhaps 35 properties – the solution of a 'Village' scheme with some 250 properties adopted in York might not meet the needs of South Gloucestershire residents. In rural areas, which could only support a small number of dwellings, one scheme might be split over two or three villages and pool staff teams. Smaller schemes we visited managed with sleeping night cover only: this works provided that the member of staff has access to immediate emergency help if necessary.

4.3 **Buildings.** Accessible buildings and the concept of progressive privacy, where tenants can move from their individual properties to the communal areas and thence, if they are able, to the wider community, are important components of VSH. For some people, accessibility or the lack of it can make the difference between being or not being independent regardless of any input from care staff. Good communal facilities including a communal lounge available for use by tenants at all time, a restaurant, and craft and activities rooms, contribute to social engagement and independence**.** We visited one scheme which was converted from OSH: some of the properties were bedsits, and the scheme could not accept tenants who were not able to mobilise within the flats, with a result that four of the properties were void. In the light of this, South Gloucestershire may wish to consider the possibility of new build instead of converting existing OSH schemes.

4.4 **The role of the scheme manager.** The skills and characteristics of scheme managers are key to the success of the scheme. In all the schemes we visited the scheme manager had direct managerial responsibility for the in house care team as well as dealing with housing issues. Although the literature gives examples of schemes where the manager has only a housing responsibility and does not manage the care team (as in Hanover Housing) this does not necessarily work well. Scheme managers we visited had skills in community building, and were able to change a client's care hours at short notice (whether to increase or decrease them). Where the emphasis is on rehabilitation, care hours can be reduced as well as augmented, and the expectation is that peoples' care hours will typically reduce within 6 months after entry to the scheme.

Scheme managers we visited had a finite number of care hours at their disposal, and were responsible, in consultation with the social worker, for allocating those hours across the scheme. Allocation of tenancies was made with reference to the number of care hours available, with the aim of maintaining a 'balance of dependency' whereby some tenants engrossed few care hours, but helped to contribute to the community life of the scheme. This is an important concept if the scheme is to retain its non-institutional atmosphere. Although it has been argued that it is a waste of resources to allocate tenancies to more able older people, the researchers were not convinced by this argument, as of course these tenants are making much less use of the care team and are making a positive contribution to the well-being of the more frail tenants.

Scheme managers were also responsible for allocations, in partnership with housing officers. The literature also suggests including health professionals, thus building their commitment to this form of provision.

4.5 **Joint Working.** The management of voids is a key issue in VSH schemes: social workers will be anxious to allocate the place to the most suitable tenants, housing officers will be mindful of their performance indicators and anxious to allocate places as soon as possible. The need to reconcile aims and objectives makes joint working between all agencies essential. This is supported by the Department of Health advisory document on commissioning which places emphasis on joint assessment and allocation. A shared understanding of the objectives of the scheme, and good joint working between housing and social services departments and community health teams would appear to be essential for success.

4.6 **Caring for tenants with dementia.** According to national figures, 13% of people aged 80-84 will suffer from some form of dementia. This rises to 22% of those aged 85-89, and 32% of those aged 90-94. Inevitably some of the tenants in VSH will suffer from dementia, and indeed in our visits we found the proportion to be quite high. These tenants were managed comfortably within the schemes provided they were not prone to wandering and were not a risk to themselves or other tenants. Tenants who had become confused when already in the scheme were more readily accepted by other tenants than those who moved later. They were also more able to continue to utilise the extra space and communal areas than people who were required to learn these skills anew after the onset of dementia. VSH provision cannot ignore the needs of people with dementia, and South Gloucestershire will have to take account of this both in building design and staff training.

5.0 Conclusions & Recommendations

5.1 From the survey, 11 service users were identified who were thought to have been suitable for placement in VSH at the time they were admitted to residential care. Over half of the remaining 25 clients had already made at least one move from the family home into accommodation thought at the time to be more suitable, such as a mobile home, ordinary sheltered housing, or rented flat. It is possible to conclude that most of these – at least 9- would not have needed residential care had their previous move been to VSH. Therefore, albeit based on a small sample, over 50% of those currently in residential care may have had that admission either delayed or made not necessary given the availability of an appropriate VSH scheme in the authority. To achieve this figure would also mean taking into account many of the following factors.

5.2 Developing VSH cannot be in isolation from other forms of provision. Consequently there is also a need to define the role of OSH. If the authority is to follow the principles of offering a home for life to older people and that people need to enter VSH early if it is to be a viable alternative to residential care, then what role OSH will perform in the future may be open to question. The solution probably lies in some form of mixed response.

- The ideal would be to design all sheltered housing so that it is capable of providing high intensity care. This means high standards of accessibility both within and between accommodation units.
- Similarly, many of the principles of dementia design for sheltered housing and for residential care need to be incorporated into premises.

- Smart technology or at least to including cabling etc into design should be undertaken.
- It may be appropriate to develop larger schemes that split into low intensity and high intensity tenancy arrangements so that people move within a scheme rather than from one scheme to another.

5.3 If very sheltered housing is to become an important cornerstone of care policy for older people within the authority it is vital that housing and social services work closely together and either construct joint management arrangements or work within clear protocols and guidelines. It is also necessary to consider what role health services should play in commissioning and managing services. Other documents note the importance of joint admissions and allocations policies. This is particularly important if both OSH and VSH are to have populations of mixed dependencies. There will need to be clear guidelines over who is offered which kinds of accommodation and why. The literature review offers some indications of who are felt to be the most likely beneficiaries from VSH.

5.4 The literature review and the survey indicated that if the residential carer population is to be reduced then positive and early intervention needs to be introduced if appropriate populations are to be recruited into OSH and VSH. Given that several people in the survey made an early and inappropriate move it would have been helpful for those people if information about the full range of housing solutions had been available at the time of their earlier move. Given this conclusion it may be appropriate if regular information – perhaps a newsletter – to people aged 60 and over in South Gloucestershire was available. This could give information about different services available, types of tenure and information on financial planning. This could help, service users, their carers and relatives and other professionals who may offer advice, information about the options available and eligibility for services.

5.5 In line with the above approach and given the profile of the authority it is vital to look at mixed purchase and tenancy schemes in more detail. Such an approach could be crucial in making OSH and VSH attractive to owner occupiers. Further work should be done to explore models form other schemes that have developed this approach and further discussion should be had with both voluntary and independent providers to both explore what plans they may have for the area and also what partnership arrangements may potentially be available.

5.6 South Gloucestershire does not have an even population distribution across the authority, with high population densities in the south and a lower rural density in the north east. This may mean it is possible to build larger more 'village type' schemes in the former but smaller more diverse schemes in the latter. To ensure cost effectiveness in the smaller schemes it may be necessary to develop multi-purpose units, eg, combining day care and housing and/or to have combined staffing and managerial arrangements across more than one scheme. If smaller schemes are to help facilitate relatives keeping in touch with tenants then public transport routes may also influence location of such schemes.

5.7 Appropriate staffing for both OSH and VSH needs to be explored and in particular the role and expectations towards wardens/scheme managers. Key points to note are:

- Building in an expectation that both forms of housing will have a rehabilitative as well as a care focus. Therefore, staff roles need to be focussed on providing help and assistance rather than just care. To

achieve this may require a greater health care input from physio and occupational therapists than at present and training staff in following basic rehabilitative programmes.

- It is important to allocate staff hours to the provision of social and communal activities for clients (there is a tendency to expect care staff to run outings and events in their own time, which is not satisfactory given the importance of such events to maintaining independence and social engagement).
- Training in rehabilitative methods, building communities, and engaging older people, would be invaluable in an OSH as well as a VSH setting. Joint training with Intermediate Care Teams and Home Care Teams – possibly with CPNs – would broaden the skills of wardens and allow full use to be made of this resource.
- Scheme managers need to be in post several months before the opening of any new scheme, so that they are involved in developing policy, recruiting staff, and selecting potential tenants.

6. Next Steps

6.1 This work needs to be combined with work on financial options to develop potential models of provision. Early discussions should take place with the housing and planning functions within the authority and with the appropriate health care trusts.

6.2 A favoured model for development of OSH and VSH should be specified and an outline policy developed regarding the distinction between these two forms of provision if OSH as currently configured is to remain.

6.3 Discussions should take place with a range of voluntary and independent sector providers to both ascertain their future plans and potential partnership arrangements that may be developed with the local authority.

6.4 A feasibility study of OSH provision should be conducted to determine how much of the current stock will meet the specification developed under 6.2 above.

6.5 Following on from the above it may then possible to conduct locality studies and consultation with local groups to discuss proposed forms of provision.

Institute of Public Care

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Literature Review

Introduction

Although in some local authorities VSH as an alternative to residential care has been in operation for many years, it is only with the recent emphasis on low level preventative work with older people and the promotion of independence that it has begun to attract a lot of interest. For this reason the available literature, although it is rapidly expanding, does not afford any examples of rigorous evaluation or even definitive methods of costing this service in comparison with other options.

The vignette method of the Royal Commission (1999) was the most thoroughly executed, but is only useful for policy making if costs can be generalised, and if the vignettes yield figures which can be treated as some form of statistic – and neither of these conditions is the case.

A number of providers, both local authority and private, have described their experiences in setting up schemes and interviewed the people who live in them, and these studies are interesting and informative, if not always generalisable from one local area to another.

1. Precipitating factors which result in a move to residential care for older people.

1.1 Safety and Security

Studies have identified a number of factors which direct people towards residential care. Many of these factors relate, not so much to the physical or mental state of the individual, as to the congeniality of his or her current living conditions and situation. The DoH (Implementing Caring for People: 1994) found that fear was often decisive in persuading people to move from their own homes: fear of falls, of crime, of becoming ill, of imposing on relatives. Building on this work, Wolverhampton Borough Council found that the issues identified by older people as most important to them included safety and security, as well as the availability of help, provided as and when required, with immediate assistance in an emergency (Bailey, 1998). In a small sample (12) of tenants in VSH, Baker (2002) found that falls and disabilities, and difficulties with stairs, were important factors in the need to move. Security was also important. Lang and Buisson (1998) found that increased care needs and unsuitable housing precipitated admissions.

The factors which contribute to the uncongeniality of a neighbourhood are correlated with deprivation. South Gloucestershire is a district with relatively little deprivation, with pockets in perhaps 6 wards. The remaining 32 wards have less deprivation than average, and 9 (24%) fall in the least deprived decile of all English and Welsh wards. Table 1, derived from National Statistics 2001 census data, shows into which deprivation deciles local wards fall.

Table 1: Deprivation deciles, South Gloucestershire wards

Most deprived decile	
High deprivation	Kings Chase; Staple Hill; Yate (W); Filton (Conygre)
Slightly higher than average deprivation	Patchway; Stoke Gifford
Slightly lower than average deprivation	Filton; Westerleigh Rodway; Pucklechurch; Yate (S); Siston; Woodstock; Pilning & Severn Beach
Low deprivation	Parkwall; Almondsbury; Dodington; Winterbourne; Hanham; Oldbury on Severn; Cotswold Edge; Chipping Sodbury; Filton Northville; Yate (NW); Wick and Abson; Bitton; Alveston; Oldland Common; Ladden Brook;
Least deprived decile	Yate (N); Frampton Cotterell; Thornbury (S); Stoke Gifford(S); Downend; Charfield; Thornbury (N); Bradley Stoke (S); Bradley Stoke (N)

In South Gloucestershire, slightly more people aged 65 and over are helped to live at home than is the case nationally – 95 per thousand adults aged 65 and over, compared with a national figure of 90 per thousand (Performance indicators 2001-2). If people generally feel reasonably safe living at home, it may be easier for Social Services to support them at home for longer. It is likely that the perceived risk of remaining in the community will vary according to local characteristics: crime and the fear of crime will be more prevalent in some areas than in others, whilst the level of support given by community alarm or warden schemes will vary. It may well be the relatives rather than the older person who find the risks intolerable.

The age distribution of the population will of course be a major determinant of overall demand for social care. The age banding of the South Gloucestershire population is similar to the national distribution, with very slightly fewer females than nationally in the age groups above 60 years, a bulge in the numbers of persons aged 30-44, and a slight deficit in those aged 15-29. (2001 census data)

1.2 The Role of Relatives and Advisers

Hanover Housing Association (1997) found that advisers to older people (usually children or neighbours) were much more likely to judge that an older person needed help than did the older person him or herself. Woolham (1998) found that informal carers of people on the waiting list for residential care reported that most people on the waiting list did not want to live in a residential care home, but informal carers themselves overwhelmingly felt that the decision to apply had been the right thing to do.

Woolham (1998), in the course of an interview study with informal carers and care managers of 148 older people waiting for funding for residential care on 1st December 1998, reports that almost all informal carers indicated that the decision to apply was made as a result of a crisis or an emergency of some kind, such as a fall or hospital admission. His work tends to confirm the 1994

DoH study in concluding that perceived risk, rather than actual need, is often the decisive factor in opting for residential care. In Woolham's sample, two out of three people who had previously been supported by a family caregiver in the community entered a care home following discharge from hospital. Other factors included carers' health, and the fact that the cared for person was wakeful in the night, was incontinent, or needed to be lifted.

In Woolham's study, the majority of carers said that their role as informal carers involved providing continuous 24 hour care to the person they cared for. The great majority of carers who reported that their own health was poor said that they provided care on a continuous basis. Nevertheless, although the range and reported level of formal care provided to people (before the decision to apply for residential care) were relatively low, most carers did not feel that the provision of more or different help would have delayed or prevented admission to residential care. Those that did thought that a range of equipment, aids and adaptations might have helped them to continue caring for their relative at home.

1.3 Lack of future planning by older people

Hanover Housing Group found that older people who are still living at home are reluctant to plan for their extreme old age. Of 164 people aged over 70 and living at home interviewed by Hanover Housing Association in 1997, 60% said that they would definitely not consider moving to a different type of accommodation as they grew older. Hanover concluded that the unwillingness of older people to plan their housing future meant that deteriorating health is often the trigger for a move, and often means a last minute decision. This is endorsed by John Woolham's interviews with informal carers and care managers, who reported that medical professionals were the first to suggest residential care in well over half of the cases studied, and in over a third of cases this professional was a doctor working in a hospital.

1.4 Married couples

People who were cared for by a spouse tended to remain at home with a higher level of dependency than those who were cared for by a son or daughter. (Woolham 1998). Lang and Buisson (1998) found that having a spouse is one of the most important factors keeping people out of care homes. Few residential homes have double rooms to accommodate married couples. Wright (1998) found that, when the main carer was the spouse, the relationship between the couple deteriorated when the cared-for person was admitted to residential care, although the relationship between the cared-for person and grown-up children tended to improve. One problem identified by Wright is the lack of guidance to staff in residential homes on how to treat partners of residents. Several spouses reported being discouraged by staff from assisting the resident in a practical way, and privacy during visits is difficult to achieve. Although visitors are usually offered tea and biscuits, it is unusual for spouses to be invited to share meals with the resident. Given these disincentives, carers who are spouses are likely to cope with higher dependency levels at home than are carers who are children.

1.5 Previous tenure

Oldman (2000) speculates that, from equivalent populations, people are more likely to move to residential care from sheltered housing than from ordinary housing, because wardens are able to negotiate placements on behalf of their tenants. Tenants who are perceived to be a risk to themselves or their

neighbours may be directed towards residential care, and wardens are in a good position to monitor the increasing frequency of falls or activated smoke alarms among their tenants. Whether this is in fact the case must depend very much on the culture and training of wardens in sheltered housing, and the policy of encouraging people to stay or to move in will depend on individual schemes. Those who are still rooted in the idea of a 'continuum of care' are likely to have an expectation that tenants will move into residential and nursing care as they become more frail.

1.6 Choice

The degree of effective choice open to individuals who suddenly find themselves unable to remain at home depends very much on which professionals they encounter. Information about all the available options is crucial to choice. There is evidence that people who are already tenants of local authorities or housing associations are better informed about future housing options and also about how to finance their move than owner occupiers who have no contact with social housing providers. For the middle-income band, means testing and the complexity of rules governing annuities and the effect of markets on the value of pensions, make future planning difficult. (Kings College London Debates: 2002). Although some private rented VSH schemes are starting to be built, rents are very high and will not be affordable to everyone (Oldman 2000).

Once the decision has been made that the older person can no longer remain at home, the choice of residential care seems often to have been made with little or no consideration of alternatives. There has been a general withdrawal of low level preventative services in the community, and social care priorities have been distorted by the need of the health service to discharge patients (Woolham 1998, Kings College 2002). Woolham suggested that, when discharge planning fails, hospital doctors see admission to residential care of the older person as the quickest way to release a bed. He also reported that *in some cases the assessment process was focused on determining if the person was appropriate for residential care rather than arriving at a view that residential care was appropriate after exhaustive consideration of community based alternatives.* Wright (1998) found that most family caregivers found the process of choosing a care home intimidating – many only looked at a single care home. Hanover Housing (1997) found that approximately half of older people and advisers surveyed were aware of sheltered schemes, old people's or residential homes, nursing homes and retirement apartments in their neighbourhood – so roughly half were not.

2. What constitutes a good model of VSH appropriate to South Gloucestershire?

2.1. Being safe and feeling safe.

The South Gloucestershire Community Safety Audit (1998-2001) has found that South Gloucestershire is one of the safest places to live in the South West. Fear of crime is more widespread than is warranted by the actual incidence of crime and addressing this fear is a key aim of the local Community Safety Strategy 2002-2005. Nineteen percent of people aged over 60 have been a victim of crime: of these, 16% think that crime has affected their health. (South Gloucestershire Community Safety Partnership 2002). The Community Safety Audit found that the wards in South Gloucestershire that experience the highest levels of anti-social behaviour are

Kingschase, Filton, Patchway, Woodstock and Staple Hill, and it seems likely that older residents of these wards are more likely to feel unsafe.

Given that considerations of safety and security are major factors in persuading older people to leave their existing housing, people who feel relatively safe are likely to be able to live longer in the community. This in turn suggests that the population seeking VSH will be older, and there is evidence that generally the population of sheltered housing is becoming more frail. (South Gloucestershire Best Value Review).

2.2 Balance of Dependency.

In order to maintain a balanced community within a scheme, many schemes operate a rough guide of one third of tenants with low dependency, one third medium, and one third high dependency, although this can be difficult to maintain (Baker 2002). The debate is, on the one hand, that people with low dependency are using a valuable resource which they don't really need, and on the other, that if all the tenants were very dependent the numbers of care staff needed would be similar to that in nursing or residential care, and the feeling of independence and autonomy enjoyed by all the tenants would evaporate. With respect to the first point, tenants with low dependency are not engrossing the same levels of home care as those with high dependency, therefore the resource is not wasted although the less dependent tenants benefit from the ready access to services when they become necessary.

Schemes vary in the way in which they manage this balance. Some offer 'a home for life,' and continue to support tenants as they become more frail and confused, unless there is no alternative other than nursing or hospital care. Managing the balance of dependency can only be done by monitoring the dependency levels of new tenants, and ensuring that, if existing tenants are very dependent, only relatively independent people are allocated a place. Other schemes offer what is referred to as 'ageing in place', whereby the balance of dependency is managed both at the point of allocation, and by encouraging very frail or confused tenants to move to residential or nursing homes.

Another solution, adopted by the Joseph Rowntree Trust in Yorkshire, is to develop what has been called a 'Village' approach (Appleton and Porteous 2003). In addition to flats and bungalows designed for independent living the scheme provides a wide range of communal facilities for communal activities and leisure pursuits. Care is delivered in the tenants homes, but if the care rises to a very high level – assumed to be more than 21 hours per week, there is a residential home on site to which tenants can move.

Although building on such a large and centralised scale would probably not be a suitable option for South Gloucestershire, it may well be necessary to retain some residential care provision for those for whom VSH is not a suitable option. This would allow VSH schemes to retain a balance of dependency whilst offering a home for life to tenants, because those clients who have no wish to be independent or who have remained so long in the community that they have effectively 'lost their nerve' can be offered alternatives. Although this may well increase the cost of residential care (because those who do take this option will be much more frail than has previously been the case) – retaining a small amount of residential care will mean greater flexibility and more choice for older people and their families, and will make it easier for VSH schemes to avoid taking on the characteristics of institutions.

2.3 The Contribution of Relatives

The potential for relatives, including spouses who can themselves become tenants, to continue to provide care to tenants adds considerable value to the scheme. Relatives of care home residents are often marginalised when the resident is admitted, (Wright 1998). In contrast, relatives of VSH tenants continue to provide a whole spectrum of support from practical, social and emotional to, in some cases, huge volumes of hands on care (Oldman 2000). They can share mealtimes with tenants, help them with shopping and remain part of a close family unit if they wish. Oldman (2002) found that relatives were highly satisfied with VSH: it relieves them of the worry of maintaining the tenant's house, places the tenant in an accessible environment making all the care tasks easier, gives peace of mind and makes for a more relaxed relationship. Good practice guidelines for fostering these relationships need to be developed for scheme managers and their staff, and the added value they provide needs to be included in comparative costings between VSH and residential care.

2.4 The essential characteristics of VSH

A number of studies have attempted to define the essential characteristics of VSH, some of them in great detail. Baker, (2000) summarises the defining elements as

- self contained accommodation
- equipment for care
- care staff, probably including at least sleeping night cover
- catering: communal facilities
- social activities and religious worship
- an appropriate level of care for tenants
- help with domestic tasks and shopping
- wider activities and services.

Bartholomeou (1999) summarises the critical elements of VSH as the tenants' sense of ownership of their own space, and the notion that the communal areas and services are additions to, not substitutes for, this basic independence of status.

Practice can be split into a number of areas, for example

- Design of the building
- Locality, access and neighbourhood
- Structures in terms of joint working and the provision of a seamless service
- The degree to which staff know the tenants and their individual requirements
- The nature of the community within the scheme
- The way in which the scheme relates to the outside community

These elements are discussed in more detail below.

2.4.1 Design of the building.

In a sample of people aged over 70 still living at home, Hanover Housing /Winstanley (1997) found that the preference of 64% of older people in their sample would be for a bungalow. On the whole, older people do not like bedsits, evidenced by the number of voids for this

type of property. In general, the amount of space available to tenants of VSH is considerably greater than that required in residential home provision.

Baker (2002) describing a new scheme in Plymouth, found that tenants liked corridors to be kept short, and that the positioning of lifts is important. Tenants with first floor flats may have power scooters or wheel chairs which need to be reversed either into or out of the lift, and this needs to be done comfortably. Bartholomeouou (1999) cited as examples of good design within the flat

- A light switch which is reachable when the tenant is sitting down
- Wide doors
- Kitchens accessible to wheelchairs
- Living rooms and bathrooms with appropriate adaptations

whilst in communal areas tenants prefer

- Wide corridors with solid handrails
- Frequent seating areas
- Level access.

The possibility for married couples to remain together, enabling the more able partner to continue to care for the other, but with the support of the care providers within the scheme, is a major advantage of VSH, but the accommodation in the scheme must be large enough to allow this.

Facilities for care must be integrated into the building. Essential requirements include assisted bathing, laundry and storage space for equipment.

2.4.2. Locality, access and neighbourhood

Baker (2000) describes the method of locality appraisals as a crucial way of assessing whether very sheltered housing is viable in a particular area and, if so, the best options. The appraisal includes a profile of the population of older people in the area, including those already in supported accommodation as well as those being supported in the community, and an assessment of the potential for using communal parts of the building as a community resource or base for community health or home care teams.

Baker describes the locality appraisal as an ‘in principle’ assessment of whether a scheme would be viable in a particular area. Where a local authority area is home to a diverse population, a number of small locally based schemes may be more appropriate than a single large one that requires potential tenants to move away from their local support networks. In 1997, the consultancy S.A.M.E.C. undertook a survey for Hanover Housing of the housing options of older people from ethnic minorities in 6 local authorities. This study emphasised the importance of locality in the provision of VSH. We have already drawn attention to the major contribution of relatives in providing help for older people in VSH. When people come from relatively small cultural communities, SAMEC found that it becomes even more important to build within an individual’s local area, so that at the end of their lives people are not excluded from their cultural roots. The study found that the absence of small, culturally sensitive schemes built in

peoples' own locality was more important in restricting choice than was a supposed culturally based resistance to the concept of VSH per se.

2.4.3. Structures in terms of joint working and the provision of a seamless service

A number of solutions have been found to the problem of working across agencies. The practice of working together that has developed between health and social services has not always included housing departments. Although the importance of housing in determining outcomes of social care was stressed in the Audit Commission Report Home Alone in 1998, nevertheless it is clear that some difficulties remain. Despite this, there are both new and long established examples of good practice in joint working which include housing departments (see report of visit to Scheme A).

Bartholomeou (1999), in describing Hanover Housing schemes, was of the opinion that the on the whole it is better for organisations to concentrate on coordinating the separate expertise's of housing and social services rather than try to combine different skills in a single managed structure. One reason she gave was that this makes it easier to extend the partnership, for example to include commercial interests and the wider environment.

Clear lines of communication, and clearly assigned responsibilities are necessary for joint working to be effective. In the Hanover Housing study, a number of tensions between housing and social services were identified. For example, an important performance indicator for housing managers is the number of voids in a property, and housing officers will want to find a tenant quickly. Social services managers will want to delay until the most suitable tenant is found.

Bartholomeou found that the single most important determinant of the success of a scheme is the personality and ability of the estate manager, who needs to be skilled in building relationships and maintaining lines of communication. She found that estate managers need to be appointed several months before the scheme opens in order to be involved in planning, discussions with social workers, and defining entry criteria.

2.4.4 The degree to which staff know the tenants and their individual requirements

Most of the authors reviewed believe that VSH is already much ahead of the residential and care home sector in its therapeutic and rehabilitative attitudes. Instances of marked improvement amongst new tenants are noted, especially in their mobility (encouraged by accessible buildings) the development of confidence, a feeling of security, and increased motivation. (It should be borne in mind that the literature consists partly of evaluations funded by VSH providers)

Increased interest in this form of provision has coincided with the introduction of Intermediate Care, and with an acknowledgement by government of the benefits of low level preventative interventions to keep older people independent for longer. However, delivering this kind of preventative care will mean developing the role of care workers

to incorporate a rehabilitative approach, and also implies a thorough understanding of the needs and expectations of individual tenants. Care packages must be capable of being changed at short notice, and when housing support and care are delivered by different agencies this will mean good communication systems to agree change.

The provision of meals can be made into a meaningful element of care, increasing people's social contacts and encouraging them to leave their rooms. Meals are sometimes included in the rent for financial reasons. This may be thought to weaken the "anti-institutional" thrust of the scheme.

2.4.5 The nature of the community within the scheme

Ensuring a balance of dependency within a scheme is a difficult art which requires managing entrance to and exit from the scheme. South Gloucestershire has found that people in its Ordinary Sheltered Schemes are growing older and more frail (South Gloucestershire: Best Value Review). Because of the increase in the numbers of the very old, there is a notable increase in the number of persons with dementia. VSH schemes cannot therefore ignore this group although there is a view that too many confused people in a scheme may deter new tenants and overburden staff.

Generally, estate and scheme managers were of the opinion that other tenants would support people who were becoming confused if they had known them prior to the onset of dementia, and also that people who become confused in a scheme they know have an advantage when compared with people who become tenants for the first time when they already have dementia, and may not be capable of new learning. However, working with people with dementia requires special skills and training which are not usually provided for care staff, and the buildings may not be designed to maximise independence for this group.

As communities of tenants, VSH schemes have the same experience as other communities: there may be cliques and resentments. Bartholomeouou (1999) found discrimination by more able tenants against less able ones. She regards the absence in a scheme of a policy on dependency mix as a serious omission.

Nevertheless, people come to VSH as to a home for life, with secure tenancies. Moving them on when they become more frail might not be regarded as an option by scheme managers, which would mean that a balance would have to be maintained solely through the operation of entry criteria. This would only be possible if either the onset of dementia could be predicted for individuals,- which is not the case;- or if persons could be admitted whose physical health was likely to deteriorate so that they needed to move permanently to hospital, or to die, before they became very dependent – which is bizarre. It may not, therefore, be possible to operate a selection policy *and* to achieve the "home for life" goal.

2.4.6 The way in which the scheme relates to the outside community

The use of the tenants' communal lounge by other organisations can be seen as a benefit inasmuch as it strengthens the relationship with

the wider community. On the other hand, initiatives such as day centres which use the tenant's lounge need to be introduced sensitively if at all: they may be resented and the users seen as intruders.

Services such as a hairdresser or shop can be encouraged to operate from within the scheme, although ideally the scheme would be located in a position from which most tenants can get a bus or walk to a shop, bank and post office. Baker (2000) recommends an on site hairdresser who also takes customers from the community, as well as the provision of a shop, although he notes that retail managers may prefer to provide goods through a shopping delivery service.

Often care workers are expected to participate in social events outside their contracted hours. It is important to allocate care workers' time for input to recreational activities, both individual and group, and estate or scheme managers need to be skilled in organisation and community work.

3. To identify any work which may link particular eligibility criteria with success, either measured on an aggregate or individual basis.

3.1 What constitutes success in VSH?

Descriptions of what constitutes success in the provision of VSH are to be found in a number of recent strategy documents and guidelines, as well as in the mission statements of individual schemes. The National Service Framework for Older People (2001) emphasises the importance of person centred care and the promotion of an active and healthy life in old age, and to support this policy intermediate care services are being put in place with the aim of to helping people avoid an unnecessary hospital admission and to speed recovery and rehabilitation.

Service reviews for sheltered housing set out in the Supporting People Administrative Guidance (Section 3B(16) provide guidance on 'home for life' support service reviews. This guidance notes that categorising sheltered provision through a buildings based mechanism (Category 1,2 etc) is no longer helpful in describing the roles played by the different types of sheltered housing, and suggests instead categorising housing schemes in terms of a continuum of 'enabling', which places the focus on the outcome of the schemes under scrutiny rather than on their structure.

Thus the 'enabling' model of sheltered housing, first put forward by the Audit Commission Joint Review Team, is construed as the most successful model, where 'enabling' refers to the balance achieved between risk and intervention. Unsuccessful services are variously described by the Audit Commission as *stifling*, or *focussed on crisis* or *rescue*, or *leaving service users and carers out on a limb*, or *dangerous*. The preferred outcome is one whereby tenants are enabled to remain independent for as long as possible, by enabling them to exercise choice and remain in a non-institutional setting, whilst not leaving them unsupported or in danger.

3.2 Identifying and measuring desirable outcomes.

Although a number of studies have been completed concerning user satisfaction with VSH, The Royal Commission (1999) concluded that very little is known about the quality of care provided within schemes, or about

outcomes, and points to the absence of a strong and credible user perspective in the evaluation of VSH. So far, most evaluations have been done by providers. Moreover, Oldman (2000) takes the view that the various models of very sheltered housing have emerged as a response to organisational and management problems and the availability of funding, rather than by working with older people to see what they might want.

Nevertheless, questionnaire studies for older people have repeatedly found high levels of satisfaction with VSH. Respondents value the concept of their own front door, and of progressive privacy – security in the public spaces and privacy in their own – afforded by VSH (CPA Code of Practice 1996). The availability of low level preventative care, or "help" as older people put it more simply, contribute towards the sort of enabling environment described by the Audit commission.

3.3 Ageing in Place versus A Home for Life: who is VSH for?

Who, then, are the people likely to benefit most from VSH? Once again, this depends very much on the philosophy of different schemes: whether they aim to offer a home for life or simply ageing in place: whether the scheme has arisen as a remodelling of ordinary sheltered housing, or whether it is designed as an alternative to residential care (Fletcher et al 1999). Oldman argues that VSH schemes which arise primarily through housing models tend to offer ageing in place, whilst those that aim to replace residential care are more likely to offer a home for life. Netten (1998) found that nearly half of all residents of residential homes had low dependency, and, given the opportunities for taking advantage of Housing Benefit and now Supporting People funding, redirecting these people towards a more enabling environment is an attractive policy. The differences in models which arise primarily from housing initiatives, and those based on social services provision such as residential care, need to be resolved through close working between Housing and Social Services Departments as well as Health and Primary care trusts in order to develop joint assessment and allocation criteria, to develop jointly approved policies for supporting tenants VSH, and to include sheltered housing as part of the wider strategic approach to services for older people. (Audit Commission 1998)

If different models of VSH take a different attitude to the level of frailty they can support, when are people required to move on? The notion of a balance of dependency is key to allocation procedures in most schemes. A preponderance of highly dependent people means extra staff, presenting more of a feeling of an institution, and making the community less attractive to prospective tenants. The balance of dependency has to be managed through the way in which people are moved into and out of the scheme.

If the tenants within a scheme differ in their degree of dependency, a relatively small care team can provide a high level of care to the few tenants who require it. It must be possible to increase care staff if necessary – in most cases, payment would come out of the SSD community care budget, as with any other domiciliary care. One care manager noted that clear criteria should be developed to govern when residents are to leave, for example when the tenant needs nursing care beyond that offered by the community nurse. However, given the variety of schemes available it is unlikely that criteria could be generalised from one scheme to another, and, unlike residential homes, tenants of VSH have secure tenancies which can be invoked if the tenant is very anxious to stay.

Woolham (1998) quotes one Social Services manager who has developed a summary of the type of people for whom VSH is most appropriate. This includes:

- A couple where one spouse may be very disabled and where the other spouse may wish to continue providing care, but in a better environment.
- An older person whose health, and self-care abilities can fluctuate and change rapidly
- An older person who has been living in institutional care but who might benefit from greater opportunities to exercise independence within a secure context:
- An older person suffering from anxiety, including one who is particularly anxious at night.
- An older person who doesn't necessarily require a whole day's attendance, but a couple of hours - for example, to give a partner respite to enable them to go shopping etc.

3.4 Barriers to access

For certain groups, there would appear to be barriers to accessing VSH. These include:

- Owner occupiers on middling incomes
- People who are mentally frail
- People from ethnic minorities.

3.5 Affordability

People who have not previously been in touch with housing departments or housing associations are less aware of the range of options for supported housing. (Hanover Housing 1998). Moreover, it is largely Housing Benefit that makes VSH affordable, and this benefit is means tested. Appleton and Porteous (2003) describe the series of complex financial arrangements which have been developed to make the Hartrigg Oaks Village in York affordable to people from all tenures. Information and financial advice for older people, including addressing and if necessary amending the expectation that people will leave their capital assets intact to their heirs, will be an important service to offer as part of a wider strategy for older people. It may be appropriate to offer some properties within a scheme for sale, or at least to enable tenants to buy some equity in the property.

3.6 Older people who are mentally frail

Managing the interface between risk and intervention which has been identified as key to providing an enabling environment is much more complicated in cases of dementia and mental frailty, and the demands of people with these conditions are more likely to be fairly constant (ie not just help with going to bed or getting up, but also with finding their way around, dealing with post, reminders about medication and so on), and some estate managers have expressed the opinion that only one or two can be supported in each scheme at any one time if the balance of the dependency is to be maintained. (Baker 2002).

3.7 People from ethnic minorities.

People from ethnic minorities seem generally to be under-represented in VSH (Hanover Housing /S.A.M.E.C. 1997). Whilst the reasons for this are likely to be as diverse as the communities affected, some broad similarities apply.

Many Asian families are owner occupiers, so presumably experience the same lack of information about available choices as white owner occupiers. For this group, VSH as it is currently structured may not be affordable. Both for the ethnic majority and for minorities, locality, neighbourhood and the accessibility of services are crucial factors in the decision to move into VSH, but for ethnic minorities there is less likely to be a scheme reflecting the values of their own community in their immediate neighbourhood. For older people from all groups, both majority and minority, religious observance is often central to their lives and people want to be able to continue with their own religious and cultural observances, which is more difficult for people from a minority group living in a setting designed for the majority.

During the course of the S.A.M.E.C. survey, researchers found a number of different cultural factors acting as barriers to access. In some areas, looking after the older members of a family is a duty and younger family members did not wish to incur disapproval from their community by failing in this duty. In others, people expressed interest in the concept of VSH, provided that the initiative was seen to be endorsed and control shared by leading members of their own community. In Leicester, there was found to be an over supply of both Council and Independent Sector managed Sheltered Housing Schemes, but schemes run by Black and Asian community groups are over subscribed and run waiting lists.

These findings suggest that the reason people from ethnic minorities are under-represented in VSH schemes is not because the philosophy of a home for life is necessarily inappropriate for them, but because people have no confidence that schemes will meet their needs, whilst schemes arising from initiatives rooted in particular communities are few and far between.

4. Costs

We have found no generalisable cost model from which it is possible to make estimates of the relative costs of different methods of caring for the elderly. This is not surprising, but it means that whereas the literature yields considerable information on how the arrangement and quality of services can affect outcome in different care settings, it yields few clues about cost effectiveness. Most of the costing work which we have seen is based upon actual comparisons of different types of care in particular settings, and all studies make different - and often ad hoc - assumptions, explicit or implicit, which hampers comparisons between studies, and their usefulness for the development of policy.

Cost headings which are dealt with most unsatisfactorily are the cost of land and capital and the value of the contributions of unpaid carers. A confusing and almost universal practice is to cost care in a residential or nursing home at the standard charge. Although this may be appropriate for short term financial decision making, it will lead to instability in the medium to long term. This is because the charge made by a home reflects the *average* dependency of its residents, or, put the other way round, dependency mix can be manipulated by the home manager to allow an imposed charge to yield a positive return. So a conclusion, based upon average costing, that a person's care will be cheaper in a residential home, may well be untrue in real terms if that person's dependency is at the higher end of the spectrum.

This confusion makes it difficult to interpret even the most careful exercises in resource use costing. The most thorough is probably the work of the Royal Commission (1999). This uses a "vignette" approach, and shows, for

example, that for a vignette in which the person who is the focus is highly dependent and a constant wheel chair user the following comparative annual costs pertain:

Own home	*£41,740*
Very sheltered housing	*£37,322*
Residential (LA)	*£21,285*
Residential (private)	*£16,532*

These cost differences are mainly caused, in this case, by the need for care at night. Since waking night cover tends only to be provided in VSH with more than about 50 flats, special provision was costed into the estimation for this care in the VSH scenario, as it was also, of course, in care at home. Waking night cover is provided in residential homes, and was not added in as special provision. Yet the cost of care for this individual would only be as low as the figures given above for residential care on a *marginal* basis – if all residents were highly dependent wheelchair users the home could not survive on a charge of £318 per week.

Some studies (Fletcher et al, 1999; Bartholomeou, 1999) use methods which are not transparent in order to arrive at different conclusions; Fletcher, in a study in Cambridgeshire, finds residential care more expensive than VSH, Bartholomeou the converse.

Costing care for the elderly is rather like valuing Auntie Ada's jewellery; the amount depends not upon underlying truth but upon the purpose of the costing exercise. There are so many legal/financial considerations and administrative constraints upon a local authority that the concept of a "real cost" becomes not only difficult to approach, but perhaps not particularly useful to employ. For example, it would be absurd to ignore the effect on local authority costs of housing benefit payments; yet the real cost of occupied serviced space by an individual is not necessarily the rent paid, but is, especially in times of housing shortage, the opportunity cost of that space. Housing officers are familiar with this concept, insofar as they attempt to match families to appropriately sized accommodation – but how should this be operationalised to include the value of unused space in a privately owned three bedroom house?

Local cost comparisons which contribute to a decision on what to build, or convert, and where to build it, will depend upon special factors which will dominate the decision. In "real cost" terms the value of "similar" land should be the same, yet the planning system gives the local authority a degree of manoeuvrability in the use of land for socially desirable purposes; so to a certain extent the local authority can itself determine the opportunity cost of land for sheltered, very sheltered, or residential home development. There may also be local budget constraints which distort the cost comparison of high capital, low revenue cost, with low capital, high revenue cost schemes, and this may lead to sub-optimal developments. For example, the conversion of existing sheltered housing schemes into very sheltered can be difficult; where the accommodation units are inferior, such as bedsit flats with cramped kitchens, it is very difficult indeed. Such flats are actually difficult to let even in areas where staying on in one's own home is a less attractive proposition than it is in South Gloucestershire.

Probably the only guide to cost comparison is common sense. The extra overall cost (for persons of equivalent dependency) of a VSH scheme over residential care is the considerable extra serviced space per tenant, and the

(slight) organisational diseconomies involved in providing care or catering services on a less uniform basis. The benefit is the possibility of using, in some cases, the tenants' own labour to perform tasks which would be performed routinely by staff in a residential home, such as the preparation of breakfast and supper, and involving family and friends in caring or helping – that is, substituting cost-free labour for paid care. This is only a valid factor if the family's or friends' labour is genuinely cost-free, (and if it is given with pleasure). There is no social benefit if a relative must sacrifice paid employment to visit and help, (or indeed if the help is grudging or stressful).

Bibliography

Appleton, N and Porteous, J (2003) Extra Care Housing for Older People; An Introduction for Commissioners. DoH Housing Network, Change Agent Team.

Audit Commission (1998) Home Alone: the role of housing in community care. London: Audit Commission.

Bailey, A (1998) Making God Wait: an alternative to residential care. A report on very sheltered housing schemes in Wolverhampton: Section 1.

Baker, T (2000) Promoting Inclusion Using Very Sheltered Housing. Education and Ageing, Volume 15, Number 3.

Baker, T (2002) An evaluation of an extraCare scheme: Runnymede Court, Estover, Plymouth. Staines: Hanover Housing Group.

Bartholomeou, J A (1999) View of the Future: The Experience of Living in ExtraCare Staines: Hanover Housing Group.

Belcher J (2002) Speech to the Laing and Buisson Assisted Living Conference 26 2.

Department of Health (1994). Implementing Caring for People: The F Factor: reasons why some older people choose residential care. London, The Stationery Office.

DETR/Dept of Health (2001) Quality and Choice for Older Peoples' Housing – a strategic framework.

Greenwood, C & Smith, J (1999). Sharing in ExtraCare. Staines: Hanover Housing Group.

Hanover Housing Association / S.A.M.E.C. (1997). Housing Options for Ethnic Elders. Staines, Hanover Housing Group.

Hanover Housing Association / Winstanley Research Limited (1997) Evaluating Older People's Housing Needs. Staines: Hanover Housing Group.

Hofman, A et al (1991) The Prevalence of Dementia in Europe: International Journal of Epidemiology 20: 736-748.

King's College London Debates on Ageing, Research and Public Policy Issues (2002). Care in the Early 21st Century; How Can Older People Exercise More Choice and Control? Report to the Nuffield Foundation.

Laing and Buisson (1998). Care of Elderly People: Market Survey, 11th edn. London: Laing and Buisson.

McDonald A, Curtis J (1997) Not Alone: A Good practice Guide to Working with People with Dementia in Sheltered housing. Anchor /Housing Corporation.

Netten, A, Bebbington, A, Darton, R, Forder, J and Miles, K (1998) Survey of Care Homes for Elderly People. Final Report. Kent: PSSRU

Oldman, C (2000) Blurring the Boundaries: A fresh look at housing and care provision for older people. Pavilion /Joseph Rowntree Foundation.

Royal Commission on Longer Term Care (1999b) Alternative Models of Care for Older people, Royal Commission on Long Term Care Research Vol. 2 Cm 4192-11/2. London: The Stationery Office.

Supporting People: (2002) Administrative Guidance. Section 3B(16) Service reviews for sheltered housing. ODPM.

South Gloucestershire Council (2002). Best Value Review – Accommodation for Older People.

South Gloucestershire Community Safety Audit (Full Version) 1998-2001.

South Gloucestershire Community Safety Partnership (2002). Fear of Crime and its Impact on Health Survey. Bostock Marketing Group Limited.

Sumner, K ed (2002) Our Homes, Our Lives: Choice in later life living arrangements. Centre for Policy on Ageing /Housing Corporation.

Woolham, J (1998) Very Sheltered Housing: A study of its impact and effectiveness in meeting the housing and social care needs of older people. Northamptonshire County Council, Policy Division.

Woolham J (1998) Report for the Northamptonshire Best Value Steering Group for Residential Care. Northamptonshire County Council, Policy Division.

Wright, F (1998) The effect on carers of a frail older person's admission to a care home. The Age Concern Institute of Gerontology, Kings College, London.

Visits to Very Sheltered Housing Schemes

1. Summary of main findings

We visited three VSH schemes, two in Worcestershire and one in Birmingham. Two of the schemes were owned and managed by the local authority: the other was owned and managed by a charity, but the local authority had donated the land and retained nomination rights. Table 2 shows the key characteristics of the sites visited.

Table 2: Key characteristics of sites visited.

	Site A	Site B	Site C
Buildings			
No of dwellings	35 one bedroomed flats: 19 sheltered housing bungalows on site	Thirteen bedsits, two one bedroomed flats	58 one bedroomed flats
Buildings	Purpose built: all flats fully accessible	Adapted sheltered housing: kitchens not accessible to wheelchairs	Purpose built: all flats fully accessible
Stairs	2 floors: accessible by lift	2 floors: stairs and stair lift.	3 floors: accessible by two lifts
Location	Central location, close to shops, bus stop, local facilities	Central location, close to shops, bus stop, local facilities	Central, but very hilly: difficult for tenants to walk to shops
Voids	One	Four bedsits	None
Staffing			
Management	Scheme manager employed and line managed by District Council: Scheme manager line manages in- house care staff	Scheme manager employed by Social Services Department: Scheme manager line manages in-house care staff: also responsible for provision of Home Care within the Borough	Scheme manager employed by Charitable Trust: Scheme manager line manages in house care staff
Care staff	Care and Social Support Assistants: joint post Housing and Social Services.	Extra Care and Day Care provided by Residential /Day Centre Officers. Home Care provided by the private sector and by Social Services	In House care team managed by scheme manager, funded by social services via care packages.
Night cover	1 sleep-in member of staff: able to access Borough-wide emergency warden service if help required	1 sleep-in member of staff	1 sleep-in and one waking member of staff
Tenants			
Balance of dependency	Scheme manager plays key role in allocation: seeks to maintain balance of very frail and more able tenants to maintain a sense of community.	No suitable new applicants for two years: prospective tenants must be able to mobilise independently within the bedsits as they are not fully accessible.	Scheme manager plays key role in allocation: seeks to maintain balance of very frail and more able tenants
Support for people with dementia	Will support people with dementia who are not a risk to themselves or other tenants.	Will support people with dementia who are not a risk to themselves or other tenants.	Will support people with dementia who are not a risk to themselves or other tenants.
Ageing in place or a home for life	Scheme aims to provide a home for life	Scheme aims to provide a home for life	Scheme aims to provide a home for life

1.1 Location

All three schemes were in a central location, with shops within walking distance for the more able tenants, and good public transport links.

1.2 Balance of Dependency

All three schemes we visited offered a home for life. Scheme managers had a key role in allocation of places, and maintained a balance of dependency in the scheme by accepting tenants needing little or no care if the existing population was becoming very dependent. This meant that there were always more able tenants who could take a role in the tenants forum or social committee, and help to foster a sense of community within the scheme. Dependency at schemes A and C was assessed on the basis of the amount of care hours required: however, at Scheme A the input of relatives and private care was included in the estimate: at Scheme C only formal care was counted.

All the schemes reported that the more able tenants supported the less able: there was no evidence of the sort of discrimination by more able tenants against the less able that was reported in the literature. However, one tenant with learning disability at Scheme B tended to be a bit left out.

1.3 People from ethnic minorities

Only two tenants across all three schemes came from Black or Asian communities, although all three schemes were in local authority areas with significant ethnic minority communities.

1.4 Support for people with dementia

The literature suggests that VSH can only cope with a very small number of people with dementia. However, tenants at all three schemes we visited were usually aged between 80 and 100, and all three offered tenants a home for life. The incidence of some degree of dementia was estimated at Scheme A as being 50%: nor was this seen to present a particular problem unless people were prone to wander.

1.5 Contribution from relatives

All the Scheme Managers met the relatives of new tenants in order to assess whether they wished to continue to support their relative, and in what way. In scheme B, outings for tenants depended on relatives being there in order to help the more frail. In scheme C relatives were encouraged to use the communal facilities. Whilst some relatives elected not to continue caring once the new tenant had moved in, many continued to provide high levels of care.

1.6 Married couples.

At Schemes A and C, all the flats were capable of accommodating a married couple. At Scheme B, 2 of the 15 properties were flats for married couples. The potential for married couples to remain together in Very Sheltered Housing schemes is a very important differentiating factor between VSH and residential care. Where one spouse is caring for the other, this is of course an important contribution to the totality of the care provided. The cost in

human terms of separating couples after a lifetime together must also be considered, especially in view of new Human Rights legislation which incorporates the right to a family life.

1.7 Joint working and Service Delivery

Each scheme afforded a different example of joint working and delivery of care. All these worked well, and the common theme seemed to be good quality training, and well paid, highly motivated staff, coupled with good lines of communication across agencies. In the one authority where communication between agencies had proved problematic, this was being deliberately addressed in the recruitment and job description of the scheme manager.

1.8 Role of the Scheme Manager

In all three schemes, scheme managers had managerial control over either the in house team or, in the case of Scheme B, the community home care service which was based on site. This was seen to allow greater flexibility in the delivery of care.

1.9 Buildings

Although Scheme C was 10 years younger than Scheme A, both had light, well designed buildings, with a communal lounge which was available for use by tenants at all times, and all the flats were fully accessible. The building at Scheme B was much older, most properties were bedsits and not fully accessible, and this put a very serious constraint on the operation of the scheme. Limitations on the buildings, coupled with the fact that the same high quality home care service was also available in the community, was seen to make this option less attractive than remaining at home for most local people. Moreover, the fact that the tenants' lounge was used by a day centre four days a week, so that the luncheon club only operated on one day, also detracted from the overall success of the scheme.

Both Scheme A and Scheme C had waiting lists, whilst in Scheme B there were 4 voids from a total of 15 properties. Both Schemes A and C had attractive, light buildings with large communal rooms giving access to the more private areas. The bedsits in Scheme B were accessed directly from corridors beyond the main door, and there was no feeling of spaciousness. It is clearly important to make the buildings attractive to potential tenants in order to ensure there are no voids.

1.10 Tenant characteristics and achieving independence

Scheme managers largely concurred in summarising the characteristics of new tenants who became more independent on moving to the scheme, as opposed to those who deteriorated or stayed the same. The characteristics were described without prompting from us.

Characteristics of people who become more independent after moving to the scheme include:-

- People who have suffered bereavement and have become isolated
- People who are very disabled physically
- People living in fear of crime
- People who have suffered a stroke
- People with diabetes

- People with clinical depression or those who suffer mood swings: staff can monitor when people suddenly take to their rooms and encourage them to come out and participate.
- People caring for partners

Characteristics of people who remain the same, or become less independent, include:

- People who have experienced a lifetime of institutional living
- People with progressive disorders.

2. Scheme A

2.1 Location

The scheme is situated 100 yards from local shops, including a chemist and a post office. There is a bus stop outside the scheme gates, with frequent buses to the town centre, about two miles away. The scheme has close links with the local Dial-A-Ride service, and also with the Shopmobility scheme in the local shopping centre, who sometimes lend power scooters or wheelchairs for use by tenants.

2.2 Buildings

Scheme A is a purpose built scheme of about 12 years old. The VSH scheme was added to the site of 19 sheltered housing bungalows, known as cottages, and comprises a total of 35 one bedroomed flats, each with its own bathroom and kitchen. One flat has been void for one week. The flats have walk –in showers, but no bath: assisted bathing is provided for tenants who prefer it by a private bath nurse in the scheme's own bathroom. There is no dedicated crafts or computer room: activities take place in the large open plan lounge.

The flats are spread over two floors, and one large lift provides access to the first floor. There is a hairdressing salon on the first floor, and on the ground floor a large open plan communal lounge, of which one part serves as a restaurant at midday.

Every flat has a pull cord in each room, in order to summon help. Tenants at risk can also use a pendant alarm.

2.3 Joint working /resources

The local authority is non-unitary, but has always been a strong advocate for sheltered housing. Initially the scheme was run by housing wardens, and care was provided by social services, but this resulted in a lack of continuity for tenants receiving care, as well as a certain inflexibility: for example, some tenants were having to go to bed at 6pm in order to accommodate home care working schedules. In 1998 closer partnership arrangements were agreed with Social Services, and generic in-house staff were employed who deliver both housing support and care. They are called Care and Social Support Assistants (C&SSA), and are joint posts shared by Housing and Social Services. They are line managed by the scheme manager and her two deputies. C&SSAs will not lift tenants in terms of weight bearing, but will use a hoist following training. They will also administer medication, such as diabetic blister packs, for which Boots the Chemist offers training. Staff turnover is low: staff are well supported in terms of pay and training, and are generally

highly motivated. Staff have some training in rehabilitative techniques. In addition to the care provided by the in-house team, tenants receive support from relatives, and are free to employ private home helps if they wish.

The scheme is funded for a total of 269 hours a week of which 143 are for care and 98 for support. The remaining 28 are for the luncheon club. An additional 87 hours per week are funded for the Scheme Manager and the two deputies, and 20 hours for an administrator.

The scheme provides sleeping night cover. There is a 24 hour emergency warden service in the Borough, so the member of staff on duty can summon help if necessary.

2.4 Referrals and allocation procedure

Referrals are taken from GPs, ordinary sheltered housing, community nurses, residential homes, and from the community. Applicants or their families. can apply directly. To be eligible, applicants must be over 60 and in medical, social or housing need: they must also be eligible for the Council's housing list, so must either live within the Borough or have some family connection with the Borough. The scheme currently has no policy about admitting people with dementia, but the scheme manager feels that they should have one as, in her estimate, at least 50% of tenants experience some degree of confusion.

New applicants are first invited to visit the scheme, and asked to apply for inclusion on the Council's Housing Waiting List if they have not already done so. This application then goes to Housing Advisory Services, who will check that the applicant is eligible for the Housing List and, if so, add his or her name. If the potential tenant is in receipt of home care, the scheme manager and social worker will then visit the applicant together: if not, the scheme manager does a home assessment on her own. This leaves the scheme manager and social worker with considerable discretion to screen applicants at an early stage.

The most important allocation mechanism is the allocations panel, which is attended by the scheme manager and her line manager, the social worker, and a housing officer from the Neighbourhood Office. In practice, the individuals attending this group tend not to change.

Currently there is a waiting list of 19 applicants, with a further 9 awaiting completion of assessments.

We asked why, given the accessibility of the scheme, they were not inundated with requests. The answer was that most people prefer to stay in their own homes. The scheme manager pointed out that most of their tenants had lived through the war and were generally self-reliant: moreover, the communities in which they live are long-established and on the whole feel fairly safe. She also said that older people do not want to spend money: having been used to poverty in their youth, they prefer to save it. Future generations would take a different attitude, and the scheme manager said that she herself would very much like to spend her declining years in VSH.

2.5 Balance of Dependency

Maintaining a balance of dependency entails managing entry to the scheme so that places are allocated, not only to the very frail, but also to people who

are less dependent and thus better able to contribute to the community within the scheme, by helping to organise social events, running the tenants forum, and generally supporting the more frail tenants. The scheme manager acknowledged that this is difficult to manage: the scheme provides a home for life, so inevitably tenants become more frail both mentally and physically, and the scheme manager remarked that '*if we are not careful, we shall become an EMI home'.* Average age on entry is about 81 years, but most of the tenants are over 90. To maintain a balance, new tenants may have to be selected on the grounds that they are fairly independent and can contribute to the life of the community within the scheme. People are placed on the waiting list according to the eligibility criteria, but when a place becomes vacant it will be allocated at a joint allocation meeting to a client whose care needs are the best fit with the resources available.

Although it has sometimes been objected that this policy means allocating a scarce resource to those who are not strictly in need of it, such tenants are only taking advantage of the buildings and are not engrossing care hours, and they are essential to the working of the scheme. By working closely with housing officers, the scheme manager is able to tolerate a void whilst a suitable tenant is found, although current housing Performance Indicators mean there is pressure on housing officers to fill vacancies as soon as possible

There are no married couples at the moment although the scheme does accommodate married couples from time to time. Although there are tenants who are Irish, Polish, and in one case German, there are no tenants from Black or Asian Communities although one person from an African Caribbean background attends the luncheon club.

2.6 Levels of dependency

Dependency levels are measured once a month in terms of care hours received. People receiving fewer than 3.5 care hours a week are deemed to have a low level of dependency, whilst those receiving more than 3.5 care hours a week are deemed to have a medium to high level of dependency. Care and support from other sources are added in to the calculation on the basis that those receiving support from relatives will probably be receiving about 5 hours a week, those employing private home help will get approximately one hour a week, and those employing the bath nurse will have another hour.

The scheme manager was in no doubt about the characteristics of people who become less dependent following admission. She identified a group of people who will find it very difficult to cope with independence: these include those who have spent a lifetime in an institution, (including the armed forces), or people with learning disability: or people who have always lived with a parent. In her view, people who have spent a short time in residential care can renew their skills in independent living, but those who have never acquired those skills are unlikely to learn them in old age.

People with certain conditions such as Parkinson's disease or MS are unlikely to become more independent on admission.

People who can make rapid gains on admission include:

- People who have suffered bereavement and have become isolated – they suddenly gain lots of new neighbours.

- People who are very disabled physically: accessible buildings enable them to do much more for themselves, and make it much easier for relatives and formal carers to help them.
- People who have become worried about security, especially those who have been burgled, are able to relax and enjoy life.
- People who have suffered a stroke may well continue to improve.
- People with diabetes who have been managing their insulin regime alone become much more independent when they have help from scheme staff. Staff are trained by Boots the Chemist in monitoring and administering blister packs, and people feel able to go out much more freely with this reassurance.
- People with clinical depression or those who suffer mood swings: staff can monitor when people suddenly take to their rooms and encourage them to come out and participate.

2.7 Achieving a good outcome

Before reorganisation in 1998, home care came from outside the scheme and tenants often did not know whom to expect or at what time. Under the new arrangements tenants know all the staff team.

By bringing care and support in house, under the control of the scheme manager, care has become much more flexible. However, the care manager must not exceed the funded number of hours so to some extent she has to juggle the care hours. Care hours range from 30 minutes a week to 20 hours: care packages can be reviewed every day if need be. Because of her very good working relationship with the social worker, the scheme manager can provide extra care hours to the client before the social worker reviews the care package, if for some reason this becomes necessary.

With hindsight, the scheme manager regrets that the team was not clearer from the start about what staff would not do, as she feels that tenant expectation is extremely high.

2.8 Liaison groups between agencies

The scheme manager and deputies work closely with the local intermediate care team. Intermediate Care can be delivered in the flats, and meetings take place to decide roles. However, operational staff are not involved in these meetings.

Tenants continue on the list of the GP that they attended prior to moving. After some initial difficulties the scheme now has a very good reputation with local GPs, to the extent that one GP wants her mother to move into the scheme. The scheme manager attributes this to the quality of the care offered: to the positive attitude of the staff and the amount of training they receive.

2.9 Contribution of relatives

Whilst relatives are encouraged to continue in their caring role after the tenant moves in, the scheme manager stressed that staff do need to know what the relative is contributing, in case that care is suddenly withdrawn. When the tenant moves in the relatives are asked if they will continue to provide care and support: in some cases they may not wish to do so. If however, they do

continue in their caring role, an informal handover may take place between the relative and the C&SSA in order to ensure continuity on a daily basis.

2.10 Service User Involvement and social activities

There is a tenant's forum, although the scheme manager reports that tenants are usually keen to keep this short so that they can play Bingo, which is very popular.

The programme of activities is as follows:

1. Delivered by volunteers
   Monday, Tuesday, Thursday and Saturday afternoons: Bingo
   Tuesday evening: Whist
   Wednesday afternoon Keep Fit

2. Delivered by staff and the social committee
   4 evenings a week between 5pm and 8pm: activities such as knitting, sewing, carpet bowls, a quiz, dancing, pool or cards, sing song or chatting.

   Bi-monthly: tea and entertainment.

   Staff liaise with the local college, activities are funded from the Prevention Grant, now known as the Promoting Independence Grant. (The four activities evenings require one or two extra members of staff to be present).

2.11 Tenure

Tenants have assured tenure. If a tenant goes into hospital, the flat is kept until their return. If the scheme is informed that the tenant will probably not be able to return, then Housing Benefit stops and the tenant or relatives become responsible for the rent. Under these circumstances, the tenant usually gives up the tenancy. However, as long as the rent is being paid the tenant retains rights over the property.

3 Scheme B

3.1 Location

The scheme is situated on the edge of a shopping centre, and some tenants regularly walk to the shops.

3.2 Buildings

Local Authority scheme in a metropolitan borough, developed from ordinary sheltered housing. Staff thought that the buildings were about 30 years old. There are fifteen properties, of which 2 are flats and the rest are bedsits. Four of the bedsits are void.

The buildings are on two floors, with a lift and a stairlift. The rooms are very small, and in all but two of the kitchens the units are too close together to allow for the passage of a wheelchair. In addition, they are too small to accommodate a fridge or a cooker.

There is a communal lounge on the ground floor: however, for four days a week this is used as a day centre for people from outside the scheme until 4pm. This means that lunches are provided on one day a week only. On this day, the luncheon club is very popular. There is a small lounge on the first floor, with seating placed in a circle. There were no tenants in this lounge when we visited.

At the moment, there is a Piper alarm system wired into the block. The housing department will shortly replace this with a system which uses a phone line, so tenants will be charged for the calls they make. Two tenants do not currently have a phone line. No consultation has taken place, either with tenants or with the scheme manager. Scheme staff make 60 calls every morning, to VSH tenants and also to local OSH schemes, and the new system will have implications for the scheme budget. Closer working between housing and social services might have made it possible to introduce change in a way that reduced the impact, both on tenants, and on the scheme budget.

The constraints of the building are such that people with severely restricted mobility are not suitable for the scheme. There are no tenants from ethnic minorities.

3.3 Joint working /resources

The in-house Extra Care team for the scheme is funded by housing. Social Services fund home care, and there is a strong rehabilitative element which is funded by Intermediate Care.

The scheme is managed by a Care Co-Ordinator, who is employed by Social Services and is also responsible for the provision of Home Care throughout the Borough. The Care Co-Ordinator comes from a housing background, and the authority is a unitary authority: when the relationship with housing is working well she feels it gives added value to the scheme. However, although this is a shared initiative between social services and housing, there have been some difficulties in the relationship with housing. The Care Co-ordinator, who has been in post for two years, was appointed to help improve the relationship. The manager attributes some of the difficulties to the lack of advocacy in the borough for older people, which she thinks extends to other vulnerable groups such as people with mental ill health. This is largely a political matter, and she sees little prospect of change. In contrast to her previous post '*we never see politicians: nobody complains to politicians here*'. In her view, a stronger steer from politicians might help to raise the profile of the client group and ensure better joint working.

Extra Care and Day Care are provided by the Care co-ordinator and the in-house team, known as Residential /Day Centre Officers. The scheme provides sleeping night cover. Users like the in-house staff, although with the introduction of the Care Standards Act the team may change, with the provision of more support and training for staff.

Home care is provided more and more by the private sector. However, the Social Services Home Care staff are highly skilled. All are trained at least to NVQ level 2, most to level 3 or 4, most have the diploma in Care Management. Staff have access to the Social Services Training Department, which is reported to be extremely good. All have training in rehabilitation. Most of the managers are also NVQ assessors, and the service has already exceeded the target for NVQs.

The social services Home Care Team enjoys close links with the local Intermediate Care Team. Although currently based on site, the team is due to move shortly in order to share offices with the Intermediate Care Team at a local hospital. Social Services Home Care serves, not just the VSH scheme, but also the local community. Therefore both people receiving care at home and those receiving VSH will be visited by the same team and get the same quality of care. This care is designed to maximise independence, and Home Care workers will if necessary work under the guidance of the Intermediate Care Team.

The scheme provides sleeping night cover.

3.4 Referrals and allocation procedure

Applicants must be eligible for the Council's housing waiting list. They must also be in housing need, or have a recent or future need for personal care, or a need for support. The scheme does accept referrals from outside the Borough, for people who want to move nearer their family: however, people from outside can only be offered a bedsit, and these are proving increasingly hard to let. The Care Co-Ordinator visits the applicant with a housing officer. Some applicants are very dependent, having come from residential care or spent more than 3 months in hospital. Although the scheme will take people with mild dementia, and also has a tenant with learning difficulty who receives a lot of support, they can not take people who are unable to mobilise within the flat.

The population is very stable, and within the past two years two tenants have died and two have gone into a nursing home. There have been no new tenants in this time. The Care Co-Ordinator attributes this partly to the limitations of the building, partly to the effectiveness of the rehabilitation team, which in turn is due to highly motivated and well trained staff. Intensive rehabilitation means that people regain their independent living skills in a supportive environment. Clients pay for home care but not for the rehabilitation element. In addition, local people tend to be well housed already and to feel relatively safe (although the last new tenant came because of fears about safety and security at home). Referrals, when they do come, are usually from the less prosperous areas of the Borough.

Although there is only one council-run residential home in the Borough, Residential Care may often be the placement of choice by social workers for their clients. Communal meals, the availability of waking night cover, and family pressures combine to direct older people towards Residential Care.

3.5 Balance of Dependency.

The scheme aims to provide a home for life. With few referrals, and few people moving out, it is difficult to manipulate the balance of dependency. Staff have successfully managed a tenant with quite acute dementia. Five of the tenants are in receipt of home care and 6 are not. Currently there are no married couples, although the two flats are designed for married couples. Tenants are encouraged to do things for themselves, but if they are unable to cook for themselves Home Care staff will prepare meals for them. The Residential /Day Centre Officers provide a 24 hour service, and will deal with emergencies, including helping to clean up if tenants are incontinent. Following training they can administer eye drops.

3.6 Achieving a good outcome

The suitability of the VSH scheme depends very much on the level of care that people want. In the opinion of the Care Co-Ordinator it is especially suitable for independent people who are recovering from strokes or those who experience disabilities. As with all the scheme managers we spoke to, she insisted that rehabilitation only works if people want to get better: however, she also feels that everyone should be given the chance of rehabilitation.

The added value provided by the VSH scheme is the provision of out of hours cover, funded by the Housing Department. This budget is added to the funding for the day centre workers and 'stretched' to provide 24 hour cover.

On the whole the scheme has worked well with housing. There are also good links with local pharmacists, who deliver prescriptions to tenants. The chiropodist visits and treats both day centre clients and tenants on site. There is a link with the local church: all the tenants belong to the Church of England. The close working relationship between home care and rehabilitation makes it easier to deliver services.

3.7 Contribution of relatives /Programme of Activities.

The involvement of relatives is encouraged, and outings depend on their coming to help. There is a genuine sense of community in the scheme, and the more able tenants will help the more frail. However, the one tenant with learning disability tends to be left out of this supportive network. The Care Co-ordinator feels the provision of a restaurant would help to reinforce the sense of community: the luncheon club, although only provided one day a week, is very popular.

Except on Saturday, Sunday and Wednesday tenants cannot access their communal lounge until 4pm. This is seen as a marked disadvantage of the scheme, making communal life more difficult, and denying tenants ownership of their lounge.

Activities are arranged by staff as part of staff targets, and the intention is to work jointly with Age Concern to deliver a social programme. The tenants enjoy Bingo.

4 Scheme C

4.1 Location

The site for the scheme was given by the local authority to the charitable trust which designed and built it. The scheme is situated on the side of a steep hill, and is hence not an ideal site for older people. Although not far from the town centre, residents able to walk into town usually return by taxi or dial-a-ride. There is a bus stop within 100 yards, but local supermarkets are a taxi or dial-a-ride trip away.

4.2 Buildings.

This scheme was built two years ago. Care is provided by another charitable trust which has close links with the organisation that provides the buildings. The local authority has retained nomination rights, which it is diligent in exercising.

There are 58 properties on three floors, and the corridors have been given the aspect of streets, with brightly coloured doors with polished letterboxes and door-knockers, space for milkbottles, and a small trellis which allows tenants to decorate their entrance with flowers or pottery. The corridors are wide and light, with wooden handrails on each side. Each corridor is decorated according to a different theme, allowing tenants to locate themselves easily. Views over the surrounding landscape are spectacular, especially from the top floor flats There are two lifts, one capable of carrying a power scooter or stretcher, and one for pedestrians only. There is also a set of carpeted stairs, usually used by staff. Each flat comprises a double bedroom, sitting room, kitchen and bathroom, all fully accessible.

All the communal facilities are on the ground floor. These include a greenhouse, a craft room, a large communal lounge and restaurant, a bar serving beverages and, in the evenings, alcohol, a shop staffed by tenants, a bathroom for assisted bathing, and a well equipped gym with spa bath. There is also a small hairdressing salon, and both the gym and salon are open to people from outside the scheme – in practice usually relatives. A number of treatments are available for which tenants pay, but the gym is also equipped for use by the community physiotherapist, who comes weekly and instructs the member of staff responsible for the gym in exercises to maintain the regime the physiotherapist has prescribed for her patients.

There is a laundry with two large washer dryers for exclusive use by tenants, and a row of industrial sized washer dryers for use by extra care workers in the mornings, which tenants may use later in the day if they wish.

4.3 Joint working /resources

The dedicated extra care staff are recruited and managed by the charity, and paid for via social services care packages. Restaurant meals cost £2.85, which the tenants pay. Income is from rents.

The scheme manager works closely with the local authority housing department in allocating properties. None of the staff have any nursing training: nursing care is provided by community nurses.

4.4 Referrals and allocation procedure

Applicants have to be eligible for the local authority housing list. Once their names are on the list, the scheme manager then visits them at home, and they are invited to visit the scheme. Currently there is a waiting list of 30 applicants.

The scheme provides one member of staff as waking night cover and one as sleeping night cover in case support is needed.

4.5 Balance of Dependency

It is the responsibility of the scheme manager to maintain a balance of dependency within the scheme, and she does this through judicial allocation of places, as the scheme aims to provide a home for life.

When it opened, the scheme provided homes for 17 people from a local authority residential home which had been designated for closure. Some of

these people were extremely dependent: however, the scheme feels able to accommodate people with dementia as long as they are not prone to wander.

There are two tenants from Black or Asian communities.

4.6 Achieving a good outcome

Some members of the group from the local authority residential home mentioned above were institutionalised to the extent that the extra care staff have not been able to rebuild skills of independent living. The scheme manager was of the opinion that in some cases such skills may be irretrievably lost after only twelve months of institutionalisation. However, with others the scheme has had remarkable success, and one member of the residential care group is now a regular helper in the shop.

At least one couple in the scheme had previously been separated when one partner was placed in a residential home following a stroke. We discussed with this couple and the scheme manager the suffering imposed on couples who have to be separated at the end of their life, and the benefit that VSH offers in allowing them to stay together. The right to a family life is now enshrined in the Human Rights Act, and this in itself may have implications for the future of residential care.

4.7 Contribution of relatives /programme of events.

When a new tenant arrives, relatives are asked to what extent they wish to continue with support and care. In particular, in the case of married couples where one couple is the carer, the caring partner is offered as much or as little support as they require.

Tenants are encouraged to use the library and computer room. Each is encouraged to write a 'life book' in which he or she records the past, either the recent past, or the events of their lifetime. When we visited, one of the residential care group was poring over old photographs in the lounge, choosing which to include in her book.

In the craft room tenants complete and glaze pottery figures in the scheme's kiln, or engage in other crafts. Those who enjoy gardening are encouraged to use the scheme's greenhouse: some of the ground floor flats have small garden plots attached.

A tenants social group works closely with staff to arrange a programme of entertainments and outings. Transport for outings is usually hired from the social services fleet, which provides a driver and a 27 seater wheelchair accessible vehicle at a reasonable rate. As on all the schemes we visited, outings and events are recorded on camera and the photographs displayed in the communal areas.

4.8 Tenure

All residents have secure tenancies.

This scheme provided an attractive and stimulating environment in which people were enabled to lead independent lives with the necessary support. Making some of the scheme facilities accessible to local people strengthened links with the local community and the provision of a restaurant and cafe /bar enabled tenants to invite their friends for meals and coffee. The presence within the local area of such an accessible resource ensured that older people

locally knew of it, an awareness that was reflected in the size of the waiting list.

Survey of South Gloucestershire residents recently admitted to residential care.

1 The sample

A total of 36 residents were included in the survey. Seventeen residents were interviewed, and fifteen relatives. In some cases client and carer were interviewed together, and we achieved a total of 24 interviews with either client, relative, or both. For 13 of the cases we interviewed the care managers, and for 21 we examined the case notes. For two clients, the only married couple in the survey who shared accommodation in a residential home, we interviewed the residents but did not see the case notes or interview the care manager.

Thirty of the residents were women and six were men. Three of the men were married, as were three of the women. One couple shared accommodation (see above), three had a spouse still living at home. The husband of one client had been in EMI provision for seven years. All the rest were widowed.

The age distribution of the sample is shown in Figure 1 below. The mean age at admission was 86 years 5 months: the youngest in the sample was 71, and the oldest, 103.

Figure 1

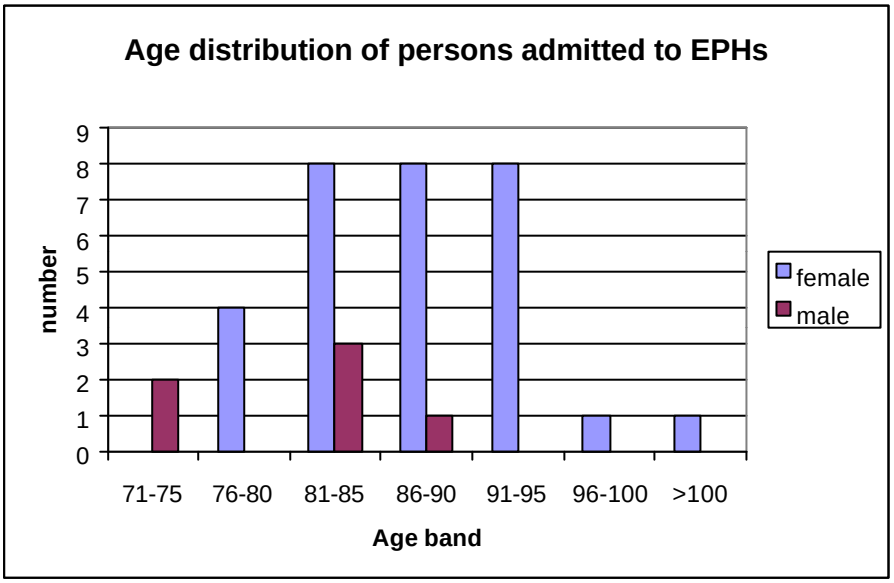


Table 3 below shows the client's accommodation prior to admission.

Table 3: Previous accommodation

	Living with spouse*	Living with son or daughter	Living alone	All
Ordinary Sheltered Housing	2	0	13	15
Client's Family Home	3	0	2	5
Mobile Home	1	1	0	2
Flat or bungalow, no warden	0	0	6	7
Son's or daughter's home		8		8
All	6	9	21	36

* Of those clients reported as living with spouse, two (both women) were cared for by their husband until the husband's death, at which time they had been urgently admitted to residential care. One client was living with her daughter and a grandchild with Downs Syndrome: the daughter was the main carer, and when she died suddenly both the 99 year old client and her granddaughter went into residential care.

2 Might the client have stayed at home with more support?

We asked whether clients might have been able to remain at home, either with more home care or more aids and adaptations. However, the client group was so frail that in over 80% of cases the problem could not be addressed by increasing care packages or adapting homes. Most of the clients we interviewed either needed 24 hour care, or had become too isolated and no longer wanted to continue at home whatever help was provided.

3 Increased care packages

In 28 cases, the client was thought not to have been able to remain at home, even with more home care. For three cases we had no information on this question. Of the remaining cases, one was a lady of 99. One was a much younger man who had suddenly become blind: he attributed his subsequent acute anxiety and depression to a lack of support in the early days of his trauma. One was a lady who had suddenly become unable to cope after the death of her husband, for whom she had been caring: the family urgently found her accommodation in a residential care home which was local to them, without seeking any help (or apparently knowing that they might do so). The lady subsequently had a fall and was discovered to have had an undiagnosed previous fracture of the hip, and the family felt that EPH admission might have been avoided had this been known earlier. One couple moved from sheltered housing into residential care to be nearer their son, and in fact became more dependent because they were no longer in accessible accommodation and the wife was unable to go outside without the help of care staff.

Of the 28 cases who would not have been able to remain at home, their being lonely and isolated was cited as the main factor in 7 cases. Even with the provision of intensive home care, old people living alone and unable to go out will spend most of their time alone.

4 Aids and adaptations

In 29 cases the client would not have been able to remain at home even with more suitable buildings. For two clients we had no information. Five might have stayed at home if they had had level access or a walk in shower, but all had other problems which would have needed to be addressed sooner rather than later.

5 Meals

Six clients were reported by the care manager or case notes as being able to prepare meals. Where we had information from the client or family it did not always concur, but this seemed to be largely a matter of definition – whether the client was able to cook, but not safely, or whether they prepared snacks but not proper meals. There was not really a simple 'yes' or 'no' answer to this question: some clients could cook with supervision, some needed prompting, some could prepare a sandwich but nothing hot. Some reported that they were able to cook for themselves until after a fall and or hospital admission, or

in one case a hernia operation. The different abilities are shown in Table 4 below.

Table 4: Preparation of meals

		Food prepared by family	Food prepared /supervised by spouse	Meals on wheels	private frozen foods	No proper meals
Able to prepare own meals	6					
Not motivated to eat	6					
Not able to prepare meals		7	4	8	2	6
Not known	3					

6 Volumes of Care

Volumes of care prior to admission to residential care re shown in Table 3. Volume of care has been described as zero, low, medium or high, as follows:

		Approximate equivalent input
Formal care (statutory services)	zero	no care provided
	low	meals on wheels or home care 5-7 days a week
	medium	meals on wheels and home care 5-7 days a week
	high	meals on wheels and two home care visits a day
Informal care (family or private carer)	zero	no care provided
	low	Visits twice a week
	medium	between 5 and 20 hors care a week
	high	greater than 20 hours a week or living with carer

Table 3

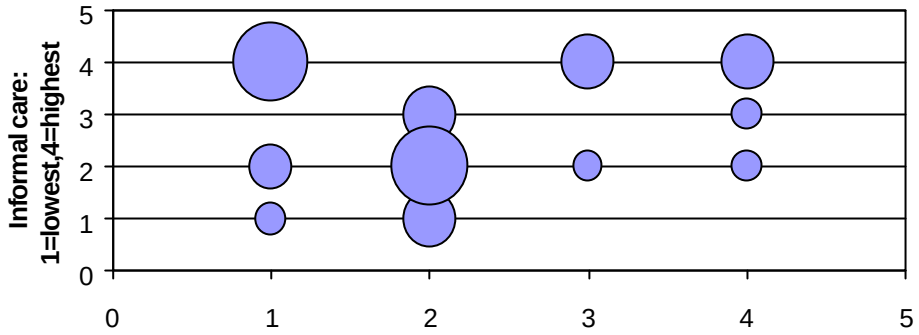
		Informal Care				
		zero	low	medium	high	Number
Formal Care	zero	1	2	0	6	9
	low	3	5	3	6	17
	medium	0	1	0	3	4
	high	0	1	1	3	5
	Number	4	9	4	18	35

One client was excluded from the calculation because the volume of informal care she received was not known.

Only one client was receiving help neither from the family nor from statutory services, whilst three were receiving a high volume both of informal and formal care. Six were receiving a high volume of care from the family and none from home care, whereas none were receiving a high volume of formal care without input from the family. No clear pattern emerges from plotting the

data – for instance, there is apparently no inverse relationship between volumes of formal and informal care (see figure 2 below)

Figure 2: Relative frequencies of combinations of care before admission to EPH



7 Did clients refuse services?

Clients and relatives were asked whether they had ever been offered services which they had refused. Eight out of the 24 respondents said that they had: care managers concurred in six of these, and added a further three cases. In one case, both sources reported that this was due to a personality clash between the client and the home care worker, but the care manager added that the client did not like having shopping done on a Monday, as it meant she ran out of food by the weekend; this was changed. One client refused a home help six years ago following a hospital admission because she was very independent – often we found this meant that the client preferred care to be delivered by the family, which often became quite burdensome for the informal carer. One daughter, who had been preparing meals for her mother because she refused to eat meals on wheels, said that her mother refused everything she would have had to pay for, including a Piper alarm. However, there was an issue about clients paying for home care which they did not deem to be satisfactory, especially during a time of reorganisation in South Gloucestershire – One client (who had become blind overnight) reported that the home help kept failing to turn up and he was helped in the house by a friend. Two clients said that they would like to have been offered more help.

8 Reasons for entering Residential Care

Twenty-eight out of the 36 clients entered residential care following a critical event. Of the eight who did not, all had suffered a general deterioration, and 5 were reported to be lonely. Six of the eight who did not experience a critical event prior to referral (75%) were previously living in warden supervised accommodation, as opposed to nine of the 28 (32%) who entered residential care following a critical event. If this pattern holds true for all those admitted to residential care with social services funding, it suggests that wardens are better able to negotiate placement for their tenants than are clients and their families, and may help to prevent crises and make for a more planned transition for clients.

Table 5 shows the nature of the critical event that was the precipitating factor preceding admission to residential care for 28 clients.

Table 5: Precipitating factors.

Sudden illness, no hospital admission	1
Admitted for respite and did not want to go home	2
Fall but no hospital admission	5
Fall resulting in hospital admission	6
Hospital admission for another reason	7
Carer fallen ill or died	7
Total	28

None of the clients we studied were admitted to residential care because of a fear of crime, although 4 were a little nervous of 'hooligans' in the neighbourhood, and one client had been burgled which upset him. One client underwent an anxiety depression following an apparent stroke which rendered him blind overnight. The client felt that more help earlier might have prevented his anxiety, which was ultimately the reason for his admission to residential care: however, this anxiety was partly focussed on fear of crime given his newly vulnerable condition.

9 Who suggested that the client go into residential care?

We asked both the care managers, and the clients and relatives, to tell us who first suggested that the client went into residential care. Often the decision grew out of discussion between the family and professionals, with the client generally going along with what was decided. One client's daughter however, who had been caring for her mother in her own home, reported that the ward sister had suggested residential care to her mother, and this suggestion had been reinforced by other patients in the ward who were already living in residential care: clearly the daughter felt a little sidelined by this mode of decision making and felt that she could have continued caring for her mother with more help at home.

Twenty-three clients or relatives reported that the suggestion had originated as shown in Table 6 below.

Table 6: Who suggested residential care? Reported by clients and relatives

Social Services	8
Relative	6
Hospital doctor	2
warden	1
Ward sister	1
private carer	1
GP	1
Friend	1
District Nurse	1
client	1
Total	23

Reports of clients and relatives did not tally with reports by care managers. According to the care managers, the decision was much more likely have

been a joint one following discussion, usually with the client included and often with the client as instigator.

From a total of 33 clients for whom we had information, the family had been involved in decision-making for 17. Of these, the social worker had been involved in four cases, and the social worker plus the client in two.

Table 7: Who suggested residential care? Reported by care manager and case notes

Family only	6
family plus GP	1
Family plus SW	2
Family plus community nurse	1
Family plus client	4
Family, GP, SW and client	1
Family, client and community nurse	1
Social worker alone	2
Client alone	12
client and friend	1
private carer	1
Total	32

This is a much more complex picture than that presented by the client and relatives, and suggests that the decision to seek a residential placement emerged from discussion and is often not attributable to a single individual. However, it is interesting to see that in 12 cases the suggestion is reported to have come from the client only, whilst clients and their relatives are much more likely to see it as coming from the social worker. This is probably because the suggestion is made to the client or relative by another professional, who then raises it with the social worker or care manager. Table 6 illustrates the discrepancy in reporting between the client and relatives on the one hand, and the care manager or case notes on the other.

Table 8: Summary of discrepancies in reporting

	Client /relative says	**Care manager /case notes say**
1	hospital doctor	client
2	social worker	client
3	social worker	client
4	friend	client and friend
5	warden	client and carer
6	district nurse	client and daughter
7	GP	client wished to stay following respite
8	niece	client and niece
9	relatives	client wished to stay following respite
10	client	client
11	ward sister	client
12	social worker	client

10 Alternatives to residential care.

Alternative provision was considered in five cases. In one case sheltered housing was considered, in the other four a return home. In all five cases it

was the social worker who proposed the return home or to sheltered housing, and the client or family who insisted on residential care.

11 How did the client and family choose the placement?

Families who considered more than one residential home had been given a list of care homes by the care manager. They then considered those care homes that had vacancies. Thirteen clients or relatives are known to have considered more than one care home before making a decision.

Locality and accessibility for visiting were important factors in making a choice, and were specifically mentioned as key factors in 9 cases by residents and clients. In some cases the client already knew the home from intervals of respite; indeed, one lady had purposely spent the previous two years taking short periods of respite in a number of homes in order to crystallise her choice. In some cases respite also decided clients where not to go. Some clients opted for their second choice if there was no place available at the first.

Reasons of clients and families for choosing a particular home are given below clients and families (these categories are not mutually exclusive).

Location	9
From respite	9
Chosen from list or saw more than one care home	14
Did not settle in first placement and moved	3
Special needs – difficulty in finding placement	2
No information	5

The importance of locality and familiarity in making a choice is striking, and has implications for the siting of potential VSH schemes. People want to be in localities they know, close to families and their own communities. They prefer to move to places that are familiar, and VSH schemes can become familiar to local people if they are to some extent permeable to the local community, sharing facilities and encouraging tenants to use local shops where possible.

12 Waiting times

Of 23 clients and relatives asked about waiting times once the decision to go to residential care had been made, 14 reported that there was no delay in finding a place – either the client went seamlessly from respite care, or a place was found immediately. Of those who reported that they had to wait for a place, 4 remained in hospital (an average of 8 weeks), three waited at home with no additional services and either managed or 'struggled through' (1, 2 and 3 weeks respectively) two had a short wait at home with an increased care package.

13 Dementia

Seven of the 36 residents had a recorded diagnosis of dementia. These were all 86 years old or under; a prevalence would have been expected of 1 or 2. In fact, a prevalence of 7 would be the number expected from 36 persons in the population at large with the same age/sex distribution. None of the residents aged 87 or over had a diagnosis of dementia; 5 would have been

likely. (Hofman, 1991) From our interview data we would think it unlikely that none of the over 86s (19) suffered from dementia. The social services notes are functional rather than diagnostic, and are unlikely to contain a diagnosis unless it is either prominent in the medical history, or important for management. However, we can be fairly sure that the prevalence of dementia was greater than in the population outside residential homes, but it is not possible to say by how much.

14 Mobility and toilet independence

Fourteen clients used a zimmer frame, and 7 used a stick as a mobility aid. They tended to use the same aid inside or out, although many had not been outside their homes except very briefly – sometimes to put out the rubbish - for a considerable time. Wheelchairs had been used by 8 to go any distance outside. Twenty-two persons could use the toilet unaided.

15 Interpretation

Having reviewed the data captured a judgement was then made as to whether VSH would have been suitable for each service user. There are of course inherent difficulties in making such judgements on the basis of case note information and one or two interviews with client and carer. In making this judgement there were two clear issues to discuss:

- The definition of suitability; most of the clients surveyed would have been safely accommodated in VSH of the types which we visited in the first stage of our study, but far fewer would have been able to take advantage of the high space standards, or facilities, of these schemes. This is mainly because of their extreme old age and frailty, and in some cases memory and psychological problems.
- Many of the clients interviewed would in all probability have been good candidates for VSH some time ago, when they were considerably younger, (but still old). If a partly VSH based care strategy is to be implemented, and if it is to be consistent with the policy aim of preserving independence for older people as long as possible, then admission to a VSH scheme must not be seen as a final admission of dependency, as residential accommodation is seen now.

In order to assess whether a client was suitable for VSH at the time he/she was admitted to residential care, the following questions were asked of the data captured.

"For this client, what were or would have been:

- The advantages of residential care
- The disadvantages of residential care
- The advantages of VSH
- The disadvantages of VSH
- Would this client have been able to take full or moderate advantage of the facilities of VSH?"

Of the 36 clients, we had insufficient data upon 4 to answer these questions at all. Of the remaining 32 clients, 11, including a married couple, were thought to have been suitable for placement in VSH.

The reasons why the other 21 clients were not considered suitable, at the time of their admission to EPH, were as follows:

Very high physical dependency	7
Very high mental dependency	6

Both physical and mental dependency	2
Strong implied preference	2
Waste of VSH facilities	4

It is, of course, possible to contain very highly dependent clients in a VSH scheme, but at a correspondingly high cost. The schemes are designed to give a degree of independence and to encourage choice; where neither of these factors obtain the costs of meeting the requirements are higher than in a scheme where care and services are less variable, as in a residential home. The concept of 'home for life' allows tenants of VSH to *become* highly dependent, where the humanity of caring for them in their own homes outweighs the cost – and this is as true for mental as physical frailty - but where the benefit of continuity is lost, as in the admission of clients who are already frail, the exercise seems to lose its point.

Most of the clients and their relatives were satisfied and happy with the placement, but usually in the sense of resignation to the inevitable effects of old age and frailty; only in two cases could we infer with any degree of confidence that the client actually derived positive enjoyment from the care regime, and would have preferred a residential home to any other placement (even had the choice been offered earlier).

It was possible to infer from the histories of many clients that there was a time before the acceleration of their frailty – in some cases this was many years ago – when a VSH tenancy could have combined the psychological advantages of being perceived as the client's own home, with the physical – and again psychological - advantages of the presence of care services to be drawn on if necessary. A number of clients, for example, had moved some time previously into accommodation which was thought more suitable to their advancing years. Some moves proved unsuccessful – in one or two cases grossly so – and it seems likely that a VSH tenancy would have been a good option at that stage.

There were 25 clients who we could *not* say would have been suitable for a VSH tenancy at the time of their move to residential care. Of these:

- Nine had previously moved into accommodation which became unsuitable but would ***probably*** not have had to go into residential care had their previous move been into VSH.
- Five had previously moved into accommodation (or from an osh scheme bungalow to the main building) which became unsuitable but would ***possibly*** not have had to go into residential care had their previous move been into VSH.
- One was living in the family home and could ***possibly*** have moved into VSH at some stage when her home care package was being increased.
- One had been controlled by an abusive partner and there was ***little*** chance of a move to VSH.
- Five had become very frail quite quickly and were probably deteriorating, and it is possible that residential care will prove insufficient. For the remaining four we had insufficient data to make a judgement.

We have seen, and noted elsewhere, that admissions to EPH from warden supervised schemes are less likely to be as a response to an emergency – and therefore more carefully planned - than admissions from other housing situations. If VSH tenancies were an option, and if wardens in sheltered schemes were to be trained to appreciate the factors which might indicate that such a tenancy were becoming appropriate for one of their residents, then this might prove an efficient

pathway by means of which VSH tenancies could be offered to elderly persons while they are still young enough to take advantage of the opportunity.

The lessons to be drawn from this exercise support the policy recommendations that granting a VSH tenancy should be a well planned event, and not a response to a medical or social emergency. The clear implication of this is that tenancies should be offered earlier than admission to residential care and this in turn implies that only if – and this is obviously desirable – a VSH tenancy is perceived as a persons 'own home' can the present policy of keeping elderly persons in their own homes as long as possible be sustained.

If it is accepted that admission to VSH, as a 'home for life', should be considered earlier in a persons care pathway than residential care is at present – especially if it is to be considered for couples where much of the caring for one is undertaken by the other, - then this has considerable implications for scheme design. Flexibility must be built into the scheme so that a person, or couple, who use few of the dedicated caring facilities can be economically accommodated – and not seen as unsuitable occupants of a scarce resource. This probably means that the ratio of staff (if the VSH system adopted is one with an on-site caring team) to apartments should be lower than otherwise envisaged – or, to put it another way, that the number of apartments should be greater.