


Preventive Approaches in Housing

*An Exploration of
Good Practice*

**Pat Parkinson
Debby Pierpoint**



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About the Authors

Debby Pierpoint was the research and analysis manager at Anchor trust who project-managed this research. She and Pat Parkinson, appointed as our researcher, are the joint authors of this report.

Foreword

by John Belcher

While it might be premature to say there is a 'prevention movement', the growing interest in preventive strategies has been remarkable. These strategies have been gaining support at all levels, from Government departments to frontline social housing and care staff. Although by no means a new idea, prevention has emerged as a catalyst for new thinking in community care.

That new thinking needs to involve housing. For too long housing has not fulfilled its potential to play an equal role alongside social care and health services in addressing the needs of older and vulnerable people. As this report shows, housing is a vital preventive service, promoting and preserving older people's independence and well-being.

By demonstrating its preventive value, this research makes it clear that housing must be central to any strategy, local or national, aimed at improving the lives of older people. Policy makers and service providers need to recognise this crucial implication.

This timely report provides further evidence for a clear assertion: prevention works !

John Belcher

Chief Executive, Anchor Trust

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Glossary

Disabled Facilities Grant (DFG)	A means tested grant from the local council available to owner occupiers and all tenants for adapting a property to suit the needs of a disabled occupant.
General Needs Housing	Rented housing for residents who do not need the extra services provided in supported housing.
Housing Action Trust (HAT)	Set up under the Housing Act 1988 as a vehicle for targeting regeneration money on local authority housing estates with the most acute problems. HATs temporarily own and manage these estates whilst regeneration is taking place. Local Authority landlords may reacquire them once work has been completed or they may pass to another provider.
Housing Corporation	The public body responsible for funding and regulating Registered Social Landlords (RSLs) in England.
Performance Standards	The Housing Corporation's published standards for the regulation of RSLs.
Preventive/Preventative Strategies In Housing	Services or strategies which prevent or delay the need for more costly or intensive services, promote the quality of life of older people and their engagement with the community.
Resident	Includes all types of legal occupier : tenant, licensee, leaseholder and Almshouse resident.
Registered Social Landlords (RSLs)	A body registered with the Housing Corporation under Section 1(2) or 2 of the Housing Act 1996 to provide housing for people in need; most are constituted as housing associations.
Staying Put	A Home Improvement Agency managed by Anchor Trust.
Supported Housing	In this study, accommodation where a resident receives support from the landlord under a formal undertaking, either in sheltered, very sheltered or extra care housing.

Executive Summary

Background and Report Structure

This research was undertaken within a context of increasing interest in the role of prevention. Preventive strategies are defined as services or strategies where the outcome :

- prevents or delays the need for more costly or intensive services
 - promotes the quality of life of older people and their engagement with the community
- (Lewis et al, 1999).

A number of recent policy initiatives have focused on the development of preventive services; key features were the involvement of older people in service development and collaborative working towards more integrated provision and delivery. This study looked at the role of housing within this policy framework.

Taking a case study approach the work looked for examples of good practice in prevention under a number of different themes. These were :

- the role of the built environment; this covered design, improvements, adaptations and issues with a preventive dimension such as location
- how responsive housing management, policies and practice can support and help develop preventive services
- effective communication with older people through mechanisms which encourage their participation in decisions affecting their lives
- collaborative work and interagency partnership
- information and advice on preventive options
- impact of wider policy issues
- funding of preventive work and related issues of costs and charges to users.

The report details how the case study organisations have responded to the need for preventive services under these thematic headings, draws examples of good practice and describes the main barriers to the development of preventive services. The voice of older people is a key part of the research and verbatim quotes are used to reflect the day to day realities of prevention. 'Pen pictures' describe the range of preventive services received by individuals and the impact they have on their quality of life and ability to retain choice and independence. The 'pen pictures' are particularly useful for highlighting the interactive nature and range of preventive services.

Difficulties in costing preventive work and in measuring outcomes are discussed. Checklists for developing preventive services are included throughout the report and brought together in Chapter Twelve. The final chapter of the report makes a number of recommendations for both policy-making bodies and for provider organisations.

Sixteen case studies were included in the research. Ten of these were studied in depth, including interviews with tenants/clients and with both front line and strategic staff. A further six case studies were not studied in as much depth, but nevertheless furnished useful and additional information to merit inclusion in the report. Selection of case studies aimed to cover as wide a range of provision as possible and the final list included Home Improvement Agencies, ordinary sheltered and very sheltered housing provided by housing associations, charities, a local authority and a Housing Action Trust.

The Findings

The Built Environment

The physical environment was key. Registered Social Landlords (RSLs), Home Improvement Agencies (HIAs) and other providers have an important role to play in ensuring that the building fits round the needs of the occupants and so reducing risk and reliance on others. There was frequently little correlation between levels of disability and dependency, if the physical environment was right. Well designed or adapted kitchens and bathrooms allow clients to retain independence, reduce the need for hands on care and support prompt discharge from hospital.

- An enabling environment is important but the preventive role of the physical environment and any adaptations goes beyond the purely functional. Other factors such as familiarity with the area, a sense of home, social networks and measures which enable an older person to continue their interests, such as gardening or singing in a choir, have a preventive dimension. Doing what can be done to alleviate an essentially hostile environment was preferable to moving home for many respondents.
- Initial design of, and adaptations to, the home often focus on supporting physical disablement and poor mobility but need also to take account of sensory impairments, given that many older people have poor vision and hearing.
- Simplified criteria to qualify for small scale services reduces administration and speeds up delivery. A simple criteria based purely on age, rather than complicated needs assessment criteria, was found to be effective in targeting services to a population of older people potentially at risk in their home. Less transparent and protracted assessments and criteria were seen as a barrier to preventive processes and frequently did not deliver adaptations at the point of need.
- Handyperson services run by housing providers and HIAs fitted minor adaptations and helped keep the home safe and in good repair at an affordable cost. HIAs were very much in demand by older people and an important preventive resource, but their uneven distribution meant some older people, mainly owner occupiers and private tenants, could not access their help. They were left to struggle as best they could with hostile environments.

Responsive Management

Services should be client-centred. Listening to what people have to say about the type of service they want, and when they want it, helps give more tailored support and keeps the aims of the service focused. A high level of participation can also encourage older people to apply, who might otherwise be reluctant to admit that help is needed or unaware of what help might be available.

- The attitude of the organisation to meeting needs is all important. The report describes a 'why not?', client centred approach, which looks for gaps in local provision and plugs them, either by setting up additional services or working with other providers to facilitate them.
- The planning of services is important. Once a strategic decision has been made to provide a preventive service, then operational issues such as staffing, job descriptions, training and recruitment all need to be thought through. Planning also needs to include continuing consultation with the client group, existing and future funding of services and consideration of the wider policy context within which the service is being provided.
- The case studies include examples where the preventive aspects of the warden's role had been expanded into outreach work in the community. Outreach services may include visiting, shopping, picking up prescriptions, liaison around repairs, adaptations and equipment, help with moving and befriending services. Sometimes these services were not enough; more intensive services, including personal care for residents, had been set up by some providers. In some instances these were also available to older people in the area across all tenures.

Partnership and Collaboration

All of the case study organisations actively listened and acted upon the preferences of older people they housed or provided a service for; in some instances this had evolved into an ongoing formalised partnership.

- The case studies were open to working with any agency, which might be of help to their clients. Strong liaison links were set up which sometimes developed into more formal partnerships; good communication encouraged collaboration between agencies and helped avoid duplication of services and scarce resources.
- In some instances organisations which could be viewed as competing had found ways of co-operating together to support each others' clients and better target resources. An example of this is building up a bank of staff available to provide support for difficult periods such as holidays and sickness. Other examples include shared staff training and information exchanges.
- Joint initiatives between housing providers and Health and Local Authorities were often described as protracted and not sufficiently responsive. There was little evidence of collaborative strategic positioning for prevention grants among smaller providers who saw their role as largely a reactive one.

A Community Based Approach

The underlying philosophy for a community based approach is usefully summed up by one of the study organisations. Their approach is based on the premise that older people are part of a larger community and that as tenants or clients should be supported in actively participating in the community.

- Being active in the community ensures that organisations are visible and raises awareness of the services they are able to offer. This is particularly important for smaller organisations who might otherwise become marginalised.
- For housing schemes there are two ways in which interaction with the wider community is fostered. Firstly by extending services provided to outreach into the nearby community and secondly by bringing other people into the scheme for social activities or by making the scheme the community meeting place on local issues such as an older person's strategy group.
- An effective community based approach is inclusive and should embrace all older people in a community. The evidence from the fieldwork suggests that there has only been limited success in providing services to groups, who might not be easy to reach.
- Success in areas with significant numbers of people from ethnic minority backgrounds, may require a longer period for services to settle in and become known or more work may be needed to refine the services. Awareness and use of a service may develop through establishing a relationship of trust with key figures in the community who may then act interpreters and/or brokers.
- Success is not based simply on an objective measure of need, but also on a more sensitive and subjective measure of want.
- The benefits from preventive work often stretch out into the surrounding community as well as benefiting individuals. Because of preventive approaches in housing recipients may become more active members of the community and families and carers are supported.

Barriers to Prevention

Information on Options

Who older people approached for information depended very much on who had previously given reliable information, even if this had been about unrelated topics. Housing managers, wardens, neighbours and friends were often approached first, then agencies such as Age Concern and Citizens Advice Bureaux (CAB). The study found that despite some excellent examples of good practice there are still large gaps in the provision of good advice and information.

- Access to advice is less of a problem for those who are already receiving some form of support but for many older people, not yet in the system, making the first tentative enquiries left them no better informed about their options.
- Harder to reach groups, perhaps whose first language is not English or those with sensory impairment or poor mobility, fared even worse.
- Initial information giving is often seen as part of the marketing strategy and does not sit comfortably with giving out information about competitor organisations.

A Lack of Transparency

The processes involved in applying for help with home care and/or adaptations can be frustrating for older people and leave them dis-empowered. The study found considerable gaps in the level of awareness of what other service offer, even where good communication exists between customer and provider.

- Stringent assessment criteria, diverse funding streams, budgetary constraints and the complexity of agencies, their procedures and waiting times all serve to make it a difficult process to navigate.
- Assessment criteria is often not transparent and considerable effort is needed to discover precisely what the criteria is and where people are in the process.
- Both this lack of transparency and the lack of nationally agreed criteria can impede on choice. For example, lack of co-ordination in hospital discharge arrangements and variance in procedures forms a major barrier to preventive work.

The Use of Jargon

- The use of jargon makes it difficult for those unfamiliar with the specific terms to participate and communicate effectively. It was often viewed by users as a means of blocking their participation.

Stereotypes and Ageism

Stereotypical views around age and dependency are a far too common occurrence and examples recurred throughout the fieldwork. These stereotypical views include seeing older people as unable to take risks and this acts as a barrier to preventive work.

- Wardens can feel pressurised to 'look after' older people and older people can feel they are being 'managed'.
- Assumptions about the lifestyles and needs of older people also fed into the design of their physical environment, leaving them with insufficient space to continue family roles or hobbies.

Funding

Funding is criticised by providers as being short term, uncertain and complex. Concern at the present time is focused around the *Supporting People* proposals, with the switch to LA distribution of funds, and the move away from funding through housing benefit.

- Costs were not always clear, making it difficult to fully cost the preventive services offered.
- Providers are concerned that proposed new funding arrangements will continue to favour high level intensive services and squeeze out lower level preventive services.
- The Housing Corporation restrictions on rent and service charge increases to RPI + 1% also impacts on the ability of providers to include preventive services where the additional charges required would take them over these limits.
- Affordability was an issue. Charging policies may hinder take up of preventive services; there was some feedback that if services were too expensive older people would do without but the picture was by no means clear.
- Many respondents saw paying as potentially a means of exercising control over the services they received and were interested in the idea of direct payments. Paying for services had already turned some into active consumers who would go elsewhere if the service they were getting did not suit their needs.
- One area of concern was that present checks on eligibility for disability benefits would be extended to Attendance Allowance. This is a popular benefit with older people, giving them extra dimensions of choice and control over how support needs are met.

Costs and Benefits of Preventive Work

Being able to evaluate the costs and benefits of preventive work is clearly an important area for both policymakers and providers. This has not been possible in this study because of the disparate nature of case studies included with their wide ranging preventive measures. There are also methodological difficulties in designing a model for evaluation of preventive services. It would need to be longitudinal, have clear outcomes and measures specified and have control of other variables.

- For many service providers, preventive services had not been costed separately, but were seen as part of their housing function. Separate costing would need to be done before an evaluation of their cost effectiveness could be carried out.
- An evaluation would also require work to identify what the costs would have been if the service had not been available, i.e. would absence of the service have resulted in a move to residential care or admission to hospital and if so, what costs would have been incurred ?
- A further important issue in relation to cost/benefit analysis is attribution; costs associated with preventive work may be attributable to one agency, while the benefits are reaped by another. This clearly has implications around partnership working, joint commissioning and identifying perverse incentives.
- Anecdotal evidence suggested that prevention in housing was working. Some providers had found that turnover and referrals to Social Services had dropped, but had not collected hard evidence. In general clients' views were that charges for preventive services were reasonable and provided good value for money.

Conclusions

Housing has a clear and effective role in prevention, but its role goes beyond the bricks and mortar and must include the support people might need to sustain their tenancy or stay in their home and provide them with a good quality of life. Prevention is multidimensional : the views of residents and clients, any informal support strategies they have set up and the community aspects of prevention need to have equal weighting with the built environment, management practices and formal care and support.

- Preventive services do not only benefit people with low level needs. They also have a role in supporting older people with high levels of dependency in the community and delaying the move to a more costly residential setting.
- Listening to older people themselves is crucial, both to ensure that the service provided meets needs and preferences and that emerging needs are picked up.
- The older people in the study were very much in favour of initiatives which allowed them some control over their environment and the preventive services they received. Direct payments were seen as potentially useful in retaining their sense of autonomy.
- Lack of transparency in criteria and procedures and lack of co-ordination between agencies, hampers the development of effective preventive services.
- The provision of easily accessible and holistic information and advice is an area that requires more work. It is particularly difficult for older people who do not already receive some support to find out what is available and how it can be paid for.
- Funding is uncertain and fragmented. This makes forward planning difficult, means that staff waste time chasing funds, and can lead to a lack of confidence that services once developed can be maintained. This may result in a reluctance to begin a service to avoid unrealistically raising expectations in clients or finding out that it becomes financially unviable as funding routes shift and change.

Recommendations

There are significant recommendations for the Government, the Housing Corporation, local government, other providers and the Preventative Task Group. They encompass embedding prevention in policy formulation and practice development at a national and local level.

For National Government

A national framework for prevention should be developed covering the key strands of prevention and incorporating strategies across housing, health, social services, education etc.

- Prevention should become a key feature of all relevant governmental reviews and legislation, such as the ongoing inter-departmental review of housing and older people, the forthcoming Local Government Bill promoting the welfare of citizens, and the standards in care to be set by the National Commission for Care Standards.
- Consideration should be given to the impact on preventive services of the *Supporting People* proposals.
- Links should be established with current moves to expand NHS rehabilitation services.
- Prevention needs to be recognised in the public health agenda particularly in relation to the link between defective dwellings and health.
- The outcomes from prevention grants need to be monitored and evaluated.
- Given the complexity and scale of the work necessary the Government should take the lead in establishing a model to provide information on the costs and benefits of preventive services.

For the Housing Corporation

The current review of the Housing Corporation strategy for older people should identify prevention as a key component.

- The Housing Corporation should encourage RSLs to work with statutory and voluntary agencies in developing preventive strategies.
- All of the Housing Corporations investment policies should adopt preventive criteria.
- Housing Corporation performance standards in relation the tenant participation and housing management should reflect the benefit of a preventive approach. For example, performance targets on voids.

For Local Government

Local government should take a strategic view of the need for preventive services in their area. This should be encompassed in the framework of a local corporate preventive strategy.

They should ensure that preventive needs are identified and met through :

- Effective collection of information relating to needs
- Appropriate targeting of resources to promote independence, including the provision of aids and adaptations
- Effective partnerships with other statutory and voluntary agencies, including RSLs
- Making sure that information and advice services are comprehensive and accessible.

For Housing and Support Providers

Housing and support providers, such as RSLs, HIAs, advice and information services should link prevention firmly in to their strategic decision making by :

- Auditing what they currently provide
- Making assessments of current and future needs
- Listening and involving their clients to shape responsive services
- Fully involving staff and raising their awareness on policy and practice
- Identifying the cost effectiveness and benefits of prevention
- Including preventive measures in their design briefs. For example, lifetime homes.

For the Preventative Task Group

The Preventative Task Group should continue to raise awareness in relation to preventive services to ensure that it is a consideration in all relevant policy debates.

- There should be greater synergy between prevention and the health and housing agenda
- The Task Group should support further research to unravel the push and pull factors involved in moves to more intensive care settings and to track changes over time through longitudinal work.

Chapter One

Introduction

Prevention is viewed as sensible course of action across a range of public policy debates. The maxim “prevention is better than cure” can be applied in settings ranging from health promotion (i.e. raising awareness of the problems associated with smoking cigarettes) to crime prevention. It avoids storing up problems for the future and it is “common sense” that it will cost less in the long run.

Prevention in the context of this report is concerned with the housing, support needs and quality of life of older people; the focus for the report is the role that housing is able to play in preventing a need for more intensive and costly services and maintaining a good quality of life.

Although this report is primarily concerned with people post retirement age it should be borne in mind that much of the subject matter for the report yields benefits for the wider population. For instance, universal design and lifetime homes prioritise independence not only for disabled or older people, but for everybody.

Background

The NHS and Community Care Act came into effect in April 1993. It set out the core principles of community care from the 1989 White Paper *Caring for People*, of enabling people to :

- live as normal a life as possible at home or in a homely environment
- stay as independent as possible through sufficient and appropriate care and support
- have a say in how they live their lives and what services they need.

Access to a range of home care services plays a key role in achieving these principles yet analysis of social care provision since 1993 shows more hours being provided to less people as local authorities targeted their resources at the most vulnerable (Audit Commission (1996), and Government Statistical Service (1996)). Low level services are being withdrawn; few local authorities now provide help with housework or shopping except as part of a larger package of care.

Concerns about what happened to people needing low level help, and about how cost effective and how equitable was the policy of supporting only the most vulnerable and dependent, led to the formation of a National Preventative Task Group in 1997, chaired by Anchor Trust. Its aim was to promote the value of preventive strategies and services for older people. Membership comprises several key organisations and is supported by the Department of Health.

Appendix One lists current members.

A programme of work was begun by the Preventative Task Group to raise the profile of preventive work with older people. Recent publications are in Appendix One.

Prevention – A Definition

Preventive strategies are defined as services or strategies where the outcome :

- prevents or delays the need for more costly or intensive services
- promotes the quality of life of older people and their engagement with the community
(Lewis et al, 1999).

and can include anything which :

- helps older people stay independent
- promotes a positive approach to older people
- gives them a say in decisions affecting them
- makes sure the physical environment is right
- supports social, family and community contacts
- promotes health and healthy ageing.

Policy Context

Recent initiatives have sought to meet the following objectives :

- to ensure that older people are secure and can sustain their independence in a home appropriate to their circumstances; and
- to support older people making active and informed decisions and choices about their accommodation, and provide appropriate services

Within this context policy has centred around the need to :

- focus on prevention and earlier intervention
- involve older people in the development of their services
- work in partnership and provide integrated services which reflect choice quality and fairness.

This approach has pushed forward the prevention policy agenda and seen the emergence of prevention in a series of new policy initiatives across health, housing and social care, to specific programmes concerning older people. These include :

Saving Lives : Our Healthier Nation

This set out a national contract for better health, which supports working partnerships between Government, local communities and individuals to improve health and well-being. In particular, it seeks to reduce the risks that affect the quality of life of older people and prescribing action which will be key to preventing illness and dependency in old age.

To aid this process, the Government have introduced a new special prevention grant over three years to encourage local authorities to take a strategic approach with health authorities on prevention. Modernising Social Services White Paper, [DoH 1998c]

The New NHS : Modern and Dependable

Preventing ill-health, disability and social exclusion as a key government priority. Modernising the NHS and social care seeks to generally create responsive, accessible and quality services.

While some of the NHS modernisation is not aimed at older people, as the largest user of health services they will benefit from the new national contract for better health. Towards this, there has been a move towards improved access to advice and information (which is primary prevention) with the creation of NHS Direct.

Health Action Zones

There are 26 Health Action Zones to date covering 124 million people in England. These are seven year partnerships between the NHS, local government, the voluntary and private sector, and community groups which are seeking to develop and implement locally agreed plans to improve the health of local people. Many have adopted preventive strategies to tackling local health inequalities.

National Service Framework

This will set national standards for the care of older people with a number of overarching preventive principles. These include :

- promoting health and well-being
- preserving older people's dignity
- respecting older people's independence
- a co-ordinated approach to care service delivery as a means to prevent moves to more costly forms of accommodation.

National Charter for Long Term Care

Recently published, Better Care, Higher Standards set out what users and carers can expect if they need support from health, housing and social services, and also what individual's own 'preventive' responsibilities are in dealing with such agencies.

Better Government for Older People

A key aim of this Cabinet Office Initiative is to give older people a greater say in how their services are developed and enhance their quality of life. The programme consists of 28 pilot projects to develop, test, monitor and evaluate integrated strategies for and with an ageing population to provide:

- clearer and more accessible information on their rights
- more say in the type of services they can get
- simplified access to services
- improve linkages between different agencies
- better opportunities to contribute actively in their local community.

Royal Commission on Long Term Care

This report *With Respect to Old Age: Long Term Care - Rights and Responsibilities*, emphasised the importance of preventive service, including access to aids and adaptations, assistive technologies, supportive environments and the role housing plays in preventive services.

Better Services for Vulnerable People

Closely aligned to prevention, rehabilitation has an important role to play in promoting independence. The development of timely rehabilitation and recuperation services is a key strand of the government's Better Service for Vulnerable People, (BSVP). Through BSVP, Health and local authorities were asked to produce Joint Investment Plans covering services for older people. These focus on improving outcomes for individuals through the development of services and identify new investment opportunities for user-focused joined up services.

Supporting People

The Interdepartmental Review on the Future Funding of Supported Accommodation recognised that prevention is a vital ingredient for maintaining independence in the home by way of delivering preventive housing and support services.

From 2003, funding for support services will be excluded from housing benefit and local authority's Housing Revenue Account. New funding will come from local commissioning of services, by block contracts and/or spot purchasing to be determined by joint planning mechanisms involving local stakeholders. Key players will include housing and social services authorities, probation services and other providers.

At the time of writing, information on how these mechanisms and arrangements will be implemented and operate at a local level have not yet been fully formulated. However, the funding is likely to be cash limited and therefore will require performance measurements to demonstrate the cost effectiveness and benefit of preventive approaches to service delivery.

Best Value in Housing Framework

The Best Value in Housing Framework forms part of the Government's modernisation agenda. It requires councils to consult with all local people, including difficult to reach groups, to review and improve services by the best means available. Best value cuts across traditional service and organisational boundaries and has a fundamental role in addressing cross-cutting issues to improve quality of life for all of the local community. This is clearly an important vehicle for carrying prevention forward.

Why This Project Came About

A key focus of the research programme for the preventive task group is the role of housing. With funding obtained from a Housing Corporation Innovation and Good Practice Grant this study was commissioned into the role of housing in preventive strategies and services for older people.

What the Project Sought to Do

The project had two main objectives:

- i) to promote the role that housing already plays in preventive approaches and
- ii) to highlight how the further potential of the role can be developed. This would be by :
 - identifying what preventive approaches in housing and housing management work - and why
 - producing an accessible report on good practice enabling providers to identify practical, preventive areas in their own provision which could be developed
 - encouraging networking of preventive strategies through inclusion of contact points
 - identifying wider policy issues around prevention in housing.

Although the report was aimed primarily at RSLs the fieldwork would include other housing providers, including local authorities, and the work done by HIAs to support older private tenants and owner occupiers. The intention was to pick up any gaps, linkages and areas of collaborative working between tenures which promoted social engagement and inclusion.

Initial discussions with housing providers showed that many are considering how best to develop preventive strategies; many more are now at the planning stage and would welcome contact with others to avoid re-inventing the wheel. The third aim of this report, to encourage networking, was included in response to requests for contacts and information on local preventive strategies.

Format for the Report

A case study approach was taken for the research; details of the method adopted are set out and discussed in Chapter Two.

Chapter Three looks first at what can be done to ensure that the built environment meets preventive objectives, including access to adaptations and equipment.

Chapters Four and Five consider how providers, as part of their housing management function, can help residents sustain occupation through provision or facilitation of services.

Chapter Six looks at collaborative working between providers and other agencies from local informal partnerships to larger strategic and more formal agreements and then considers the community aspects of prevention.

Chapter Seven brings the voice of older people into the debate, firstly by illustrating and discussing the importance of their input into preventive strategies. A series of pen pictures then shows how a complex interaction of personal resources, informal and formal support and the right environment all contribute to effective prevention.

Many of the organisations which provided examples of good practice have also encountered examples of barriers to effective prevention; these are set out in Chapter Eight. Each section ends with a checklist of suggested action points, which are collected together in Chapter Twelve.

Chapter Nine looks at the impact of funding and charging policies on prevention.

Chapter Ten considers the issues around costing and assessing the impact of preventive work. Conclusions and recommendations arising from the report are covered in Chapter Eleven.

Chapter Twelve brings together the checklists.

Chapter Two

The Study

This chapter sets the scene for the study and describes the method used. The feasibility of costing and evaluating preventive work is explored and discussed, and reasons for the evaluative framework used are set out.

Setting the Scene

Many older people as tenants and owner occupiers need varying levels of preventive support from help with housework to a more accessible bathroom to enable them to stay in their own home and have a better quality of life. Walker (1996) found that help with heavy housework and shopping was rated highly as a preventive service by older people. However, current targeting of social services resources on people with the highest needs has meant less access by older people to local authority funded low level services such as housework and shopping (Watson 1997).

At the same time making the bathroom, or kitchen, easier to use has become more difficult. Reducing funding and rising demand for Disabled Facilities Grants has led to increasing delays in making the home better suited to the occupants' needs. The average time found by the Audit Commission (1998) from application to installation of a routine adaptation was 14 months. Funding preventive services in housing, including adaptations and community alarms, is an issue to be resolved over the next three years as the existing mix of funding mechanisms through housing benefit and grants is reviewed as part of the Government's Inter-Departmental Review of Funding for Supported Housing.

The pressure on local authorities, RSLs and HIAs to create and maintain appropriate physical environments is unlikely to reduce. Residents' rising expectations and growing numbers of older owner occupiers in the next century should fuel an increase in the preventive work currently done by HIAs in supporting independent living.

Many housing providers have responded to these increasing pressures and difficulties by setting up more intensive housing management procedures which are preventive in effect; they facilitate care services, set up funding mechanisms for adaptations and do what they can to help maintain independence and quality of life. In so doing they hope to delay or avoid the need for their residents to move on or the use of more costly forms of care. HIAs have expanded the support they offer clients and now link into wider community strategies with preventive outcomes. How these providers and agencies have done it, why their approaches appear to be effective and the underlying issues of good practice emerging from the fieldwork, are the subject of this study.

Methodology

A Case Study Approach

A case study approach was chosen to explore examples of effective prevention in place. A list of housing providers, including RSLs, and HIAs thought to have a preventive approach was drawn up using a number of sources : the National Housing Federation's Directory of Members, articles and reviews in journals and newspapers, information from the Nuffield Institute of Health's mapping of preventive strategies, Anchor's Directory of Research and word of mouth.

The list was intended to include rural and urban settings and to ensure representation of ethnic minority populations. It was not restricted to sheltered housing; 90% of older people live in ordinary housing, as owner occupiers, leaseholders or tenants, (Shelter 1998). Although this report focuses primarily on good practice for rented social housing providers the study aimed at including as wide a range of tenure and settings as possible to pick up shared factors and areas of collaborative and inclusive work.

Extra-care housing where the support provided was by block contract with the local authority was not included; this level of support is not reproducible by most housing providers. Neither did the case studies include those with additional preventive measures for people with dementia or incontinence although these are often the trigger for older people moving on. Discussions with providers indicated that they saw these as specialist preventive measures and outside the run of ordinary housing provision for older people, although some of the case studies did support existing residents and clients with dementia.

Common factors in the selection of case studies were :

- a preventive approach
- that the role of housing within the approach could be identified
- that the approach and outcomes were reproducible by other providers to a greater or lesser extent
- that it was possible to talk to tenants/residents/clients as well as providers/managers.

Preventive approaches were evidenced by measures described as promoting quality of life, helping sustain occupation and reducing the need for more costly care and support. Priority was given to case studies where older people, whether as residents, owner occupiers or clients, were seen as having an active, participatory role in prevention.

30 potential case studies were contacted. The intention had been to select up to ten case studies for an in depth study, including site visits. However, a great deal of good practice emerged during initial discussions, which would enrich the report and merited reference. Time constraints meant that it was not possible to study further case studies in as much depth, but nonetheless six additional cases were investigated, but not necessarily including a visit or interviews with clients/residents.

These additional studies included further preventive services and outreach services for older tenants in ordinary housing and as owner occupiers. There were some links between the two groups of case studies through residents who were clients of preventive services from another provider. The

final list of 16 case studies included HIAs, general needs, sheltered and very sheltered housing provided by housing associations, charities, a local authority and a Housing Action Trust. The case studies (Appendix Three) clearly indicate whether a full or partial study was conducted.

The study does not provide a national picture of all preventive strategies and linked good practice; it offers a snapshot of what is being done, effectively, by some providers and agencies.

The Main Themes

Framing the Questions

What makes housing preventive? The work looked for good practice in prevention under a number of overlapping thematic headings.

The Physical Environment

This has to maximise independence and not, through poor design or a failure to meet changing needs, further disable its occupants. The Audit Commission (1998), Age Concern (1997), and Shelter (1997) describe what happens to quality of life for older people when buildings fail to meet needs or support delivery of care. Adaptations need to be both appropriate and timely; Smart et al (1997) discuss and illustrate how action by HIAs contributes to preventive outcomes at both an individual and community level.

Although this report is aimed at RSLs, housing policy since 1979 has encouraged owner occupation. Many older occupiers find it difficult for a number of reasons to keep their property in good repair. (Forrest et al 1997). An objective of the study would look for instances of collaborative working between tenures, which have preventive outcomes for older owner occupiers as well as residents. Projects such as those recently outlined by McLean (1999) and Groves et al (1999) which support owners occupiers through local authority and RSL maintenance initiatives and have an inclusive dimension were examined.

The study asked what could be done to provide or enhance the preventive role of the built environment, including timely access to appropriate adaptations and equipment? The fieldwork looked at as many factors as possible in the built environment to pick up those relevant to prevention, including adaptations, size of rooms, design, location, and accessibility.

The Role of Responsive Housing Management

Prevention in housing goes beyond bricks and mortar to include a range of support services which enable people to sustain occupation, from advocacy and help with benefits to intensive care services. The role of housing in community care and the interdependence of housing and care for older people has been spelt out in a series of recent reports (Audit Commission 1998, National Housing Federation 1997, Thompson 1999, Watson 1997). There is a clear role for responsive housing management in identifying and supporting the housing dimension of community care through access to such services.

The study examined how providers see prevention fitting within their provider role and what changes did it necessitate in their housing management? It identified appropriate policy and practice frameworks which support preventive strategies set up by older people or which facilitate provision of services from a range of agencies.

Collaborative and Interagency Work

These are not only a means of facilitating community based, preventive services at an individual level; the linkages they form also help combat social isolation and marginalisation. Without interagency working and support many older people cannot sustain independence and engage in society. *Caring for People* (1989) set out a framework for developing and delivering a seamless service for users. Practical guidance on how this can be done is found in Means (1997) and in a DoH discussion document *Partnership in Action* (1998).

The study considered how important was interagency collaboration in supporting prevention firstly at an individual level and then as part of local preventive strategies. It questioned how far did preventive strategies contribute to the inclusion of older people in a community across a range of tenures? What linkages were there with wider policy issues?

Personal Resources and Informal Support Networks

Personal resources which clients or residents have and how they define preventive support within their day to day life would be reflected in their response to and take up of support services. Biggs (1993) discusses how the threat to an ageing identity and sense of self is “*doubled once the limitations associated with age can no longer be ignored*”. More recent work by Langan et al (1996) demonstrates the determination of older people to stay put where possible, and reduce the threat to sense of self by “making an effort”. This included keeping their reliance on formal support services to a minimum and re-organising lifestyles and routines to maximise what they could do.

The study explored how far they should be mediated through client-based needs assessment. How much input did older people have in the type and level of service received? The study also looked at the interplay of preventive factors at an individual level; how multi-dimensional is prevention and how it affects planning and delivering of services ?

Accessible Information, Advice and Advocacy

Without information to make people aware of all possible options any preventive objectives could be unrealised or reduced in impact. Allen (1993) found that most older people are not aware of sources and types of help available before a need arises. At this point, they find it difficult to get information, and so exercise choice and participate in decisions about their care. More recent studies (Parry et al 1999), (Heywood et al 1999), make similar points. The role of advice and information in prevention and housing would be identified as an integral part of the study. Can people find out what their preventive options are? Can information be tailored to help people with complex queries? Is information available accessible?

Costs, Funding and Charges

Policy makers and providers want to know what works in social care to help develop evidence based practice and so better target resources. There are considerable risks in attributing outcomes in prevention; inputs can come from a range of sources the detail of which would not necessarily be known by the contributors to this study. These and the impact on prevention of shifts in funding mechanisms, of charges for providers, clients and residents would be explored in the case studies.

Preliminary discussion with providers around these themes helped shape broad questions for the study which became the interview topic guides and contextual questionnaires (in Appendix Two) They were open ended to get as wide a range of information as possible and to pick up on other areas of effective prevention not previously considered.

Interviewing Providers, Staff, Residents and Clients

Face to face and telephone interviews were carried out with 38 staff, and 49 clients and residents in the ten more detailed case studies. These interviews were supplemented by contextual questionnaires on residents, clients, services and accommodation provided, and by letters, leaflets and annual reports. In the second group of six case studies explored in lesser detail; ten senior staff were interviewed by phone and their information supplemented by additional documentation. Interviews in both groups were based on the topic guides in Appendix Two.

Where possible additional telephone and face to face interviews were done with Social Services, voluntary groups, health professionals and other providers, to establish the extent of their involvement in the preventive strategies, and to discuss the impact such strategies had on their work.

Wardens, housing managers, and community development officers met during the course of the work were asked for their views on what needed to be in place for prevention to work. All questions and discussion topics followed those in Appendix Two.

Costs and Benefits

At the outset the study was intended to include a cost benefit analysis of prevention. It quickly became clear that a full analysis of this nature would not be possible within the research method chosen. The selected case studies were deliberately disparate in their nature to try and capture as many different ways as possible of approaching and delivering preventive services in housing. This made it impossible to control variables and to make anything other than simplistic comparisons between case studies.

Clearly the cost and benefits of preventive strategies are an important issue for both policymakers and providers to ensure value for money. For this reason further research should be undertaken to develop an appropriate model. There are however a number of difficulties: firstly prevention is too loose a term to be tackled in this way. Establishing the impact of a preventive service requires the service to be broken down into separate, identifiable parts to

allow exploration of cause and effect. Then preventive outcomes would have to be closely defined to assess and put a value on observed/reported benefits. This is not a straightforward process. For example improvements in quality of life is a very subjective term. There is no “professional consensus on what constitutes a good quality of life for older people” (Hughes 1990) and how it could be measured.

Even where there is agreement on what constitutes a set of outcomes and how they can be measured, it would be difficult to establish causality given the huge range of other material factors in older people’s lives. Linking a particular preventive input to an outcome can be problematic. Mrs Jones’ health improvement may have arisen partially because an HIA has fitted a new heating system in her house but also because she has started regular trips to the swimming baths and has made new friends there.

The complexity of funding and costing structures found in the fieldwork demonstrates how difficult it is to unwrap the variety of inputs and their costs which make up preventive services, particularly where their success comes from multiple approaches and services working together. Where information on costs and funding was supplied it has been included but it was too fragmented to analyse; further discussion around costing preventive work is in Chapter Nine.

Evaluation

Evaluating how well the central preventive objectives of maximising well being, promoting independence and quality of day to day life had been met was not easy. Whatever form of measurement was used needed to reflect the aims and objectives of the service being evaluated yet many services were highly responsive, developing and adapting to meet changing needs of users or in response to changes in local conditions and could offer no evaluative baseline. Certainly as Gaster (1991) comments there was at times difficulty within the time frame of the study in separating the satisfactory experience of a process from a longer term preventive outcome. A flexible, listening response to a client’s wishes for a service may be defined as a process - but it can also represent part of an effective outcome for the client and meeting an objective by the provider.

Because many of the preventive strategies were continuing processes rather than short term interventions, the decision was made to evaluate possibly intermediate outcomes through the criteria of clients/residents, providers, health and social care professionals in the study. Using personal and professional criteria as benchmarks of effective prevention may result in subjective evaluation and difficulties in attribution but some of the outcomes, such as improved quality of life, are by their nature subjective. Evaluation was pluralistic, taking views from a number of sources to get a consensus on effective strategies prevention and supporting good practice. Throughout the study this method and evaluation framework was itself kept under review to test validity and reliability.

What supported this decision as the fieldwork progressed was that personal and professional criteria, arrived at independently by people being interviewed, shared common factors and

there was agreement on what approaches and initiatives worked and why. Residents', patients' and clients' criteria for an effective preventive approach in housing centred around :

- improved quality of life
- having an input into assessment and service delivery
- people staying where they want to be
- deferring or reducing the need for long term or more costly care and support
- affordability.

Outcomes meeting these criteria in the shape of reliable, flexible client centred services were seen by them as effective preventive measures. These attributes reflect Social Services Inspectorate attributes of quality home support services (SSI, 1993). Such criteria were equally important for providers, health and social care professionals but most had additional criteria, which could affect the viability of preventive strategies and services. These were :

- funding mechanisms which supported current projects and allowed for future planning
- impact of preventive work on other operational areas such as staffing and training
- impact of prevention on the day to day life of existing and future clients/patients/residents
- fewer crises precipitated by unmet needs
- improved health - or at least stabilised health of residents/clients/patients.

Where preventive services were one off interventions, such as in Staying Put and Care and Repair agencies, a holistic approach had meant clients receiving additional services such as information on benefits or contact with other relevant support services in the community. This in itself could become a long-term preventive process for that client and could best be measured through the above criteria.

By asking a range of people what worked for them and why, what didn't work and what could be done better, it was also possible to see what other factors, although not part of the services being provided, had a preventive effect and needed to be considered when planning, delivering and evaluating services.

Evaluating Through Comparison

Many people described what it would be like for them if they couldn't access the preventive measure :

"Without them I would be in a home"

Woman aged 73 in general needs housing, with severe rheumatoid arthritis affecting both knees and an elbow, receiving a range of low level home support services and some personal care.

"Life would be very dull if I didn't get out"

Woman aged 71, in sheltered housing, who was escorted out for coffee and shopping trips once a week in her wheelchair.

“They can’t get us out now (into a home)”

Couple in their seventies, owner occupiers, whose house had been unfit and now was warm, safe and accessible.

“I wouldn’t be able to manage - it’s as simple as that. And I wouldn’t leave here to go into a home”

Man in his 70s, in a wheelchair, RSL sheltered tenant, adapted flat and package of statutory care supplemented by lower level preventive help from independent carers.

Such comments were useful; they illustrate what residents and clients didn’t want to happen and how far the services received prevented negative outcomes for them.

Finally, all the information collected was looked at again, to identify broad principles which made for, or hindered, effective prevention across the fieldwork. Earlier correspondence and discussions during the selection of the fieldwork had produced much useful data and this was also reviewed.

Input From Older People

The voice of older people is an important part of this study. They helped define successful outcomes in the case studies. In the final stage of the study 83 older people provided a reference group. They commented on the good practices and key factors coming out of the study and identified many of the key principles and barriers in Chapters Three and Four. This reference group came from some of the case studies, from already established older people’s forums, such the Hartlepool Local Service Network (Summerville et al 1998) and from tenants groups in mainstream and sheltered housing. The aim was to get as many perspectives as possible from older people in different housing tenures.

Ethical Issues

There are ethical issues surrounding research and older people including exploitative methodology, which extracts information from respondents without giving anything back and assumes consent from people too frail to get up and walk away.

The aim of the methodology was to have all respondents as equal partners in the transaction. To this end full information about the study was supplied and consent obtained in advance. People were advised they could stop the interview at any point. Care was taken during the interview not to raise unrealistic expectations of changed local services, but people’s views were validated and the value of their role in the process emphasised.

They received a copy of the interview transcript which they could add, delete, and amend to ensure that their views had been correctly recorded. Finally the interaction was a two way process, any information they wanted was supplied.

Summary

This chapter has outlined the method and structure of the study. The themes to be explored in each of the case studies were presented as a series of open ended questions. In the following seven chapters the responses to those questions are set out as key factors, supporting good practice and potential barriers but running through much of the fieldwork was a strong sense of the interdependence of many factors. This contributed to the effectiveness of the strategies - for instance a pro-active approach to prevention coupled with good practice on resident participation and the availability of quality local support services could produce a total preventive impact greater than the sum of its parts. This interdependency will be explored further in Chapter Seven but the following chapters need to be read with that point in mind.

The next five chapters of the report look at the preventive measures found in the case studies, some personal perspectives on prevention and barriers encountered. The first of these chapters is concerned with prevention through the built environment.

Chapter Three

The Value of a Preventive Environment

Preventive environments help people stay independent through good design and timely adaptations. When needs change or at crisis points preventive environments can be altered to minimise disability or support prompt discharge from hospital. This part of the chapter looks first at how preventive the housing environments were in the case studies, and how good practice and initiatives helped older people achieve preventive objectives. Some potential barriers are also discussed.

Many initiatives described come from agencies other than RSLs; they are included because they share common preventive approaches, initiatives which can be copied or contribute to social inclusion. Other dimensions of prevention in housing, such as the importance of location and familiarity with local resources, are brought into the discussion. Finally softer design issues such as sunny rooms and bird tables are briefly considered. Examples from the case studies are used to illustrate good practice.

Getting the Environment Right

The study did not explore in detail how providers managed the process of adapting a building. Advice and good practice on this is covered in The Housing Corporation's guide (1998) to carrying out adaptations. What the study looked at was the attitude and approach of providers and the role of management. This, and the culture of an organisation, is dealt with more fully in the next chapter but what clearly emerged from the fieldwork were examples of good practice underpinned by commitment to ensuring the building fitted the occupants - and not vice versa. Good practice was illustrated by fully accessible, well planned flats which enabled respondents in wheelchairs or those with disabling impairment or diseases to live independently, often with little or no input from care services. This meant there was frequently little correlation between levels of disability and dependency on services if the physical environment was right.

It was also illustrated by small but important changes to the environment to help individuals maintain the semblance of independence. Leicester Quakers Housing Association has had considerable experience in developing housing for people with dementia and have used this expertise to provide unobtrusive support for sheltered housing residents with dementia; special timers and safety cut outs on appliances and "fiddleproof" central heating controls mean residents stay safe and warm.

Preventive features can be incorporated in either new build or remodelled dwellings. It is the preventive approach of the provider combined with careful use of often limited space and the input from occupants which matters.

Examples of Good Practice

Inkerman HA in London has converted three Edwardian terraced houses into 34 self contained flats. 31 of the flats and the shared areas such as the garden, library, activities room and dining room are all wheelchair accessible. Adapted bathrooms and kitchens ensure that tenants with progressive illnesses and severely impaired mobility can manage many activities of daily living without help.

Liverpool HAT consulted extensively with tenants over design and space issues to ensure that they moved into flats and bungalows which reduced potential need for support services and allowed them space for the hobbies and interests which give meaning to life.

Portsmouth City Council Housing Department has a strongly proactive housing strategy; a key element is that good quality, affordable and well managed housing should be available across all tenures. To support this strategy it has built up partnerships with the voluntary sector to dovetail all initiatives into a city-wide preventive approach. Areas of poor housing are identified as part of a Housing Renewals programme and a range of funding is used to get the best mix of home improvements, energy efficiency and adaptations.

During the course of writing this report, Part M of the Building Regulations came into force. This relates to access standards in residential dwellings and reflects some of the key principles of the lifetime homes standards set out below :

Lifetime Homes Standards

The Housing Corporation recognise that many sheltered housing schemes require modernisation to create an environment conducive to an independent lifestyle. Towards this the Housing Corporation have introduced a new grant for remodelling. Preventing disabling environments is a specific objective of this programme. The Lifetime Homes Standards are set out in Appendix Four.

Reducing Risk and Reliance on Others

Respondents in ordinary and sheltered housing experienced the same problems as those surveyed by Age Concern in 1997. They had difficulty getting up and down steps outside the house, using stairs, getting in and out of the bath and opening windows. Altering the environment as their needs changed had helped many respondents stay put; for some the risk of falling and reliance on others for meals and 'hands-on' care had been reduced by repairing and appropriate refitting of kitchens and bathrooms.

Where housing providers and HIAs had developed fast turnaround times for straightforward small adaptations, the prompt installation or supply of equipment had removed the need for ongoing hands-on care in getting bathed, or allowed people to leave hospital and come home. Good practice in organising prompt access to adaptations plus collaborative working with other

service providers as part of a specific project meant less delay for respondents in being discharged from hospital.

There were also examples from the fieldwork where adaptations and equipment had enhanced quality of life. One respondent had bought long handled gardening tools and then with an imaginative Occupational Therapist had worked together to adapt equipment so she could transfer from a wheelchair to an adapted shower seat and so garden on her large balcony. Her flat was already “excellently adapted” by her RSL for independent living but being able to garden gave extra colour to her life.

Example of Good Practice

Bury Staying Put runs a Home from Hospital project funded by joint finance and some charitable funding, to make sure older people come home to a safe, warm environment. Also included is benefit maximisation, advocacy and help with form filling.

With input from an occupational therapist Burnley Staying Put carries out minor adaptations within three days for hospital discharge clients. Less urgent jobs are completed in ten days.

What the client said

“What they (RSL and HIA) did was marvellous. I came out (of hospital) and there was my bathroom and bedroom all ready for me with handles just where I needed them. And they’d sorted out the step down to the kitchen too”.

Client in her seventies who’d had a stroke.

Help by handypersons with tasks which were part housework, part keeping the home in good repair and part supplying minor adaptations, was also much appreciated by older people in sheltered and ordinary housing.

Examples of Good Practice

A free Handyperson service is provided to sheltered housing residents of Leicester Quakers HA, an RSL; he helps with moving in, carries out small repairs and adaptations and will help with some cleaning.

Paddington Churches HA, another RSL, provides handyperson services to disabled tenants and older tenants in their sheltered and ordinary housing. Jobs include help with moving in, putting up shelves, laying carpets, fitting locks and small repairs. Tenants pay only for materials. Paddington Churches HA also have limited charitable funding available to help older and disabled tenants decorate their house.

Inkerman HA provides a handyperson service, carrying out small repairs, putting up grabrails, both inhouse and as part of its community support service. He also helps with repairs to household equipment.

Early Preventive Action

Innovative approaches in prevention were demonstrated by projects which aimed at adapting the environment before needs changed or became apparent.

An Example of Good Practice

A project by Nottingham Social Services offers simple inexpensive equipment such as grab rails, half steps, additional power points, door entry alarms on demand to anyone over the age of 60 living in their area. Equipment is free, there is no assessment of need but a third of clients referred have had a fall in the past year.

Projects such as these were seen as cost effective preventive measures by housing and service providers and very much so by occupational therapists contributing to the study. With the ramp or modified taps had also come a sense of security that help was available should anything else need doing. Some HIA clients remarked that they had previously been nervous, some very worried, about what they were risking by asking for help. How the service had been offered and the degree of participation by the older person had left them confident about contacting services again without risking their independence and autonomy. Evaluation of preventive work in getting the physical environment right had also to include this positive, inclusive aspect which laid the groundwork for future help.

Overcoming Potential Barriers

In amongst the good practices there are some potential barriers. Although many providers had made provision for older people with physical disabilities few automatically made provision for sensory impairments apart from the HIAs and providers, such as Portsmouth City Council, Riverside Housing Association and the Liverpool HAT, who work to Lifetime Homes standards. Yet more than one person in five over the age of 75 is blind or visually impaired Royal National Institute for the Blind, (RNIB 1995) and the Royal National Institute for the Deaf (RNID 1994) estimate that 36% of people over 60 have some hearing loss rising to 60% of those over 70. Little thought had been given to ensuring that lighting levels, surfaces, and equipment maximised impaired sight and hearing although these are key areas where independence can be undermined by poor design or supported by the right equipment.

Induction loops, non-reflective surfaces, vibrating fire alarms, colours and textures which distinguish where stairs began and similar provision was often seen as an “add-on” to otherwise well designed living spaces. They were put in on an individual basis and usually when there was a clear risk of the person slipping or being burnt. This is clearly an area where RSLs and other housing providers need to consider, in consultation with users when designing inclusive environments.

There were also examples of long delays in accessing adaptations which, when compounded with less well designed kitchens and bathrooms, created potentially disabling environments for

older people. Some sheltered housing and flats for older people built in the last 20 years assumed a person able to get into a domestic bath installed against a wall or able to reach into head height kitchen cupboards. Increasingly residents were unable to do so.

Some respondents had moved to get a more preventive environment. For example, a smaller, warmer, and easier to clean flat. In some cases, they found baths difficult to get into and that they could not lift dishes out of ovens. Where adaptations had been carried out they could still be inappropriate and indicate poor practice. In two cases a shower had been installed but the shower tray was too high to step into with ease and the residents were still exposed to the risk of falling if they used it on their own.

In another instance, where care was provided, the siting of baths and showers and the size of bathrooms meant they could not always get near enough to help. This had led one respondent with restricted movement after a stroke having to use a bathing service in a local day centre twice a week. This she greatly disliked having to do. Both her quality of life and sense of independence plummeted on those afternoons. Lack of funding had been given as the reason for the delay in adapting this respondent's bathroom.

Funding is discussed further in Chapters Five and Nine but three of the case studies had responded to local delays by setting up their own adaptations fund and one liaised with residents and relatives to part fund and speed up the process.

Examples of Good Practice

"We now use our own architects department and have our own budget for adaptations to ensure that what is needed is done - and at the right time. We have provided things like level access, flashing door bells, showers. And older tenants are prioritised for central heating installation, given contacts and information on extra security and energy efficiency"

Paddington Churches HA.

St Monica's Home Bristol has an in house adaptations service for residents and through charitable grants helps older people in the community pay for adaptations or repairs to their homes.

Portsmouth City Council has set high performance targets and streamlined application processes and procedures for adaptations, repairs and improvements. This means that applications and referrals are turned around quickly. Applicants do not suffer the same degree of delay which afflicts many HIAs.

Other Preventive Factors for the Home

There were other ways in which the environment could be preventive. Having a home which was easy to keep warm and clean, which had sufficient space to pursue hobbies and continue family and social links could be as important as a walk in shower in deferring the need for help

with housework, more expensive support or moving on. For many low income respondents HIA work on their homes as part of an energy efficiency package had reduced fuel and maintenance bills. This in turn had freed up money to pay for additional help as and when they wanted it; both quality of day to day life and autonomy had been improved.

Example of Good Practice

Burnley Staying Put, in conjunction with Burnley Borough Council and supported by Age Concern England, run a Home Improvement Plan which offers older owner occupiers a package of measures to keep them warm and make the house more energy efficient.

Where the home was located and how long people had lived there was also relevant. Some evidence came from people in sheltered housing studio flats. They weighed up the restrictions that lack of space imposed on family networks. It made it difficult to have a sister to stay overnight or grandchildren to tea, and they had decided that they could not cope with moving somewhere larger. The familiarity of their home and the surrounding area gave them security, helped them cope and maintain their role in the family.

The Resident's Perspective

"My sister's not been too well lately and comes some weekends. She sleeps on that Put-U-Up next to my bed. It's not much use her being in the guest room at the other side of the house if she needs me in the night, is it? It's not ideal, just this one room, but no I wouldn't move."

Sheltered housing resident with studio flat in her eighties; the warden knew of the arrangement and had also sign-posted useful health advice to the resident's sister.

Older people in the fieldwork struggling to maintain slightly larger properties with unused bedrooms and dining rooms were also unwilling to move from a small familiar area where they had lived for some time and could access their other support systems such as old friends, their GP or their church. Nearby shops, neighbours, access to transport or mobile facilities were important in supporting existing patterns of living and would not be easily given up unless a new home and location could match the preventive benefits they offered.

Finally, what could be considered as inessential issues in housing also had a preventive impact on respondents' lives. Bird tables, flower beds, sunny rooms and pleasant outlooks helped many respondents enjoy life as mobility decreased. Some also commented on the fact that being in the middle of a busy street and able to watch people go by, and "see what's happening" gave them a sense of still being part of a community. These were as important as more obvious preventive measures in maintaining the sense of being part of a community and are illustrated in the 'pen pictures' in Chapter Seven.

Checklist 1 The Preventive Environment

Does your organisation ensure a supportive environment through design, appropriate adaptations and equipment ?
Make friends with your local Occupational Therapists and consult the Disabled Living Foundation.



Do you make provision for people with impaired sight and hearing? Periodically consult with clients and residents and specialist sources of advice such as RADAR (Royal Association of Disability & Rehabilitation), RNIB, RNID, and local support groups to keep up to date on available help and developments in technology.



Do you provide housing that is pleasant to live in and has space for different lifestyles ? Do you listen to the occupants ?



Do you remember the preventive dimension of issues such as location, available amenities, daily routines, transport and social networks within housing strategies and consider how you can help support them ?



Chapter Four

Responsive Management - The “Why Not ?” Approach

A preventive approach goes beyond ensuring that the bricks and mortar remain responsive to resident needs; it has to include the support needed to sustain occupancy and promote quality of life. What the fieldwork produced was a range of support initiatives, preventive in effect and reflecting local needs and resources. This chapter outlines those initiatives. The next chapter discusses any changes they necessitated in policies and practice and how they were underpinned by good practices in consultation, planning, delivery and evaluation. Checklists are included after each section. Examples used are largely from housing providers but many instances of good practice quoted were also shared by HIAs.

Providing Low Level Preventive Help

Sheltered housing already offers warden services as part of its housing management function. Exact job descriptions and titles vary but generally include an overall responsibility for checking residents' welfare, helping them access services, providing information and sometimes arranging social activities. Case studies looked at had extended the preventive aspects of this role to set up low level services to support firstly their own tenants and then other vulnerable older people in the area.

The four following case studies had begun outreach warden services; all offered contact or visits at agreed times, 24 hour alarm call system, information, benefit maximisation, advocacy, liaison and referral to other support organisations plus additional help they had identified as being needed locally.

Examples of Good Practice

Paddington Churches HA, an RSL, have an outreach support worker for all older tenants; shopping or cleaning can be done in emergencies. New tenants over 60 are automatically referred for support during the first six months; research had identified high levels of tenancy failure during this period.

Accord HA, an RSL in the West Midlands, have an outreach service offering floating support to all vulnerable tenants in their ordinary, sheltered and very sheltered housing. Additional help with living skills and counselling is available.

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More Examples of Good Practice

Flagship Housing Group, an RSL, provides housing and support to people in dispersed small communities throughout Norfolk. It provides a home visiting service to its own tenants and has extended the service to people in their own home as owner occupiers. If needed essential shopping and prescriptions can be picked up and delivered by the support worker. They also rent out community alarms as a separate service to all client groups in their own homes.

Notting Hill Housing Trust, an RSL, are piloting a home support service for older people in NHHT housing, those on housing benefit and those referred by Campden Charities. Liaison with other providers over adaptations, repairs and equipment and help with moving is part of the service, which also includes befriending and escorting, using volunteers.

Additional Services

Sometimes these services were not enough; providers had gone on to develop additional in-house support such as meals, laundry, shopping and cleaning as residents began to find it difficult to carry out these tasks and local provision of these low level services was non-existent, unreliable or subject to changing eligibility criteria.

Examples of Good Practice

Very sheltered housing at St Monica's Home in Bristol, a charitable trust, includes the following in the weekly charge: daily lunch, laundry and 1 hour's domestic help a week, transport for shopping and appointments, use of on site nursing home and health facilities, including respite, and information on benefits.

Residents of Leicester Quakers HA, an RSL, can choose from a range of in-house services, comprising a part time handyman, lunch 5 days a week, assisted bathing facilities with own carer or with LQHA bath nurse, pendant alarms, on call night staff, "Finance Clinic" advice about bills, claim forms, and benefits. The bathing service began when help with bathing was unavailable locally through social services.

Flexible Personal Care

Personal care had then been added to the services being developed for the same reasons; it provided the quality and level of help which enabled residents to stay put within a known environment. In some cases it supplemented statutory provision which the client felt did not cover all their needs.

The following five case studies developed flexible personal care services initially for their own residents. Four then went on to set up a flexible outreach service for other older people in the area which largely combined housework, shopping and meals with personal care but varied in detail to reflect identified needs and available local resources.

Examples of Flexible Personal Care

Lench's Trust is an Almshouse RSL. It provides cleaning, laundry and personal care to its residents as part of the weekly charge. Assessment of care needs is by a care manager employed by Lench's Trust. Meals across the five sites are provided by a combination of family support, a catering company and a charity and not by Lench's Trust. Services began because provision of home care was not consistent across the five sites, each s covered by a different social services patch and primary health care locality.

Accord HA set up Accord Care as part of a strategic aim to develop community based services for its residents and enable residents in ordinary housing to receive very sheltered housing services and personal care without having to move on. Much of its care services are now supplied through contracts to social services. Depending on what is needed, additional support to residents can come from on site staff, from outreach workers or, for help with personal care and housework, from Accord Care.

Flagship Care have newly developed a home care service which includes pet care and a sleep in service, to supplement their home visiting service. Like Accord, residents can access a mix of preventive support services but only some of its clients receive their care through social services contracts. Others are self funding.

The Abbeyfield Society in Bristol, an RSL, and Inkerman HA in London both developed additional services from 1993 onwards as residents had problems in getting low level home help and bathing services. They set up separate companies to provide flexible home care for their own very sheltered housing residents and to older people living nearby in a range of tenures.

Inkerman's Community Support also includes accompanying clients with poor mobility, gardening, pet care, and support for clients with dementia. They also began provision and fitting of low cost equipment to remedy difficulties encountered by clients in getting grab rails installed when they needed them. Abbeyfield's Help at Home service includes monitoring of medicines and, like Inkerman HA, now has more community care clients than resident clients.

What the Clients Say

"I have no intention of going into a home which is what they (social services) suggested. This way they (Help at Home) keep me going and they fetch what I want for my allergies and do all I ask them to."

Community client aged 92.

"I could not have managed when I came out of hospital without their help. I could barely walk. I can do more now but I still need help with shopping and heavy cleaning. And it's nice to have someone there - just in case - when I'm getting in and out of the bath."

Resident aged 84.

Responding to Needs

Various triggers had stimulated the development of these preventive services from local difficulties by residents in accessing home support services to problems experienced by older people in keeping their homes warm, clean and accessible. The need was there but as Fletcher (1984) comments :

“Needs do not fall into one’s lap - they have to be found. Needs are weak, intermittent and separate signals which adults make when they are not sure, not determined and not in contact with other adults with similar feelings to themselves.”

In the case studies these “intermittent and separate signals” had been picked up, heard and acted on. Described as “plugging the gaps”, “common sense”, “practical help they can’t get anywhere else”, the response had been broadly similar; the decision to develop preventive support to meet needs which no-one else was meeting or meeting in full. Instances throughout the fieldwork demonstrate that this is still happening; Accord HA is considering setting up a Handyperson service because feedback from tenants said this service would be both useful and contribute to quality of life. Flagship Care are looking at developing respite and home from hospital projects since these are problematic areas in rural communities with few resources.

The “Why Not ?” Approach

This pro-active management was characterised by a “why not?” approach; it was particularly noticeable in fieldwork discussions about why initiatives started, why they were amended or developed and what next they might consider. How this “why not” approach was translated into action is dealt with in the next section on planning, policies and evaluation.

Examples of “Why Not”

“A daughter living miles away rang me and asked if we could include her father in our home visiting scheme, he was an owner occupier in his eighties living in our area. I ran quickly through the operational issues involved - and thought why not ? We now provide the service to other older owner occupiers as well as to our tenants, and sometimes through social service contracts”.

Service Manager, RSL.

A very disabled client could not bend to feed her cats or empty their litter trays. They were a significant part of her life, combating the isolation brought on by lack of mobility. This was discussed with the service manager and carer - and the carer now spends five minutes looking after the cats before helping the client, who is then better able to cope with pain and disability.

Community Support Service, RSL.

Services in the case studies were client centred in that they aimed to deliver support as and when people wanted it. This is dealt with in more detail in Chapter Seven but listening to the type of service people wanted made for more effective, tailored support. Care of pets is one of 35 services listed in SSI *Developing Quality Standards for Home Support Services* (1993) as an example of an ordinary living task which home support might provide but which is still outside the generality of statutory support services for older people.

Checklist 2 Responsive Management

Do you have an open and flexible approach to prevention?
Look at what might work and not just on how such needs
have been met in the past.



Do you work with clients and residents to find out
what they see as preventive ?



Have you mapped what is already available to identify gaps
in local provision and avoid duplication ?



Do you act on the information people give you,
by bringing in or developing preventive services
to plug the gaps ?



Chapter Five

Translating a Decision into Action

The previous chapter discussed a pro-active management style characterised by a “why not” approach to service development. This chapter describes how this approach is translated in to service delivery and the organisational procedures required. Once a strategic decision had been made to develop preventive services, it was supported by careful planning of each stage, including assessing the potential market for the service and how it would be paid for. This section looks at how the case studies did this and how they handled the impact of a preventive approach on operational issues such as staffing, recruitment, policies, practices and training. Assessing needs and working with clients and residents to deliver services are dealt with in Chapter Seven.

Assessing the Potential Market

Establishing likely take up of a service had been handled in a number of ways by the case studies. Initial indication of demand had often come through feedback from existing services or from residents with unmet needs. All case studies had mapped what was already available to their residents and clients to prevent duplication and point up possible areas for joint working. In some instances, such as Accord HA, this had been the first step in moving towards social services contracts for care. The next step had been to quantify potential clients, and all kept the numbers produced as a result of the exercise under constant review.

Size of organisation was a factor; providers with hundreds of older tenants could access databases and tenant profiles and, through existing partnerships with local authorities and social services, be better placed to assess housing and support needs in their area. They also had more staff on the ground to provide feedback on why people move on and what would help them stay.

Smaller organisations were often closer to their residents and, being community based, became very quickly aware of changes in provision and possible gaps. Working collaboratively with other small providers or being members of local forums alerted them to shared needs and possible development work. The following examples describe some of the methods used.

Notting Hill Housing Trust carried out a comprehensive survey of all tenants during 1999. This built on earlier work done by existing support workers for older people in the community to

indicate type and level of services required and by whom. The home support service then ran as a pilot and is being evaluated this year.

The increasing levels of services developed by Flagship Care from home visiting to home care had been in response to reducing statutory services and client preferences. Provisional client numbers had been indicated by tenant profiles but potential clients came from housing officers, health and social care professionals. At the same time villages and towns in the Brecklands area were systematically canvassed to get actual clients.

Paddington Churches Housing Association developed a pilot outreach support project specifically for older tenants from existing support services to all vulnerable tenants. An additional factor was the increasing focus by social services on high dependency clients. Housing data was trawled for tenants over 80 and then for those 75 - 79; they were visited and asked if they wanted to join the project. New tenants over 60 are automatically referred for support during the first six months of tenancy. Earlier research had identified high levels of tenancy failure during this period.

Smaller societies such as the Abbeyfield Society in Bristol and Inkerman HA had no quantifiable pool of potential clients outside their own residents. They advertised, piloted, and gradually increased staffing and range of services as demand grew. Word of mouth recommendation was found to be their best advertisement. In addition Inkerman restricted its services to people on low incomes, having surveyed what was already available and decided that there were sufficient support services in the area for those who could pay high charges.

The HIAs in the study had already had initial mapping of level and volume of work carried out as part of the decision to set up the HIA. Their role was to keep under review their client profile and numbers and to pick up on areas of development work.

Most importantly residents and clients, not just those who might immediately benefit from any services, were consulted and participated in discussions and decisions as potential services were formulated. There was of necessity more limited one-off involvement by all clients in Staying Put and Care and Repair agencies but, as the case studies and pen pictures show, they very much participated in planning present and future work on their homes.

Staff and Training

For many of the organisations, studying preventive work had meant new ways of working for existing staff and devising training to fit the new jobs. As possible client numbers and types of preventive services were being considered, existing staffing and job descriptions had been reviewed. In over half the fieldwork staff training and consultation was seen as a vehicle for managing change within the organisation as well as a way of ensuring better services to users.

Notting Hill Housing Trust had reshaped the role of the non-residential scheme manager so that managers also had a case load of 35 older people in the nearby community. This had involved extensive consultation with scheme managers and residents, including a careful mapping of what tasks could be covered.

Liverpool HAT introduced support structures for older tenants which meant redefining the role of caretakers in tower blocks to make them an essential part of the support team. Substantial consultation with tenants and staff then followed and long-term training on all aspects of the new job was given. This gave staff a sense of commitment and increased their involvement in developing new services.

“I wasn’t too sure at first, I mean you get used to your job, don’t you? But we were already doing bits of this new job anyway and not getting paid for it. So I gave it a go, and now I don’t want to go back to what I was doing before.”

Caretaker retrained as part of a support team.

Many saw preventive support for residents, and associated training as a continuing process for all staff, already in post or newly recruited. Some providers, like St Monica’s Home, recognised that small numbers of staff working together can become isolated and out of touch. Sharing training with other providers kept staff up to date on preventive ideas which might benefit residents.

“Our wardens come back full of ideas, stretched. The recent session on sensory impairment has been very useful - it’s helped us audit what we do.”

Senior Warden, St Monica’s Home.

Quality support was linked to teamwork by Leicester Quakers HA so that all staff, including the handyman, take part in dementia awareness sessions and so respond to residents in a unified way. Lench’s Trust provides in-house training and ensures that all wardens have the Institute of Wardens Certificate.

Some new staff were borrowed from other organisations. Specialist staff from social services or the health authority became part of a multidisciplinary team supporting prevention, either on secondment or through joint working as in Liverpool, Portsmouth and Nottingham. It was seen as an investment by the seconding/loaning authority which they would recoup by having less admissions to hospital, residential homes or less call on community services. Where preventive services could not call on existing staff, or borrow them, new people were carefully recruited on the understanding that their job description might need to be renegotiated with them as the service was evaluated.

One point which came through from all the case studies was the need to get across the definition of prevention in its widest sense to new and existing staff. It was at the core of recruitment and training. One senior care manager summed it up :

“I get well intentioned applicants wanting to “look after the elderly”. My “elderly” don’t need looking after, what they need is support which lets them get on with their lives. So they tell us what they can do - and we help with what they can’t do, including keeping them in touch with the outside world. And that, with risk management, takes a full day of the induction package!”

Policies and Procedures

Being flexible and client centred did not mean being unclear about the services being planned, both in terms of the tasks services would cover and the needs they were able to meet. Policies and procedures were drawn up which spelt out the preventive approach and everyone's role in it. This was evidenced by leaflets outlining new services, policies on dementia and detailed job descriptions which supported new ways of working. Tenancy allocation procedures were amended to take account of existing and potential support needs and where that support would come from.

"What if...?" scenarios had been worked through with staff to pick up on how services would link into existing responsibilities, if a support worker didn't turn up, who rang to report it and where to? How would security issues such as keys and ID cards be covered if a support worker was replaced and how would the client be informed?

"What if...?" did not stop at the point services were delivered; it also applied to ensuring quality, protecting people from abuse and putting in place a framework for review, comment and complaint which fed into evaluation.

Policies and procedures were also reconsidered in the light of the working practices of other organisations which supplied services to residents and clients. A useful exercise carried out by one provider had been to match local hospital discharge policies against new procedures supporting prevention and see if some of the problems experienced when residents were discharged could be reduced. As a result they fine-tuned bits of their procedure to better fit the hospital policies and will be monitoring how well it works in practice.

Running the Service

Considerable thought had been given by providers about how running new services could be integrated into existing administration systems and allow for evaluation. HIAs, where clients might come to them with gaps of months or years between jobs, developed systems which enabled them to identify what had been done and what other local services or agencies had been involved.

Where clients were likely to have support from a range of sources, informal care, Social Services Departments (SSDs) and independent providers, maintaining security and confidentiality of information had been discussed at some length. Flagship Care had opted for client held records, Inkerman HA and Abbeyfield had copies of SSD care plans and were open to exchanging information with other providers with some safeguards. Others were still refining policies on balancing information sharing and client privacy.

Examples of Good Practice

In Nottingham Preventive Adaptations for Older People (PAD) used existing systems and procedures within the Occupational Therapy (OT) department at Social Services so it could be implemented without delay. Access to the service is both open and quick but detailed information on each referral and use of flexible software enables later analysis and review of progress and take-up.

Flagship Care asks for the same basic information, medical conditions, GP, next of kin, contact point, from both Home Visiting and Home Care clients so that inputting and administration is kept to a minimum should clients switch between services. Additional information on activities of daily living is requested at that point for setting up risk assessments and care/task plans. This information is retrievable for progress reports and updates on the service.

Information Giving

Part of the earlier planning process had been to map what other preventive support was available locally and consult with other agencies. This process was repeated once the shape and limits of the new preventive services had been agreed. Other organisations and agencies could both tell potential clients and see where their own provision fitted in to the new services. This publicising of a preventive approach was not a one-off process; many case studies reported that it took time for awareness of changed functions and policies to sink in.

“Public relations is more than putting up leaflets in the doctor’s surgery; it’s being willing and able to say the same thing - this is what we now do - each time nurses or social workers come on duty or when someone applies for a tenancy or the district nurse calls in. And everyone has to know about it inside the organisation.”

Chief Executive, RSL.

Costs and Funding

Sheltered Housing

How much a change in approach would cost the organisation was often their first consideration but costing was not an easy issue. Many were using existing staff or resources such as buildings and equipment to underpin the new service and overall costs were not always clear. Instead, additional costs of running the service were often quoted; yearly staff costs are £22, 297, excluding overheads for the outreach support worker service set up by Paddington Churches HA. Inkerman HA has annual running costs of £120,000 for Inkerman Community Support, which provides a mix of personal care and practical help to its residents and people living nearby.

Where the funds came from to meet costs incurred in providing the new service varied. Funding for the additional services set up, including personal care, was not straightforward. There were two issues for providers to consider. Firstly housing benefit will cover only limited warden duties and cannot pay for care. Secondly if the same organisation provides accommodation, personal care and meals, then it should be registered as residential care under current regulations. Registering switches the funding routes for housing with support services for low income tenants from housing benefit, income support and attendance allowance to social services as the main funder with possibly some income support topping up retirement and other pensions.

Unlike Housing Benefit and Attendance Allowance, social services funding is limited; providers of very sheltered housing did not want to switch to this funding route. As part of their planning process ensured that if they provided accommodation and meals to residents, any care came from a separate company such as Flagship Care, set up by the Flagship Housing Group, or Accord Care or the Abbeyfield Society's Help at Home. Others, like Lench's Trust, provided accommodation and personal care and left residents to pay separately for any meals they could not prepare themselves.

Providers in the case studies also took pains to make sure that their charges were affordable and offered benefit advice and help with claim forms. This is dealt with in more detail in Chapter Eight on barriers to preventive work.

In general outreach warden services aimed at helping older residents sustain their tenancies were funded as part of housing management through housing benefit. Flagship Care and Peddars Way HA had agreed with Breckland Council what was eligible for housing benefit whilst planning the service, but not all Housing Benefit Sections were willing to see extended or outreach warden services as eligible items to be met by housing benefit. Notting Hill Housing Trust found that their £15 a week service charge was met by some London Boroughs and not by others. Lench's Trust and St Monica's Home use housing benefit to fund the warden part of the preventive support they offer residents, supplemented by their own charitable funds.

Paddington Churches HA initially intended their support workers to be funded by housing benefit service charges but this was seen as too risky for long term funding. It is now funded 60% through PCHA Community Development Fund and 40% through the Knowles Trust. Leicester

Example of Funding for an Outreach Home Visiting Service

Flagship Care clients pay £9.50 a week (September 1999) irrespective of the number of visits for the Home Visiting Service (HVS). The £9.50 can be met by Housing Benefit as long as the HVS charge becomes part of the rent and a condition of occupancy. Residents must also be assessed as needing an outreach warden service by living in accommodation connected to an alarm system or through referral from housing and social workers or other statutory agency. In essence the property they live in becomes sheltered housing for the length of their tenancy. These criteria were agreed with Breckland Council Housing Benefit at the outset. Other clients, such as owner occupiers, are self funding or have their charges paid under contract by social services.

Quakers HA also saw funding preventive services wholly through charges eligible for housing benefit as too vulnerable to change. They use a mix of rents, services charges, subsidies by social services and Leicester Quakers HA's own funds.

Funding for additional services, including personal care was either through social services contracts, or paid for by the resident or client, often using Attendance Allowance. Inkerman HA targets its Inkerman care services at older people on low incomes and keeps its charges as low as possible, (£4.50 an hour (January 1999), maximum charge of £15 a week but under review). This was supplemented by money from charitable trusts and fund-raising by residents.

The Bristol Abbeyfield Society includes one hours help from its Help at Home service as part of the weekly charge to residents. More hours costs £8 an hour to residents and community clients. Clusters of residents in its own and other sheltered accommodation can pay £4 for half an hour (Spring 1999). Flagship Care home care clients can be self funding at £8 an hour (minimum half an hour) using Attendance Allowance or other income but social services also buy in home care services from them. It is seen as a cost effective way of delivering care in dispersed rural areas.

Home Improvement Agencies

HIAs help clients fund repairs, improvements and adaptations with a mix of grants, charitable funding, equity release loans on property but the proposed changes to housing benefit and funding for adaptations as part of *Supporting People* (1998) was an area of concern for all providers and HIAs. They had begun to plan future services and set up funding or procedures to help keep the physical environment in tune with the needs of frailer residents. They had also begun to identify possible funding streams such as Prevention Grants (*Modernising Social Services*) and Section 28a money, outlined in *Partnership in Action*.

The Wider Policy and Social Context

Planning services also included an awareness of the social and political context the providers were working in, particularly where related initiatives and performance standards could impinge on provision. Sometimes these national or local initiatives were seen as supporting factors in prevention, occasionally they were seen as possible barriers as they fed through to the frontline delivery of services.

Changes to Housing Benefit, the funding of HIAs, the setting up of Primary Care Groups and Best Value were frequently mentioned. Perspectives on these initiatives was often tied into what was happening locally and reflected poor local access to adaptations or good working relationships with housing benefit sections and local GPs. Many senior staff commented on local difficulties in funding residential care placements, the possibility that residential care would greatly reduce or cease to exist in the near future and what this might mean for their provision.

Having to meet Housing Corporation performance standards was seen as creating tensions in some preventive planning; the performance standard of 4% on voids was described as particularly unhelpful. It rushed allocation of sheltered housing where few tenants gave notice of

moving out and where quite detailed support structures sometimes had to be in place, with funding, before a new tenancy began.

“We don’t meet the Housing Corporation standards on this and I can’t say I’m too worried. I think we provide a better service by making sure people really choose to come and don’t feel pushed. And we need some time to organise any help they need.”

Chief Executive, RSL.

Checklist 3 Translating a decision into action

Do you plan every part of a proposed service/strategy from training to funding and ensure that policies and procedures are in alignment ?



Do you pilot and evaluate new services with full participation from clients and residents ?



Do you consider what impact the proposed service might have on other internal operational areas ? Think through what else needs to be done to integrate a service with existing arrangements.



Do you consider what provision to protect clients and staff against elder abuse when planning new services ?



Do you check that proposals meet clients/residents needs and redesign them where necessary ?



Do you publicise proposed services to improve take-up and encourage networking? Link into or help develop wider prevention strategies in the locality.



Evaluation

Evaluation was an integral part of the preventive strategies in each case study and had been considered at the beginning *“How will we know it’s working?”*. It was supported by simply stated service aims and outcomes. In smaller organisations evaluation was continuous and broadly through looking at these outcomes; does this meet people’s needs, what do clients and residents say, can we do it and stay viable; what will the impact be on other tenants, on our joint working? Softer qualitative issues such as satisfaction, contentment and autonomy also had to be considered.

Because some services were new and untried by both organisation and resident/client, piloting was used, for example by the Abbeyfield Society and Notting Hill Housing Trust, as an early evaluation tool, to assess demand and delivery and iron out any difficulties before further committing scarce resources.

“We’ve had an extensive period of talking to tenants and reviewing provision to set up something which would support them in their homes. Now we’re going to pilot it for six months to see if it works, and continue checking with tenants.”

Older Person’s Strategy Manager, RSL.

In larger housing providers more formal tenant surveys, input from Tenants’ Associations and performance figures played a larger part in the evaluation process. Analysis of turnover had pinpointed areas at which vulnerable tenants might need support to maintain the tenancy. One of the evaluation aspects of the support being developed would be to look at whether turnover had decreased and what other factors were relevant.

“We analysed why some new tenancies for older people were failing and picked up that the first six months can be difficult. People need extra support then so we have intensive housing management for those first six months through specialised support workers. Not everyone wants it but for those who do, it keeps them going while they settle in, and smoothes over problems which might have meant them moving on.”

Elderly Services Manager, RSL

Most of the models had experienced some difficulties in deciding what the benchmarks or evaluation points should be and at what point in the process, within three months, at the end of a year? This seemed to be on two counts. Firstly these were often new services with new aims and objectives, so benchmarks/milestones were provisional until it was clear that outcomes were being measured and not solely the process or costs. Secondly flexibility and responsiveness to needs meant that objectives changed and as they did, so did the evaluation process. Many providers were very aware that purely cost based evaluation could ignore elements of the service which users saw as essential.

“We plan to check at the end of the year if what we provide suits people and if we are going about it the right way - and if we are measuring it the right way too. That sort of evaluation is a nightmare. It’s not easy when you want to provide what people need and have to keep an eye month by month on running costs.”

Service Manager on a new home support service, RSL.

In all the models there was a lack of complacency about existing provision which was reflected in ongoing evaluation and discussions about what still needed to be done and how it might be managed.

“What we need to do next is look at how we can help some of the owner occupiers who come to us for housing. I’m not sure they couldn’t have stayed where they were with the sort of support we already give our tenants.”

Support Manager, RSL.

Checklist 4 Evaluation

Do you use the information gathered during the planning stages to set appropriate evaluation criteria, even provisional ones, in consultation with clients ?
(These can include preferred outcomes, staying financially viable/affordable, supporting existing coping strategies. The criteria should not just look at outputs which are easy to measure, but also take in to account perceptions of the preventive impact of services and improvements in quality of life.)



Do you review evaluation criteria at regular intervals with clients? Check whether they need to be changed or enlarged ?



Do you review the preventive services within the widest possible context to avoid complacency and service fossilisation ?
Is it still wanted ? Can anyone else do it better ?
What else needs developing ?



Chapter Six

Partnerships, Collaboration and the Community

Working partnerships occurred throughout the fieldwork. This chapter looks firstly at those set up between providers and residents/clients and then at those set up with other agencies, from local informal partnerships to larger strategic and more formal agreements. The second part of the chapter looks at the community aspects of partnerships in prevention.

Working with Clients and Residents

All the case studies listened to their residents and clients and took account of what was important to them; some went further. They created ongoing partnerships with clients and residents as part of providing a responsive service. This was particularly noticeable in the HIAs and Liverpool HAT and only to a slightly lesser extent with other providers. The outcome was a dynamic relationship, which supported prevention; it developed housing and services around people, their lifestyles and preferences and encouraged their involvement in their community.

Perspectives

"I know we won't get as much help when the new landlord takes over, but now we've got a good idea of how things should be run and we'll make sure they're run right"

Resident in her seventies about to move on to a successor landlord.

"We ring each client once a week to check they're all right, confirm what they want doing and if the times are still OK. People's needs change and we try and plan with them how we can help."

Service Manager, RSL.

"It's important to stay involved in what's going on around you . Small things can make all the difference - like having a bus there when I want to go shopping or if my granddaughter needs it to get to school"

Resident aged 78.

Informal Arrangements with Other Agencies

Good practice was demonstrated by a collaborative approach and an openness to working with any agency which might be of help to residents and clients. Frequently partnerships operated on an informal basis, it was bottom up or small scale working and organised in a locality or around a particular group of tenants or clients.

Staying Put staff had close working links with all agencies operating in their area. In one example discussed, team working with the Benefits Agency and appropriate benevolent societies meant that a complex £20,000 repairs and adaptations package was not jeopardised for want of £150 for temporary removal costs.

In some instances, collaboration in a locality had begun as part of the initial planning phase as organisations mapped out what was available. Peddars Way Advice and Information service, part of Flagship Care, had joined with other agencies such as CAB, Social Services and Age Concern, in developing and delivering a one stop mobile information service in rural areas. Joint working is the only way for them to provide effective support for older people in very dispersed communities. Part of the role of information staff was to build up networks with other sources of help in the community and keep that knowledge updated. This had developed into a strong reciprocal network which benefited both clients and staff.

This approach meant that people whose needs could not be safely met by one organisation or whose tasks, like unblocking sinks, were declined by a home support service, were not left with a blocked sink or an applicant without prospects. Collaborative working with other agencies produced a handyman who sorted out the sink and suggestions were made where someone could apply for housing and have their needs better met.

The outreach home support services provided many examples of collaborative working around groups of people as residents and clients. Working with other organisation's tenants, Notting Hill Housing Trust worked hard to maintain good communication and consistent good practice with other providers and thus get the best mix of grants, adaptations and personal care services to help tenants stay in their flats. A key feature of most outreach work was the determination to pick up new needs as they occur and to avoid duplication of services through good communication with other agencies. Inkerman HA and Flagship Care had copies of their clients' community care plan to ensure there was no overlap in provision.

Where Primary Care Groups were being set up in their community, providers were looking at how they could work with them for the benefit of tenants and clients. Liaison was frequently good on the ground with primary care teams but strategic liaison with health authorities was difficult, Bristol for example is covered by four Health Directorates.

Other providers were very much aware that their small scale provision meant they had to be aware of what else could be done through joint working. Lench's Trust is a member of the Birmingham Sheltered Housing Partnership and, with other local Almshouses, was considering how, within their differing charitable aims, preventive support could be developed for older people. Shared training had developed from membership of groups such as Bristol's Supported Housing Forum for two of the case studies: St Monica's Home and the Bristol Abbeyfield Society.

Examples of Good Practice

"We are careful not to duplicate what other people are doing, that would be a waste of resources. What we do do is talk to each other and explore how we can jointly develop preventive support as part of our housing provision, where the funding for it is coming from and what else we need to think about."

Senior Housing Officer RSL.

"We are looking at building up a bank of staff available for sick absences and holidays between a number of smaller Almshouses. It makes sense to us as an organisation. There is also the point that additional shared staff gives us some flexibility to increase support and try out new ideas to support residents and older people in the community."

Chief Executive, RSL and Charitable Trust.

"We try to work not just with our tenants but also with the community - to listen to what older people want from us and respond."

Director of Housing, Local Authority.

There was little sense of strategic linking up by smaller housing providers with local authorities, or organisational positioning for the prevention grants available later in the year. They were aware of the major relevant initiatives, both nationally and locally, but saw their role as mainly a reactive one.

An additional perspective on how smaller providers might knit into the community emerged as access to information on prevention was discussed both with people in the case studies and with health and social care professionals. Whilst many organisations contacted had set up joint working or at least liaison meetings which furthered prevention, others were unclear about other agencies' roles and functions. Discussions about older people and prevention with two Social Services Departments showed patchy awareness about preventive strategies in the voluntary sector in their area.

Whilst some social services worked in collaboration with housing and care providers, including contracting for preventive services, others were unaware of handyperson services, outreach home support and innovative services provided by smaller housing providers in their patches. Why this was so was not always clear; services were publicised by providers and marketed locally but their small areas of operation possibly meant they fitted into larger statutory strategies only with difficulty and so had not been picked up. This clearly has implications for future development of community preventive strategies.

More Formal Working Partnerships

Larger housing providers worked on joint development initiatives with Health and Local Authorities but described the processes as frequently protracted. Larger RSLs such as Accord, the HAT and Portsmouth City Council worked to create their own very effective support strategy to assist people of all ages in the community.

Bury Staying Put is based in a local resource centre with Bury's Disability Team to provide a one stop contact point and unified service for disabled and older people. Joint projects such as the Energy Savings Trust Scheme run by Burnley Staying Put and supported by Age Concern England and Burnley Borough Council, provide a package of measures to help older owner occupiers keep their houses warm.

Accord Care and Flagship Care delivered services to older people through Social Services contracts; these were seen as cost efficient ways of providing care in dispersed communities where a housing provider already had a presence and could offer viable and quality services. There were however tensions in delivering a mix of contracted and self funded care. Self funders can and do vary the tasks carried out but social services clients cannot. It went against the training of care workers to provide what they saw as a rigid, unresponsive service which wasn't wholly what the client wanted or needed that week.

"The carer was told she shouldn't have wiped down the front door because it wasn't in the contract, but the dirty door was really getting the client down, and the contracted tasks had been done."

Home Care Team Leader.

Examples of Good Practice

Portsmouth City Council has pulled together preventive initiatives for older people by grant-aiding independent organisations in 1998 - 99 with £200,000 towards the costs of the care and support services they provide. The "Homecheck" scheme (run by Environmental Health) offers advice and assistance on home safety, security and energy efficiency; 80% of clients are older people and most are home owners. A Bogus Callers Campaign supports the Homecheck scheme. Independence and mobility are supported through £30 travel tokens to all older people from April 98, and support to the Age Concern dial-a-ride scheme. Complementing these initiatives is Portsmouth's HIA which works with Southern Focus Trust's Care and Repair and Age Concern's Handyperson service.

The Liverpool HAT saw partnership through investment in a range of services vital to ensuring that its work has an enduring impact on the community. Although many of the projects involve younger age groups they aim at building sustainable communities which benefit all residents; investment in Neighbourhood, Community and Youth Centres produce resources for HAT estates and the wider community. The HAT chat shop functioned as a residents' resource centre and training base which all could use. An RSL and a local solicitors' practice joined to provide outreach benefit advice on a contractual basis and boosted the weekly income of many housebound older HAT residents.

The Bristol Abbeyfield Society had not applied to become an accredited care provider with the local Social Services Department because it sees its present services as supporting client autonomy. Accreditation would mean any contracted services would have to fit within narrower parameters and clients would not be able to vary hours and tasks as they currently did.

Checklist 5 Partnerships and Collaboration

Do you view residents and clients as partners in prevention ? Keep them involved.

Do you actively seek opportunities to work with other organisations ? Consider sharing training, development, pooling use of equipment and staff.

Do you use local opportunities to promote involvement of older people and enable them to make use of their skills and knowledge, perhaps in intergenerational work ? Keep up to date on national and local initiatives with potential for future partnerships benefiting residents and clients, such as HAZs and Primary Care Groups.

Can you link your provision into larger community initiatives ?

Community Aspects of Prevention

This section of Chapter Six looks at the community aspects of prevention and considers linkages to wider policy issues such as exclusion and provision for minority ethnic groups.

An Inclusive, Community Based Approach

The case studies and the collaboration they fostered brought out an inclusive, community based approach to older people. It began with the premise that older people are part of a larger community and that tenants or clients should be supported in actively participating in that community. It ended with the concept that there was unmet need on an individual level in the community which organisations would not be able to identify and meet unless they were active in that community.

Part of this also was the perception that having a presence in the community, including satisfied clients, showed what could be done in preventive services and raised the profile of the provider. For some smaller organisations there was the perceived danger of being marginalised and made less effective unless they were seen as active within the locality.

Preventive services supported inclusion by older people in their community. Larger community partnership initiatives such as those by Riverside HA, Portsmouth City Council and Liverpool HAT benefited all of the population including older people by promoting local engagement and developing strong tenants' associations. As they refurbished buildings, set up regeneration initiatives and developed services, the consultation process brought people together. Groups came together out of a collective interest in getting their personal environment and support services right, and these groups continued after the refurbishment was completed.

For housing providers there are two ways in which interaction with the wider community was fostered. Firstly, by extending services provided to outreach into the nearby community and secondly, by bringing other people into schemes for social activities or by making the scheme the community meeting place on local issues such as an older person's strategy group. Practical support, such as access to reliable transport, was facilitated, enabling people to continue their chosen lifestyle within the community. Tenants' groups would charter their own bus to go shopping in, or volunteers might provide the regular weekly lift to a meeting. Up to date information on local voluntary groups running transport schemes would be supplied.

St Monica's Home was very aware that the location of the complex on the outskirts of a town and the wealth of on-site facilities could make their provision very inward looking. Strong community links were maintained and residents supported in keeping social contacts outside the complex alive and healthy through provision of a regular and accessible mini bus service. Notting Hill Housing Trust and Churchfield Court (Anchor) were developing the role of their sheltered housing in different ways as a community resource. Lench's Trust were looking at developing use of the Trust's building for community use. Inkerman HA and Leicester Quakers HA had frequent open days and social events which brought people living nearby into the building, strengthening their community base and enabling housebound residents to keep in touch with local issues.

More isolated clients and residents may not have had more than a very tenuous contact with the community for some time. Support workers from Paddington Churches HA found some residents without a GP; a large part of their initial contact work was helping residents rebuild very fragile community links.

Examples of Good Practice

Notting Hill Housing Trust sheltered housing schemes are being developed as a community resource for older people in the area, examples include current affairs discussion groups, volunteer lunch clubs, weekly open health days. Non-residential scheme managers have a case load of 35 which includes older people in the nearby community.

In 1993, Churchfield Court, Anchor Trust began links with a local school which has developed into The Generation Gap Project, promoting mutually beneficial activities between older and younger people. Residents take part in the Dark Horse Venture (based on the Duke of Edinburgh scheme) and produce and man promotional stands at local events to promote involvement of local people in the scheme's activities. Scheme residents and the warden are on the steering committee of ABC (Ageing Better in Childwell and Church) promoting active ageing, quality of life and independence. They hold Health Discussion Forums to improve primary care at local level. Consultation meetings are held at the scheme on Liverpool's Older People's Strategy for all older people in the area on issues such as : community safety; transport; community care delivery and provision of information to older people. Small but important results have been achieved, like getting a bus stop moved nearer to a surgery.

Role of Home Improvement Agencies

HIAs had a clear role in promoting social inclusion on two levels. Large HIAs like Portsmouth and Care and Repair were able to take a proactive view of their function and actively promote projects focusing around whole neighbourhoods, setting up linkages across tenures for older people. Smaller HIAs such as Burnley Staying Put and Bury Staying Put, with their holistic view of a client's needs, developed networks and joint projects which linked older people into services in the community and only occasionally with each other.

Including all Older People in a Community

An inclusive community based approach should embrace all older people in a community, including those from minority ethnic populations and those with special needs. This was not always apparent from the fieldwork. The selection of models had attempted to include non-specialist providers with preventive housing and/or services used by a diverse range of older people. As the study progressed it appeared that providers, including the HIAs, had made

strong efforts to set up preventive initiatives aimed at older people from minority ethnic groups but with varied success. What success there was seemed to come from one off responses to individuals as existing residents or clients as much as from strategic decisions to provide sensitive services. Sometimes the difficulty came from a mismatch between need and appropriate responses viewed from a community perspective. One provider had identified need but not “want”, having researched and developed an Afro-Caribbean house, which had continual voids.

Three Perspectives

“Our existing residents say we have got it right, people come and visit and compliment us, but when we have a vacancy we are told “I couldn’t come in, my daughter wouldn’t allow it” so perhaps we need to do more work in the community to look at attitudes to sheltered housing.”

Director, RSL.

A London Housing Association has no problems; its staff, residents and clients reflected the diversity of the borough it was in. Their approach is very open and tailored to the individual as resident or client.

An HIA had as of one its wider community based aims the improvement of an area of older housing stock largely occupied by the Asian community, but had achieved only middling success. It had then been approached by a disabled Asian elder and had worked with him and his family to get their house warm and structurally sound. The client was so happy with the results, and the HIA’s approach, that he is now acting as an interpreter and broker for the HIA within his community.

Sometimes the inclusion of ethnic minority older people appeared to be a function of size and location. Larger providers housed people from a range of backgrounds across county and borough boundaries and provided appropriate policies and services. Providers with smaller numbers of units were clear about what their response should be but given the size of their provision, likely turnover and image in the smaller, local pool of potential residents, had difficulty in attracting applicants in any way dissimilar to existing residents. A provider in the West Midlands had tried to develop housing and support around the needs of older people from black and ethnic minority populations around the schemes but with only limited success.

Several providers made a similar comment; that the growth of specialist housing associations could further segment a community. Older people’s housing choices were built on a complex mix of life experiences, current needs, available support, and length of time in an area. To focus on only one part of their lives in applying for housing could restrict choice. They also considered that there was a tension between promoting inclusivity and emphasising diversity.

They thought that there was a real danger that :

“The increasing sensitivity to ethnicity... may be masking an insensitivity to other categorisations which are also important to the way people see themselves and their circumstances”.

Arber et al (1993)

One solution considered by smaller providers was to link with the specialist providers and share expertise but little headway had been made at the time of the study.

The difficulties experienced by providers in reflecting the diversity of their community are not new but they can act as a potential barrier to developing preventive strategies for all older people. More work needs to be done to unpick the issues involved and there was insufficient information in the fieldwork to do this. Chapter Eight looks in more detail at the barriers to effective prevention where the fieldwork provided a wealth of detail.

Checklist 6 An Inclusive Community

Do you arrange your working practices to coincide with the definition of a community used by residents and clients ? It can be a geographical area like a street or a town or a group of people joined by common interests, beliefs or activities.



Can you help clients and residents to participate in community affairs ? Offer practical support such as transport, the use of a computer or a meeting place - if this is what they want.



Can you build bridges between your provision and older people living nearby through outreach care and support ? Can you become a local resource for them ?



Do you get involved in housing forums or similar local groups to keep up to date with new initiatives and get a wider perspective on housing in your area ?



Can you maintain/develop your own links with the community around you to pick up on new needs which you can perhaps start to meet ?



Have you considered working with specialist housing providers and sharing expertise to provide equality of access and appropriate provision for all older people ?



Chapter Seven

An Interactive and Effective Approach - The Viewpoint of Residents and Clients

This chapter brings the voices of older people into the debate; firstly it illustrates how their input into preventive strategies help keep the strategies focused. A series of pen pictures then shows how a complex interaction of personal resources, informal and formal support and the right environment all contribute to effective prevention.

Promoting Independence

How people see themselves, what parts of their life are important and need to be retained, influences how they react when they need practical or personal support from others. What came through from the fieldwork was a strong sense of insight that many respondents had into their needs, that they were continually engaged in balancing their needs against what was available, and choosing an option which would cause the least damage to their existing lifestyle. This was a complex area but a determination to stay independent and in control was a significant part of the personal coping strategies most respondents set up to deal with ageing and disability. They were aware of the *"importance of willpower in sustaining their own boundaries, whatever these may have been"* Clark et al (1998).

Hayden et al (1999) describe how definitions of independence vary with levels of disability and support; many older people in that study with high levels of disability re-interpreted their sense of autonomy through finding things they could still do to help themselves or others.

Assessing Needs and Preferences

Effective prevention in the study took account of what older people wanted from preventive services; finding out what they wanted, (and when), was part of service development and delivery. Initial assessing of needs was seen as a joint task, building on what people could do and with equal emphasis on quality of life - and frequently on having fun.

"Can't just provide the services and ignore other needs...having a chat and a laugh are important too"

Carer.

This assessment process was often described as an informal chat or discussion, but one backed up by a framework of clear policies, records and regular reviews. As equal partners in the process, tenants and clients usually had copies of their assessments and all were aware of the content. Flagship Care has client held records which client, family and any other carers are encouraged to use. Comments showed this approach was valued. It was *“not going behind your back”* reflecting earlier research by Age Concern Scotland (Robertson 1995).

Older people in that study wanted more than being “fed and watered” (Robertson *ibid*). They wanted input into the assessment procedures, and a range of wider needs to be met. In this study providers did their best to tailor help around existing personal coping strategies, providing more on “bad” days and less on “good” days and not disturbing what was already in place and working. Where possible tasks were agreed according to what older people as clients wanted and did not have to fit into a timetable of one bath a fortnight and vacuuming every second Tuesday. Risk analysis (and risk management) was evident and seen as an essential part of needs assessment where people being supported were very frail and might otherwise be in a residential setting.

Perspectives on Good Practice

“We need to listen and provide what they (clients) want; sometimes we’ll tactfully suggest something they might have overlooked - and accept “no” if the client doesn’t want it doing just yet”.

Care Services Manager, RSL.

“It’s marvellous to have someone come when they say they will and do what you think needs doing. I couldn’t do with being bossed around in my own house.”

Client of home support service.

“We know she (client) is borderline residential - so does she - but at the moment she’s coping well and feels good about it, so we’ll see how it goes and up the support if needed.”

Care Services Manager, RSL.

A key feature of the case studies were approaches and processes which gave residents and clients an effective voice in the assessment and delivery of support services and a mechanism for saying what they liked and what they didn’t like without seeming ungrateful.

Providers, housing managers, wardens and care workers described people who might benefit from preventive services but who were unwilling to accept them. One provider said “They want it on their terms” but at that point had not managed to work out what their terms were. Implicit in this was the concept that effective preventive approaches took such matters into account and that providers were aware of how their services and approaches might be perceived by potential

clients. Paddington Churches HA described how being seen as less threatening “housing people” and not social services staff was an advantage in contacting the most isolated amongst their older tenants and setting up preventive measures such as outreach warden services.

Support Networks

Support networks are a key part of many older people’s coping strategy (Wenger 1984) and need to be factored into assessment procedures. Networks in the fieldwork ranged from meeting friends whilst shopping, and having a chat, to being a member of a painting class and finding pain lessened when one was involved, and on common ground, with other people. There was also a sense that long term friendships supplied continuity, of being known and appreciated at different life stages.

Residents Perspectives

“Do you know, you still miss old friends. I’ve kept in touch with people I knew during the war, mainly letters now, but recently someone I’ve known since 1938 died. We had some good times together. It did upset me. People are pleasant here but it’s not the same”.

Resident, RSL aged 87.

“I do miss my friends in Kent, I was in the Townswoman’s Guild and the choir and I can’t somehow get organised here, and my leg seizes up”

RSL resident aged 84 who moved to be near son on discharge from hospital.

Such friendships and activities were valued; they might not provide practical support but they helped older people retain a sense of self worth and cope with increasing disablement. (Wenger 1992) Maintaining these links was part of personal prevention and could be easily integrated into a larger preventive strategy. In the last example given above poor mobility, lack of transport and uncertainty about local clubs had become barriers to making new friends.

Action by the provider could remove these barriers; other providers had done so as people were re-located. Liverpool HAT had built the importance of networks into their allocation procedures so that parents could stay near children and friends of long standing could continue enjoying each other’s company. If staying nearby is no longer a realistic option then help in maintaining contact is valued by residents. Paddington Churches HA and St Monica’s Home actively help in maintaining contact with old friends and communities.

Frequently in the sheltered schemes there was a sense of being part of a community with reciprocal networks of help. These were often low level, fetching small amounts of shopping or “popping in” but they were important to both parties. They helped maintain the appearance of still being able to manage and residents were keen not to have these low level services

disturbed by formal services. However this partial reliance on other people was sometimes fragile and could be restrictive. Grandchildren coming in had to be quiet in the communal corridors and not be too noisy in the flat otherwise “*remarks are made*” by other residents who object to their peace being disturbed and may then not be too keen on maintaining their part of the support network.

Family Roles and Keeping Busy

Clear messages about not wanting to be a burden to families, and ensuring that any support they did receive from friends and family was reciprocal, came from Langan (1996) and Allen et al (1992). Housebound people in the study found visits from family and friends gave a structure to the day. The support they provided was important but most were keen to emphasise their independence from their family. They did not want family support to be disturbed by formal services but neither did they want their families to play the role of main caregiver.

Others relied on their families for a sense of being valued as a functioning family member. They were able to have the grandchildren over after school whilst parents were at work, help a granddaughter with making new curtains or support a sister recovering from an operation.

These activities also helped them “keep busy”, a phrase which reoccurred throughout the interviews. Many of the social and family networks previously described kept people interested and occupied but when there was little social contact or people were on their own for long periods during the day, “keeping busy” was important. Hayden et al (1999) describes respondents in residential care finding tasks to do which structured the day and kept them busy; it was a way of finding a form of independence. For respondents in this study it was also a way of continuing adult patterns of behaviour into old age and of ignoring or coping with increasing disability.

Resident and Client Perspectives

“I look forward to my brother coming, he does make me laugh, when he tells me what he’s brought in for my tea. But you can’t live in your family’s pocket can you ?”
HIA client aged 71 with poor mobility and reliant on her family for shopping.

“Didn’t want to go into a home where I would have nothing to do all day...What do I do here? I read, try to get out each day for a walk , knit, crochet, help wash up after lunch, tidy my rooms, I do miss my piano so I’m thinking about getting an electric piano.”
RSL resident aged 84 with limited mobility.

“Why do I like keeping busy? I’ve never been a lady of leisure, never had the chance, I worked till I was 70. Anyway the doctor told me it was best to keep doing things otherwise this leg seizes up.”
RSL resident aged 86.

The Meaning of Home

The significance of “home” to residents and clients was clear to respondents and recognised by providers and agencies in the assessment and delivery of services. An earlier quote from a client of home support services had said she couldn’t do with being “bossed around ” in her own home and this sums up what clients and residents appreciated about flexible services. They had always controlled what happened in their home and found it difficult to have someone else decide what parts of it should be kept clean and what could be left for another week. It was sympathy with this viewpoint which had caused the carer in an earlier chapter to wipe down a dirty front door although it wasn’t in the contracted tasks.

This reduction in autonomy had caused one respondent to switch providers from a social services contract to an independent agency which she employed herself. It had cost her slightly more out of her Attendance Allowance but she considered it was worth it. It was this aspect of control within the home which stimulated the most discussion and a keen interest in direct payments in one of the older persons’ reference groups and is discussed further in Chapter Nine.

Recognising that the meaning of home also included a place where friends could call and have tea and buns had led two smaller providers to make cakes or sandwiches available for residents’ guests.

HIAs saw the role of the home as being more than the bricks and mortar needing adapting or repairing. Help was organised in a way which met the client’s need to stay in control and the joint aim of getting the roof done. Work proceeded at the client’s pace to get the most effective preventive outcomes, even though this sometimes appears not to be the most efficient use of resources.

Example of Good Practice

A couple, early sixties, both severely disabled, had contacted a Staying Put scheme with one query - about help with heating their cold house. They were “nervous about what they were letting themselves in for”. A Disabled Facilities Grant paid for central heating, handrails and a bathseat. Other repair issues were picked up and will be dealt with when the clients can cope with further disruption. The worker also helped them increase their income with a claim for Disability Living Allowance, and put them in touch with occupational therapists for equipment. They can now stay where they want to be, have more money coming in, know people they can approach for further help and no longer need social services help with bathing. And most importantly - they felt they were in charge of the process throughout.

The Interdependency of Preventive Strategies

Interviews with clients and tenants and feedback from the older person's reference group showed how preventive services and approaches were often only part of a larger personal preventive strategy, in which autonomy and the role of housing as one's home had a significant part. What also came through from the fieldwork was the interactive nature of many of these strategies, that to alter or remove part could threaten their stability.

The many ways in which preventive strategies interact are illustrated in the following seven 'pen pictures'. They describe very individual mixes of preventive measures. They also show that preventive services support some very frail and disabled older people who might otherwise be in a more costly residential setting. They clearly demonstrate the need to take account of the older person's perspective and personal strategies when delivering preventive services and evaluating them. Otherwise preventive outcomes may be mistakenly or wholly attributed to specific services instead of to the complex interplay of a number of factors in the lives of older people.

1 Mrs Lair

“It was the answer”

Mrs Lair is in her late 70's and was widowed over 20 years ago. She has very limited mobility because of severe osteo-arthritis and other long-term health problems. Some years ago Mrs Lair began to find her house and garden difficult to maintain; lately she has needed help getting in and out of the bath.

Finding things to do which interest her and keeping in touch with friends are important, as is loving and practical support from her family. For the last two years she has had help with a range of practical tasks as and when required, including housework and having a carer from a local charitable organisation with her whilst she takes a bath. The cost is £8 an hour. Approach is flexible, leaves her in control (“it was the answer”) and allowed her to look at other housing options in the area, knowing she could take the service with her.

A few months ago Mrs Lair moved to well designed, adapted sheltered housing with a strong preventive approach and lots of interesting facilities on a landscaped site. Warden services are included, and registered care facilities are available for rehabilitation and convalescence at no extra cost to sheltered housing residents. Mrs Lair sees it as a very positive housing choice in terms of both adaptations and facilities and because it is a desirable place to live. Having and creating a pleasant environment is important to her - she renovated and redesigned previous homes and is busy planning colours and fabric for this new home.

The sense of being in control comes across very strongly in Mrs Lair's story. She has been able to decide on a move which is right for her, to a building which is suited to her needs, can offer a lot of activities, on site preventive health support plus some low level services which she can supplement with her own carer. She can then get on with what she enjoys doing - creating a home and keeping active. The new home is not too far from her previous address and she can easily keep in touch with family and old friends.

2 Miss Eyrie “Is that alright with you?”

Miss Eyrie is single and in her early seventies. Because of polio some years ago she can move around only in a wheelchair (manual), or by using crutches and took early retirement on medical grounds when she was 49.

She is used to coping with her disability and organising preventive support. Miss Eyrie has help with cleaning and some shopping from social services but feels she has little influence over the nature of the service. They will only do certain prescribed tasks. Their help is supplemented by a telephone shopping service costing £20 for food and £3.50 for delivery, and by an independent charitable provider which costs under £5 an hour. Miss Eyrie goes out each week with them for coffee, to the bank and they will do any additional tasks she wants doing; staff are always punctual, keep her informed of changes and their approach is one of “Is that alright with you ?”

This client centred approach is important to her. Mobility Allowance and Attendance Allowance mean that money has not hampered choices or use of preventative services - more the lack of suitable services or problems in getting them to do the tasks she wants doing.

Strong family ties and friendships are also important; Miss Eyrie enjoys going out especially to the theatre but wishes there were more voluntary escorts on a one to one basis. She doesn't want group outings with unknown people who just happen to be disabled. She likes to keep mentally and physically as active as she can and this RSL studio flat supports that wish. It is pretty and sunny with long windows giving access onto a wide balcony with planted tubs and is completely wheelchair accessible. The conversion of bathroom and kitchen was “very well thought out”, the warden is “excellent” and she says her landlord was very good at providing adaptations. Miss Eyrie moved here in 1986; there is a lift, alarm system and communal rooms.

Having appropriate equipment is also key. Miss Eyrie has a lifting armchair, half steps to balcony, and a shower seat with wheels on for gardening from plus long handled tools. She enjoys gardening and has won prizes for the display on the balcony.

Long experience of disability has made Miss Eyrie skilled at organising her life to minimise her disability but her present strategy centres around the fully accessible, sunny flat and equipment which enables her to live independently and follow her interests. Having sufficient income to buy in what she needs and the availability of support services are also factors. For her, barriers are not being perceived as an independent person, capable of decisions, who just happens to be disabled.

3 Mr and Mrs Croft “You ask about preventive services ? This is the best preventive service available”

Mr and Mrs Croft are in their seventies and live in a very large semi-detached house which has just had substantial repairs carried out by a home improvement agency. Mr Croft has a progressive degenerative illness and five years ago suffered a stroke. His mobility is limited. Mrs Croft’s health is fair. They do not use Social Services or any other home help/care services but have had practical support from a Primary Care Team and Occupational Therapist. Equipment such as a table trolley, push wheelchair and commode have been provided.

The house is now warm, sound and weatherproof and allows them to resist any suggestion they should move to somewhere smaller and in a better state of repair because of their health. Renovating it was “the best preventive service available”. Their location is convenient, near to shopping precinct, library and medical centre.

The approach of the home improvement agency was key. The Crofts felt in control of the process as the house was renovated. The agency listened to what was important to the couple, helped organised both the finance needed and a temporary stay in sheltered housing whilst flooring was renewed. They also picked up on small but important preventive details; as part of renovating the kitchen they plumbed in the washing machine. This was a significant preventive measure for someone of 75 who had previously dragged the machine each week across the kitchen to the taps and sink.

Both believe it is important to adjust to life changes by keeping as busy as possible, mentally and physically. They enjoy music and reading and have common interests with a neighbour who calls regularly. For them Attendance Allowance is an important preventive benefit; without the extra money it would be difficult to manage.

An enabling, listening approach was central to the success of the HIA who arranged the renovation of Mr and Mrs Croft’s house. They have been able to come back to a place which has great personal significance for them and which is now warm and safe, meets their physical needs and is in an area they know well. They have sufficient income to live there and follow their interests. Provision of appropriate equipment has removed the need for hands on care.

4 Mrs Burrows “I wouldn’t want to move - I have all I need here”

Mrs Burrows is 79, and has lived in this sheltered housing studio flat for some years. She has had Parkinson’s disease for four years and has suffered two strokes which resulted in falls and broken bones. She is an ex-CAB worker and she believes in keeping both body and mind as active as she possibly can and she strives to minimise the impact the disease has on her lifestyle. A keen sports-follower she now watches it on TV and likes to keep abreast of news. The scheme has a strong community spirit and **“a really good warden”**. They have exciting days out with other residents. An adapted coach is organised for residents in wheelchairs so all can go. Mrs Burrows enjoys living here, the conversation and banter, she has friends, feels secure and wouldn’t want to move.

Two consistent and reliable carers from Social Services come in each day. They treat her as an adult and are missed when on holiday. The carers also know where things are and how she likes things to be done - important in terms of quality and effectiveness of care. Mrs Burrows pays £15.91 a week through a smartcard at the post office; Attendance Allowance (suggested by SSD) is of great help. In addition, she has help from Age Concern Good Neighbours Scheme with shopping, and with awkward clothes and buttons and items like tin openers. A good local health service, consultants and GP provide **“excellent services”**.

Her flat is accessible and she can keep it clean herself. It is adapted for easy movement with a walk in shower plus equipment, such as an electric chair lifter which helps her get out of her own armchair, tap adjustments and wheeled trolley, supplied by social services. As a countrywoman, waking up in this light and airy flat with views of the garden and the sound of birds is very important to Mrs Burrows. **“I have all I need here”**.

This pen picture illustrates a complex personal preventive strategy knitting together several areas of support: - an adapted, easy clean environment, the garden and birdsong, specialist equipment, reliable, client centred formal and informal care, a sense of community and of being at home, preventive management which promotes activity and inclusion, plus the determination to stay mentally active.

5 Mrs Warren “One just makes the best of things”

Aged 82, Mrs Warren was widowed 30 years ago. She lives alone and has heart and thyroid problems, diabetes and slight cataracts. She is almost housebound and gave up driving last year, but thinks it important to get out when she can. **“One just makes the best of things”.**

Her family provide both love and practical support. Working at a medical centre, Mrs Warren’s daughter calls daily, provides lifts when needed and is up to date on available help. Mrs Warren is careful about her health; she has regular health checks and six weekly chiropody appointments. Taking pride in one’s appearance is also very important with regular trips to the hairdressers. Having always enjoyed the company of other people Mrs Warren has now started going to a lunch club (suggested by practice nurse) as sadly many of her older friends have died recently.

20 years ago Mrs Warren bought this large purpose built owner occupied flat on the first floor because it was full of light and easy to run. It has an accessible bathroom, small adaptations such as tap levers, but no lift. A burglar alarm was fitted after one burglary to help her feel more secure. An Age Concern pendant at £32.50 a quarter, linked to a central alarm and her telephone ensures she can contact help in an emergency.

She has no intention of leaving her home whilst she can manage. An independent domiciliary service irons, spring cleans, helps with bathing and other tasks when needed at £8 an hour. Mrs Warren feels this is excellent value but will claim Attendance Allowance; she is worried about not having enough income to pay for care.

The key to Mrs Warren’s preventive strategy is her flexibility in maintaining what is important to her lifestyle, staying safely in her flat, family contacts, remaining healthy, and enjoying the company of other people. To this end she is proactive in bringing in services, altering her flat, making new friends, and claiming benefits.

6 Mrs Billet "I manage very well now"

Mrs Billet is in her eighties. Her sight was always poor but she managed well until an accident four and a half years ago which left her totally blind and with very restricted mobility. Expected to go into a nursing home on discharge from hospital, Mrs Billet was determined to return to her own home where she has lived for 41 years. She is still there four years later.

Mrs Billet's family call daily and help with household tasks. Social Services are "so good". They helped increase her benefits and provide a twice daily home help. Mrs Billet feels she can contact them at any time for reliable help and information but it is their approach as much as the actual help which she appreciates. The home help always tells her what she's doing as she moves around her tidying up, including what clothes are being put out. Mrs Billet can then visualise what she looks like, staying smart is important and her hairdresser calls once a fortnight.

Mrs Billet uses all the equipment she can to help stay independent. Day to day things, such as her radio cassette, clock, four channel no vision TV, flasks and sandwiches are arranged neatly around her and she cooks her own supper using a microwave oven, given by her family.

Because she can no longer go upstairs, the front room in her small terraced house is used as a living room, the dining room as a bedroom, the unused bathroom is upstairs and the WC is outside. The local home improvement agency have rewired the property and provided storage heaters, new windows and a covered porch between the back door and the WC for easier and drier access. Mrs Billet is proud of her house and is now thinking about redecorating the inside. She also has help with gardening once a fortnight. She likes to know that the garden looks well kept.

At the core of Mrs Billet's preventive strategy is the decision to stay put and not to let being blind dictate her life. Mrs Billet maximises what she can do, such as getting washed and dressed and organises and accepts help for what she can't do. This help comes from her family, social services, the right equipment and from having a warm, safe house which she is proud of.

7 Mr Gupta “They did not just come in and do things”

Mr Gupta was widowed when in his early sixties. Up to his wife’s death she had done all the cooking, washing, ironing and housework but he gradually taught himself how to do these tasks and takes pride in his clean and tidy house. Now aged 85, he cooks himself a proper meal each day with fresh vegetables and tries to get out for a walk if only to the nearby shops. In recent years his left leg has stiffened up, won’t bend at the knee and he couldn’t get in and out of the bath. Walking was also painful.

Some years ago the council gave him a grant to put a bathroom into his old terraced house which he bought 41 years ago. He went back to the council and asked for help with putting in a shower. A man came round and **“overhauled the house”**. He now has double glazed windows, central heating, a new damp course, loft insulation, and new flooring to replace rotten floorboards, plus a walk in shower. It took about three – four months to do this work from start to finish.

Although he was proud of his home before Mr Gupta says it is **“lovely now”**; it gives him pleasure and the more efficient heating helps keep him mobile and is cheaper to run, a key point when on a low income. He also very much liked the council’s approach, everything was explained and checked with him before the work was done. **“They did not just come in and do things”**. They also checked that he was receiving all the benefits he was entitled to. Mr Gupta feels that he gets a very good service from the council. Because of his experience, other older neighbours have now asked them for help in repairing and adapting their homes.

He is in regular contact with his family living nearby His daughter does his heavy washing. Mr Gupta does his own personal washing and ironing. He has good friends and neighbours, they help each other out with shopping and occasional meals.

Mr Gupta’s independence is important to him. He enjoys the company of his family but asks for help only in what he can’t do and ensures that support from his neighbours is reciprocal. What this pen picture demonstrates is how that independence was supported by the HIA’s approach which gave him a more energy efficient house and left him feeling in control. His independence is further enhanced by increased mobility and having some spare money in a very tight budget.

**Checklist 7 An Interactive and Effective Approach -
The Viewpoint of Residents and Clients**

Do you view listening to what people want as a starting point rather than starting from what has traditionally been seen as appropriate ?



Do you use the information to design and deliver services people want ? If not they may at best only be "fed and watered". At worst they may decline help and be at risk.



Do you make sure that existing coping strategies and family support are not disturbed ? Where possible support and facilitate them.



Do you build in client and resident participation to keep services focused ?



Are you aware of the interdependency of preventive factors and do you consider the impact of any changes to an individual's personal preventive strategy ?



Chapter Eight

Barriers to Effective Prevention

This chapter looks at four factors which can hinder prevention. These are inability to access information on options; lack of transparency combined with local variations in procedures; jargon and ageist stereotypes and perceptions of older people. They are rooted in poor communication and assumptions which colour attitudes and approaches. To some degree the four factors overlap but have been separately explored to enable providers to audit their provision.

Information on Options

This section looks first at what clients and residents said about access to information and then at the views of providers.

There are already several studies on the importance of enabling older people to make housing choices based on good advice and information Parry et al (1999), Heywood et al (1999). There were some excellent examples of good practice in the fieldwork. But large gaps were also evident in the provision of information, as was the difficulty experienced by some providers in reaching people whose first language was not English or who had sensory impairment. Tapes or leaflets in different languages might be available but people have first to know that they and the services they describe exist.

Examples of Good Practice

Portsmouth City Council was described by respondents as providing reliable and accessible information through City Council offices in the centre of Portsmouth and in local housing offices. An holistic approach meant residents got quality, tailored information in a range of formats.

Peddars Way Advice and Information service takes advice and information out to older people in their villages, in supermarkets, in GP's surgeries, using information roadshows, local media, and intensive leafleting to reach more isolated clients. Information is given face to face, by telephone, in written format, through tapes - and working with local associations for people with impaired hearing and sight keeps information current and accessible.

For Clients and Residents

Most clients and residents said they had access to good advice and information but this was mainly because they were already in the system. Who they currently asked depended on issues like their mobility, who had previously given sound information, the relationship and degree of confidentiality required by the query. Wardens, HIA managers and technical assistants and housing advice workers were all mentioned as the first source of information. Organisations like Age Concern and CAB were seen as possible back up should none of the first group be available or able to answer the query. Future sources of advice and information frequently depended on reliable known sources, even though they had previously dealt with quite different issues.

Asking how people had initially found out about the services and housing they now used indicated word of mouth combined with serendipity as the most common method. For instance, a client benefited from a leaflet drop advertising The Abbeyfield Society's home help services, coincidentally shortly before admission to hospital. A domiciliary hairdresser knew someone who had got social services in to fix a grabrail and install a ramp and this had brought the client and Care and Repair together. Two respondents who had got used to coping with their disability and had not thought to ask for help. Whilst cashing pension books pro-active post office assistants in Portsmouth and in Burnley had suggested they contact their Social Services Department. Members of one of the reference groups had remembered driving past an Age Concern Advice Shop whilst staying with her son in Oldham, and had rung to ask for information on respite for her husband.

Local Authorities have a statutory duty under the 1996 Housing Act to provide housing advice. The Code of Guidance to the Act on what constitutes housing advice would appear to cover many of the queries respondents described, but few had been able to find a centralised information point on preventive options in housing and services, including funding, at the point of need. Such a centralised point may have been there but as Age Concern England/HACT (1999) comment in their report there is very low usage of local housing advice services by older people. Or the respondents had queries which were a mix of housing, support services, help for informal carers and accessing adaptations and had met with the response described here:

“They explained how I could go on the waiting list but there might be problems because I had my own house. I owned it but it was too big for me. And they gave me this handful of leaflets but I didn't understand half of them.”

Member of a focus group who had had a stroke and needed somewhere smaller with a ground floor toilet.

This respondent had been unable to relate the leaflets to her problems and had not sought further advice. Instead she had relied on local knowledge and on limited but holistic information from neighbours, friends and people in the group to sort out what was possible. This pattern was repeated in the fieldwork and has been echoed by other studies which point out the difficulties encountered by owner occupiers who may just want information on housing, repairs and adaptation options and not necessarily a place on a waiting list. (Age Concern Scotland 1998).

For Providers and Staff

Discussions with providers and staff about what information older people could access to find out about services produced mixed responses. Some, as part of their services to clients and tenants, had outreach information services which all older people could tap into and this, by sharing information and resources with other agencies, had developed into a very effective mobile one stop information point. The queries raised could then be used to identify gaps in service provision.

From the point of view of many providers and staff, initial provision of information to applicants generally focused on their housing and services, and was usually seen as part of marketing and publicity. As such it did not publicise competing provision and this was a tension within the system which could prevent people from finding out about other preventive initiatives. A few providers also gave good all-round advice about local preventive options, and how they were accessed and funded. This was usually part of the response to initial enquiries and seen as an essential part of an effective allocation process. Where possible, such providers would also help potential residents access support services before they came in. Clients and residents wanting information on other providers or on complex issues might be directed towards known information sources in the area such as CAB or Age Concern.

Checklist 8 What Information ?

Do you map what other agencies can/do provide in advice and information on housing and support options ?
Look for more than leaflets in a display and check accessibility for those with sensory impairments or whose first language is not English.



Are there gaps in this provision ? Check with older people what they would see as useful subject areas to be covered.



Is existing provision one stop in approach or do people have to link up separate pieces of information before they can act on it ?



Checklist 9 Getting the Information Over

Can existing providers of information (Age Concern, LA, CAB) develop their services, through collaborative working or commissioning additional services, to meet identified gaps and demonstrate good practice ?



Where else can the information be made available, e.g. as leaflets, help-lines, signpost publicity to alert older people to competent and updated sources ?
In Post Offices, surgeries, hospitals, tea shops, leisure centres ?



Who is in contact with older people on a regular basis, e.g. carers, wardens, voluntary workers, and can act as information providers or signposts to appropriate sources of information ?



Have you planned and set up a dissemination strategy and do you review it regularly ?



A Lack of Transparency

This in part overlaps with the provision of information but many older respondents and workers interviewed described obtaining information on home care or access to adaptations only to find that getting the help depended on other local criteria which were difficult to find out about. Others had had services terminated with no real reason given and had assumed that other older people now needed the services more than they did. A few had experienced what Robertson (1995) describes as “betrayal”, people enquire, are assessed, and promised services which never materialise for reasons which nobody explains.

The local criteria usually centred on budgetary constraints, revised eligibility criteria, quota systems or queues for adaptations, longwinded procedures and difficult to track down application and referral forms travelling between social services, hospital discharge teams, housing and environmental health departments. The process left some respondents feeling very disempowered and actively hindered older people’s sense of being an adult and their ability to participate in decisions affecting them. The help offered with forms or as advocate by Leicester Quakers HA was a direct response to difficulties encountered by residents in accessing services and benefits.

Where the outcome was a refusal, it could lead to delay about re-applying if their needs changed. First hand and anecdotal evidence emerged from the fieldwork to support this and feedback from the older person’s reference groups produced several stories about long waits for adaptations which never came or being refused help with keeping the house clean. Many respondents had come to the conclusion that many statutory services were not available to them and this attitude might result in future crises and more expensive intervention.

Their reaction to such an outcome was not helped by knowing other people in their community, which was perhaps not coterminous with the Local Authority’s patch or the Health Authority’s locality, having got the items or services they needed without any problems. This had provided an additional barrier.

This was discussed with housing providers and HIA staff who had acted as advocates for their residents and clients. Some described obscure processes and unpublished criteria as a form of indirect discrimination against older people. The information was there if one was persistent, but factors such as impaired mobility, hearing and sight, unfamiliar language and not wishing to be seen as awkward, made it difficult for many older people to find out the appropriate eligibility criteria or where they were in the process. These difficulties have been reflected in other reports (SSI 1997). Wardens and housing managers also cited lack of transparency and changing provision to explain why they sometimes seemed unwilling to support preventive approaches.

An additional viewpoint came from the Older People’s Reference Group, which showed that even where services are assessed and are being delivered, uncertainties about each parties’ rights and responsibilities can hinder preventive outcomes. Two members of the group had recently been assessed by Social Services and offered badly needed services which were just affordable on incomes a few pounds above Income Support. Both were fretting about possible increases in charges recently announced, the embarrassment of stopping the services and how

else they could manage. Neither knew that once assessed they were entitled to the services and should discuss the charges and their affordability with Social Services, but did say that *“this might have been in all the leaflets they (SSD) left behind”*.

Hospital Discharge

When discussing local variance in provision many providers also cited the variance in procedures for hospital discharge as a major barrier to preventive work. Two providers work across four Health Directorates with varying published procedures and policies which are not always followed. Older people were discharged with inadequate notice to housing and social care providers, and frequently were readmitted or went temporarily into residential care whilst the support system was set up.

Problems resulting from un-coordinated hospital discharge is a well researched issue (SSI 1998a, Audit Commission 1998) and some providers were following the practical advice in Means (1997) in clarifying the limits of their help but problems still arose. Wardens, especially where the discharged resident had previously not needed any help, described it succinctly :

“They (the hospital) send home these instructions about temporary nursing care with the resident - like keeping them under observation for concussion or putting in eye drops - with no instructions about where the temporary nurse is coming from”.

Example of Good Practice

Lench’s Trust’s schemes covers five different social service patches and the patches are not coterminous with health authority localities. The four hospitals providing care to the schemes vary in their discharge practices. Difficulties were experienced in accessing both long-term support for residents and short term help on discharge, which were exacerbated by mistaken perceptions of the warden’s role in supporting residents. The response has been to work with the hospitals and other agencies in clarifying the wardens’ role and to develop services for residents to plug perceived gaps.

Leicester Quakers HA found that residents, particularly those with hearing and sight impairments, experienced problems in accessing benefits and services. Claim forms and procedures were difficult to follow. In response they have developed support and advocacy services for residents.

Checklist 10 A Lack of Transparency

Have you audited your provision ? Are your policies and procedures clear ? If not, can you amend them in consultation with residents and clients ?



Do you need to develop/strengthen advocacy support to help residents and clients access services ?



Are there mechanisms/structures for participation ? If not, can you start them?



Can you start the liaison procedures on hospital discharge outlined in Means (1997) ?



Can you work with other agencies to simplify/explain their procedures ? What do their policies say they should do in terms of customer service ?



If not, can you take action which will nudge them into reconsidering their processes ? Publicity through local paper/Ombudsman/MP ? Collaboration with other providers to get the point over ?



Can you take action locally to even out inconsistency in service availability. Are agencies and providers aware of sharp differences within small localities ?



Are there legal remedies/campaigns which can support action to even out provision ?



The Use of Jargon

Preventive strategies support the independence and involvement of older people; using language which excludes them, was identified as the opposite of preventive by many respondents.

This came from providers who saw jargon, often allied with unfamiliar consultation procedures, as putting older people, their carers, family and support workers at a disadvantage when discussing preventive services. It stopped them from participating in decisions affecting them. Other providers saw jargon as a form of indirect discrimination against older people, and described how they had checked their own procedures and paperwork to make sure they were clear and intelligible.

These points were checked with residents and clients and members of the reference group. Getting valid responses during the fieldwork had meant explaining and discussing terms such as preventive first so that people were familiar and comfortable with the language being used. One member of the reference group said she had joined in a local pensioner's group because she was angry at cutbacks in services, but had been put off (and frequently irritated) by the longwinded jargon used to explain the cutbacks before inviting their consultative comments.

“You have to argue in their language and by the time you’ve learnt it, found out what they mean, it’s too late. They’ve gone and done what they were going to do anyway. Consultation was just a way of telling us, not asking us what we thought.”

For her and others at the meeting the use of jargon had been a means of blocking their participation. This point was repeated by other older people as they discussed the emerging findings. One respondent in a tenants group explained that she had learnt the language. She used to talk about “empty flats”, now she talks about “voids” at meetings but still has to use “empty flats” when reporting back or discussing issues with friends and families. Her advice was: “make it as simple as ABC if you really want us to take part.”

Checklist 11 The Use of Jargon

Are your documents straightforward and written in plain English ? Re-read and audit all your documents, beginning with those which go out to clients and residents and ending with policies and training materials which staff have to understand.



Have you considered asking/paying people not working for you to say what they think they mean ?



Can you hold workshops with residents/clients/staff to agree the complexity/type/amount of information they need ? You may be swamping people with information they don't need.



Have you considered asking clients/staff/residents to re-write material ? Offer prizes for the best entry.



Do you ensure that a solicitor checks rewritten documents, such as tenancy offers, which have legal implications ?



Do you check the vocabulary used to describe situations, processes, people's needs ? Do you use jargon as shorthand ? Is it needed ?



Stereotypes and Perceptions

Use of jargon partly came from its use as an easy working language but it also illustrated perceptions of older people as “people to be managed”, a case to be sorted out and not as an adult entitled to take part in the process. Such perceptions influenced approaches and attitudes and hindered good communication. Examples of older people seen as less than adult and unable to take risks recurred throughout the fieldwork and was cited as a barrier to preventive work in housing. Each group had respondents who felt stifled or resentful about ageist attitudes governing what older people could or should do and that this was embedded in the language used.

Wardens and housing managers said pressure from families to “look after” their relative in sheltered housing sometimes inhibited the risk taking which is an integral part of adult life and made it difficult to encourage residents to have as active a life as possible. They felt that residents’ families held them accountable for every risk residents took as disability increased.

Health and social care professionals also described battles with housing staff, wardens, housing managers and committees about assumptions that disability meant dependency and dependency meant residential care. Such labels were easy shorthand and obscured real discussions of the individual involved and their needs. This was supported to some degree in discussions with wardens but their reluctance to retain older and frailer residents also came from fear that other essential services would not be forthcoming or would be withdrawn.

Clark et al (1998) make the point that older people prefer the word “help” to “care” when discussing services because of its connotations of working with people instead of doing things to them. In this study respondents also used “help” when describing services but frequently used passive terms such as “being looked after”, “given a bath” or “taken out” implying a dependency which many didn’t feel but had imposed on them. The most forceful comments came as older people described not the language used but their degree of participation or consultation in important decisions. They were trying to reconcile their self image as adults needing a bit of help, with other people’s perceptions of them as old and vulnerable, and unable to participate in decisions affecting themselves.

Perceptions of Self

“I’m not stupid, you know, but I like to think things through. And to hear them talk to me you’d think I was”

86 year old, widowed, had chosen and was in very sheltered housing but originally had residential care suggested because of her age and disabilities.

“They wanted me to go into a home (on discharge from hospital) but the noise would have driven me mad. I came back home and I don’t think they thought I’d last the month”

83 year old owner occupier, lives alone, is blind and has much reduced mobility after the accident which put her in hospital. Still at home four years after discharge.

Assumptions about lifestyles and choices made on behalf of older people also inhibited preventive outcomes. Much of the fieldwork examples show older people as recipients of services but there were also many instances of older people volunteering or providing care and finding that housing design and policies for “the elderly” hindered them. This was especially apparent in sheltered schemes. The scheme design and policies on guests did not consider that residents might be disabled but would still want to provide care to grandchildren or family members and need larger living spaces instead of communal lounges and guest rooms. These residents were bending their lifestyle to fit the bricks and mortar around them.

Other respondents with newly allocated housing illustrated how collaborative planning with older people and recognition of changing lifestyles could both support them and promote active engagement with others. One resident in her seventies showed me their new two bedroomed bungalow where the second bedroom was the painting room, full of paintings, frames and equipment. Underneath were the spare beds for when one of them was ill or when the grandchildren came to stay. Another had a large kitchen diner and the dining part had become the computer area and office for keeping up the committee work as a volunteer.

“We had a one bedroomed flat before with a tiny kitchen and everything was on top of each other. Now I can do the minutes on time, well nearly on time.”

Volunteer and new resident in her sixties.

Checklist 12 Stereotypes and Perceptions

Does the design of the built environment assume a lifestyle for older people ? Does it match what they actually do ?

Does your design of services assume how older people spend their day or what support is needed ?

How have you factored preferences/daily routines into assessment procedures ?

Do policies, staff training, daily routines support independence ?

Chapter Nine

Funding Issues

This chapter looks at the impact funding and charging had on prevention. For some providers and agencies they hindered preventive work but the position was by no means clear across the case studies as this chapter shows. This was largely because of the proposed changes to funding supported housing and services, which had some providers developing services and setting charges within current transitional benefit regulations. This was a short term arrangement which would be reconsidered when the proposed *Supporting People* funding routes from April 2003 became clear.

Funding

Funding was described by one provider of housing and support services as :

"Perpetually short term - takes up a lot of time and energy to keep it going."

and by another as :

"A complex and rather uncertain system of grants, charitable funds, charges to tenants and service charges as part of the rents."

Another compared it to :

"A set of hurdles which change from year to year and seriously challenge any attempt at developing a preventive strategy."

These descriptions were echoed across the fieldwork with the exception of the Housing Action Trust (HAT). For some smaller providers their preventive strategies and some low level services fitted the criteria for housing benefit eligibility; they relied on it and were worried about long term funding once it moved from housing benefit to as yet unspecified Local Authority bodies. Others had set up separate companies or bodies and funded services not eligible for housing benefit from combinations of charges to clients and charitable income. Maintaining these support services was an essential outcome for all providers, including the HAT and its successor landlords, but many were uncertain about whether they could achieve this unless the funding system was overhauled.

Developing preventive approaches and services which fitted the criteria of the Housing Benefit transitional regulations also had to fit within The Housing Corporation limit on rents and service levels of RPI + 1%. This had hampered some providers with previously low rent levels and low

capital reserves who were trying to start preventive approaches and catch up with what they saw as changing tenant requirements. To do this, they needed to increase their income from charges but could not; neither were they sure that their low income tenants could afford any increase unless it was eligible for housing benefit.

Some hoped that the proposed changes to housing benefit and the switch of funding support services from housing benefit to possibly social services, would promote more flexible people-based services, particularly for older people in general needs housing. Over half saw the long term proposed changes as potentially damaging to sheltered accommodation if support continued to target high dependency people and ignored the importance of low level services. There was little expectation that the focus of prevention grants on low intensive community care services would set a pattern of supporting low level preventive services in housing. Recent draft transitional housing benefit regulations defining sheltered accommodation as including communal areas was an area of concern for housing providers with separate bungalows, visiting wardens and support workers and no communal areas. (This provision has now been dropped).

What was of perhaps more concern was that the uncertain nature of future funding made it very difficult for housing and service providers and home improvement agencies to plan on a long-term basis. This was said to be hampering some development work and had led to some larger housing providers switching funding of all preventive services from housing benefit to charitable income. One had moved the other way with clear identification of support eligible for funding through Housing Benefit. Many were planning "worst case" scenarios should they have to rely purely on charges paid by clients and tenants, supplemented by fundraising and charitable income.

Charging Policies

Information from the fieldwork indicates that having to pay could be a possible barrier both for clients and providers. Affordability of services was a desired outcome for residents and clients. Every attempt was made by providers in the fieldwork to ensure that charges were affordable, and all gave benefit advice on maximising income. Having to work within tight calculations of what was needed and could be afforded by someone on benefit, possibly with attendance allowance, could restrict development of services. Close working with older people on low income had told providers that some would do without the support if it took too much out of their budget, and for many people there was no alternative service available in the area.

Asking older people if having to pay restricted the help they could get or hindered their choice produced mixed reactions across the fieldwork, largely because of local variations in who paid for what and the range of complex packages some people had set up. Many people interviewed were paying for private help from independent providers and social services with frequent use of volunteer and family help.

Charging policies by statutory bodies were seen as inescapable. Only a few people were indignant or resentful at having to pay. Many thought the services were excellent and worth paying for but for others having to pay for services which didn't suit them had turned them into

active consumers. They had complained, surveyed what else was available, and switched to an independent provider.

Direct Payments for older people should come on stream within the next year and in theory should give recipients more control over services. The older people surveyed had not heard of the proposed changes but were interested, seeing it as one way of having more say and more choice in who they used and what they got. There were clear linkages in some respondents' minds between being able to pay for services and having choice and control over what was provided, especially where independent providers were used. Attendance allowance had already given them additional money and autonomy; without it they would not be able to manage or would have to accept other people's decisions on what would be appropriate support and when the support began and ended. This was not a popular option.

Discussing services and charges with the Older People's Reference Group in the later stages of the study produced a slightly different viewpoint. Many of them, unlike the respondents in the case studies, were not currently receiving any form of help but had friends and relatives who were. The views were presented as coming from the friends and relatives and the consensus was that charges inhibit some older people with very little disposable income or savings. They won't begin the assessment process and commit themselves

"Because you can't switch off their helper (social services carer) like you can the electric."

This contrasts with the more accepting reaction of those in the study who were already paying for services. It raises the question of how much the consensus instead reflects the reluctance of older people outside the system to pay for care. It was not possible to explore this further within the study but it needs to be considered as a potential barrier when planning services.

Chapter Ten

Costs and Benefits of Preventive Work

Initial thoughts on this project suggested some cost benefit analysis of information from the fieldwork as evidence for targeting resources at prevention in housing. This chapter considers the issues around assessing the value of preventive work. Firstly it looks at accurately costing complex preventive strategies of which housing is a part; the next section asks whether preventive benefits can be adduced from the case studies discussed - so that even if total costs are not clear the benefits are? The third section looks at costs from the clients' viewpoint and the final section discusses the wider community aspects of prevention.

Costing Prevention

Work has already been done on costing the benefits of lifetime homes. Cobbold (1997) presents a strong case for building to Lifetime Homes standards with clear savings on the current costs and delays incurred in adapting existing buildings. The calculations include quantifiable savings in residential care and home care costs and provision of minor adaptations. Unquantifiable but very real savings in freed up hospital beds, from staff time and resources now spent in rehousing are also outlined, as is the enhanced quality of life arising from living in well designed housing. Some of these issues were reflected in the fieldwork as occupational therapists (O.T.s), housing and HIA staff considered the time and resources spent on achieving a better fit between client and their home; as one O.T. said :

“How much could be saved if housing meant for older people got it right first time ? Instead we go in three or four years later and say this needs altering, that wants moving. And the delays and disruptions. Perhaps Occupation Therapists should be in at the planning stage.”

Savings from the provision of preventive services such as low level home care are less easy to calculate. Given the disparate nature of the information on costs from the fieldwork it has not been possible to cost much of the preventive support studied. Firstly, the range of models, their size and their funding sources were too fragmented to do anything other than look at costs on an individual model basis, where costs could be identified.

To carry out cost benefit analysis costs have to be clear. Although many respondents were happy to give useful information on charges and costs, others had not costed the preventive approach separately. It was seen as part of their housing function and the time spent by wardens, scheme co-

ordinators and dedicated support workers in largely preventive work was included in overall staff costs. Most had not costed items such as the use of buildings, administrative staff and resources. Additional problems arose from factoring in the cost of informal care or one off visits from community nurses.

Secondly, there has to be some idea of what alternative costs would be. Comparisons abounded in the fieldwork, usually describing the alternative for a client if the service was not there. It was possible to say if Mrs X had not got this service, for which she pays £32 a week, using Attendance Allowance, then Mrs X might be in residential care costing £320 a week, or more frequently in hospital costing £620 a week. In addition Mrs X might be funding her residential care costs (after the first three months?) from capital but her hospital stay would be free to her.

Thus comparative calculations were possible at an individual level to indicate that prevention worked for that person but could not be used as a basis for long-term modelling for groups of people. These calculations also presupposed that other factors such as Mrs X 's physical health, the family support she got, her own mental attitude to coping remained stable. Otherwise benefits may not be attributable to the costed service.

Lastly the benefits have to be measurable; benefits described in the fieldwork frequently concerned intangible and difficult to measure outcomes, such as feeling useful and independent, enjoying local amenities and feeling part of the community.

The 'Stitch in Time' Principle

If the costs of prevention cannot clearly be determined, should not the next question about prevention ask what are its benefits? Taking action now to save time, money and effort later. The stitch in time principle summarises the preventive approach taken by many providers in organising and facilitating services such as the Preventive Adaptations for Older People (PAD) initiative in Nottingham and the HIAs. For them it was a worthwhile activity. They took a broader view of who might benefit from the preventive work and were not expecting to recoup in proportion to their input.

Case histories showed that low level help with minor adaptations prevented further deterioration of the property and improved quality of life but the stitch in time effect was not always so clear cut. There were some instances where the adaptation of the property was a short-term gain. It made the occupant's current life more bearable but other issues, such as the location of the house in an area with severe drug problems or the wish to be near relatives, meant that the client would move as soon as possible and perhaps into a property again needing adapting. But the current adaptations added to the stock of adapted property in an area and, with careful management of the adapted property as a resource, the benefits could be passed on to another person.

Handyperson services improved home security and safety; their current value was clear to clients and providers. Longer term preventive benefits were difficult to assess because funding sometimes meant the handyperson service was available only intermittently or it was difficult to disentangle it from a larger preventive pattern of services.

There was much anecdotal information from models which said "our turnover is lower now since we started the home care, we have less referrals to social services", but little rigorous evidence

to support it. A home visiting service had found isolated older residents without a GP and with minimal access to preventive health care. Putting them in touch with the practice had brought small but identifiable health care benefits. One provider had a “behind the clock” service for correspondence and forms which residents had put to one side (behind the clock) for a number of reasons. Support workers helped residents sort out the paperwork and could point to it as a preventive measure which got benefits claimed on time, kept fuel supplies connected and helped residents keep in touch with families and useful organisations. Immediate outcomes were clear, on a day to day basis people had the practical support they needed and improved quality of life but whether fewer people moved on to more expensive care at a later date because of this intensive housing support was difficult to measure.

A development of this approach for some providers when targeting scarce resources was to look back at actual examples of what had worked, provided the stitch in time and develop or facilitate these initiatives. Again there were some difficulties because of the size of the study and the need to be sure who had provided the stitch. Was it the provider or the supportive family or both and could the benefits be reproduced?

For Clients and Residents

Part of any costing exercise on preventive services needs to consider costs and benefits from the client’s perspective. What are they willing to pay and what benefits will they expect in return? The case studies and pen pictures set out the available information on costs, charges and what people wanted for their money but in summary the costs of much low level preventive work by housing providers was included as service charges in the weekly rent and was eligible for housing benefit. Where clients and residents were charged for additional preventive services either provided or facilitated by housing providers this ranged from £4.75 to £8 an hour, but many of these figures were under review.

Considerable emphasis was given to ensuring that these charges were affordable and that benefits, such as income support, attendance allowance and housing benefit, were claimed. This meant that many clients got the services they needed plus additional weekly income available for other preventive measures such as transport costs.

In general, the view was that the charges were reasonable and provided good value for money. When asked to expand on this, clients and residents said they got services which helped them stay at home and they felt in control of the help. They weren’t worried about future needs; past experience had given them the confidence that they could cope. These were the benefits for them.

Charges for statutory services varied but in general were less than those of independent providers. Benefit maximisation advice was also given but in two instances increase in benefits had resulted in greatly increased charges but no increase in autonomy. One of these respondents had then used the increased benefits to switch to wholly independent provision. She had less money left at the end of the week but total control over the tasks done. She valued this; her view is shared by others in the fieldwork and in earlier studies indicating that providers might need to start viewing their clients as customers when direct payments begin for older people.

A Community Perspective

The benefits of effective prevention on a community needs also to be considered. How far did it support the engagement of respondents with the community whether at an individual, family or group level? What other benefits were there to the community?

Preventive support allowed older people in the fieldwork to manage better; this may produce long term savings for providers and statutory services but its immediate impact was the sense of older people freed up to get on with their lives. Participation meant they were active contributors in decisions affecting themselves. The right physical environment gave them space for interests, for taking on a caring role or volunteering. Flexible home care did not pin them to their homes, waiting in for carers, or disturb existing support networks. Transport enabled them to stay independent and at the same time to join larger groups and take an active part in local society.

Not everyone wanted to be visibly active within the community. For some isolated clients in general needs housing or as owner occupiers their link with the community was tenuous. Low level support, such as outreach warden services or provision of adaptations, helped rebuild fragile links and enabled them to stay quietly at home in an area they knew. It combated their isolation and provided a contact point for other services if needed. These benefits were not confined to them as individuals. Such low level support provided a sense of security not only to them but frequently to their immediate community of concerned neighbours and families. There was little direct information in the fieldwork from carers but two support workers had noticed that their home visiting service had made it easier for families and carers. They no longer felt alone in supporting an older relative.

Preventive services also raised awareness of what was possible in prevention amongst other older people and this in itself could create a demand for better services and become a force for preventive change. That part of the fieldwork dealing with advice and information showed how strong was the exchange of information amongst older people as they shared their experiences of available, local help and encouraged others to ask for support.

Because of the support they received older people in the fieldwork were better placed to be seen as "doers", their presence in the community promoted positive images of older people. Mention was made earlier in the chapter of home improvement work providing only short term benefits to an occupier intent on moving - but at the same time the available stock of adapted properties in an area was increased and so the community arguably benefited from potential access to more adapted properties. What preventive services do is help increase the "stock" within a community of older people able to play their part as citizens, with benefits both to them as a group and to the wider community. These are essential parts of adult life, raising the question of whether older people should pay for these as clients rather than enjoy them as citizens.

Chapter Eleven

Conclusions and Recommendations

This chapter sets out some conclusions on the role of housing in prevention and then outlines several recommendations arising from the conclusions.

Conclusions

Housing has a clear role to play in effective prevention. The study showed how preventive approaches in housing management and the right physical environment had positive preventive outcomes for residents, clients, families, housing staff and providers. But effective prevention needs to be multidimensional; the views of clients, existing coping strategies, informal support, access to home support services and community amenities have important roles to play and need to have equal weighting with the physical aspects of housing in the development and evaluation of preventive strategies. Otherwise benefits may be incorrectly attributed.

Personal Care Versus Low Level Support

The study had begun with the assumption that low level services were used by people with low level needs but it became clear at an early stage that this wasn't so. Older people with high levels of disability, including those in wheelchairs, used low level services such as help with housework to stay independent. With well designed and adapted housing, the right equipment and help with practical tasks, they were able to manage without personal care packages. What the fieldwork suggests is that there may be groups of very disabled older people who do not need personal care but who do need low level preventive support to enable them to stay at home and delay the need for more expensive residential living.

User Involvement and Participation

The continuing involvement of older people in the design of housing and delivery and evaluation of preventive services is key. It helps keep the aims of the service focused and ensure that preventive outcomes are achieved and new needs identified. Effective housing models in the study did this; they listened to and acted on input from older people, demonstrating that the management and culture of provider organisations can be as crucial as the actual services delivered. A flexible, enabling response and appropriate support can help remedy defects both

in the environment and in other support services. More importantly it sends a message to older people that what they have to say about their housing and support services is relevant. Older people's sense of autonomy and control is reinforced through real participation which acts on their views and which does not treat them as incapable of making decisions.

Inequalities of Access

Some of the barriers to effective prevention found in the study were partly rooted in the view of older people as problems to be managed. This diminished the level of respect and control of decision making normally enjoyed in adult life. These views were evidenced by lack of transparency in local criteria for service delivery, in processes and consultative procedures which blocked participation. Other factors such as unco-ordinated hospital discharges and support services put pressure on older people and providers. Whilst these problems could affect all client groups, older people, as major service users, experienced it as indirect discrimination. Combating local variations to achieve equality of access and provision for their clients and residents took time and valuable staff resources which providers could have better used elsewhere.

Active Citizenship

Where preventive services, such as outreach care and warden services, were located in the community, they helped combat isolation and maintain community links which were perhaps beginning to weaken because of age or disability. More active involvement in local affairs, which could have an impact on local decisions and events, presented positive and inclusive images of older people and enabled them to feel useful, independent, and part of that community. These are essential parts of adult life and outcomes which any healthy society sees as desirable for its members, raising the question of whether older people should pay for these measures as clients rather than enjoy them as citizens.

Stock Condition

There were other wider social outcomes from housing preventive services in the regeneration of areas and the renovation and adaptation of older housing stock. The English House Condition Survey found 263,000 unfit owner occupied dwellings headed by older people and 167,000 unfit privately rented dwellings with older tenants. The main source of help and advice for these older owner occupiers and tenants would be HIAs and Handyperson services such as those described in the study. They had a preventive impact on the local housing stock but their uneven distribution across the country means that many older people have no access to such help. This limits their preventive role and was a barrier to effective preventive strategies going beyond borough boundaries. Difficulties in accessing or funding adaptations for all tenures with no local HIA were commonplace in the study, leaving older people managing as best they can in hostile environments.

Housing Design

Sometimes these hostile environments were found in fairly new housing which restricted residents' lifestyles, interests and family roles. This should improve as more homes are built to Part M of the Building Regulations or Lifetime Homes Standards. But the comparison with those models which did offer flexible lifetime homes highlighted how some housing design had not caught up with changing needs, necessitating expensive alterations and adding to the queue of older homes awaiting preventive work.

Health Promotion

Because of this, the role of housing in supporting healthy ageing was not easy to disentangle. There were instances of individual preventive health care strategies, of good design which gave people space to stay active in and some promotion of healthy active ageing through group activities, but overall the role of housing and housing management in healthy ageing was largely a reactive and not a preventive one.

Advice and Information

Accessing information on preventive options is key, but good information was available only to most older people in the study once they were receiving preventive services. Limited information was available before people were in the system and, with some exceptions, what there was did not deal with complex queries encompassing housing, care, funding and adaptations. Those providers who did provide a one stop information service showed how it could be used to improve the quality of information available and support collaborative working. Such services were also of benefit to providers, giving them a higher community profile and helping identify further areas of need. There was insufficient awareness of national agencies such as the Elderly Accommodation Counsel, which provides independent information on all housing and care options for older people.

Networking and Communication

However, competitive forces meant many providers supplied information only about their own provision and this was a tension in the system which could limit choice for older people. Because of this many respondents had relied on word of mouth and serendipity to find out what was available in their area. Word of mouth may re-affirm social networks whilst providing information, but it can be an uncertain information source since it derives from individual problems and experiences which may not be appropriate for another.

Funding Mechanisms

The complex and uncertain nature of funding for supported housing and the lack of focused funding for preventive, community based initiatives caused problems for providers. Initiatives taking support to owner occupiers, or to people in general needs housing drew on a mix of

benefits and self funding by clients, social services contracts, charitable sources and trusts and their own RSL funds. Disproportionate amounts of staff time were spent in obtaining alternative short term funding, as providers used scarce resources to chase more scarce resources instead of providing services. There were a range of concerns expressed about the possible impact of *Supporting People* and the effect uncertainty and lack of details about a new funding system had on their planning. Charging was shown to inhibit possible use of preventive services by some clients but against this other clients enjoyed the power and choice paying gave them and relished the thought of direct payments. Attendance Allowance was mentioned by many respondents as a benefit which allowed them some choice and control over the preventive services they received.

The study and conclusions suggest a number of issues to be considered by older people, housing and support providers, the Housing Corporation and local and central government. Running through each of the issues is the need to work in partnership to reinforce positive preventive action and reduce or overcome barriers to prevention. These recommendations need to be read with that point in mind.

Recommendations

For National Government

A national framework for prevention should be developed covering the key strands of prevention and incorporating strategies across housing, health, social services, education etc.

- The ongoing governmental inter-departmental review on housing and older people should view prevention as a key objective
- Provisions in the forthcoming Local Government Bill promoting the welfare of citizens and directing local government to develop strategies on welfare should have preventive measures as a key component
- Standards in care to be set by the National Commission for Care Standards should reflect a preventive approach in the care of older people whether in a domestic or residential setting
- The introduction of *Supporting People* has meant an increased level of uncertainty in the funding regime. Uncertainty about the size of the cash limited grant for support services, how it will be distributed between authorities and what services are likely to be prioritised could all act as a disincentive to setting up preventive services where their future may be uncertain. Guidance to local authorities should encourage support for preventive services
- Proposals by the Secretary of State for Health to expand NHS rehabilitation services for older people are to be welcomed. Development of community based rehabilitation should acknowledge the preventive role of appropriate housing and the need to work collaboratively with housing providers and HIAs
- Prevention needs to become firmly entrenched in the remit of public health bodies. Clearer links to environmental health emphasising the link between defective premises and negative health outcomes need to be made. The Health Development Agency should take the lead on this in conjunction with the Preventative Task Group.
- The DoH should carry out a review of existing preventive strategies encompassing a baseline audit of how the prevention grant has been allocated. The review should consider the extent to which strategies are collaborative between health, housing and social services agencies and how well the targeting of resources has reflected a collaborative approach and met preventive objectives.
- A cost benefit analysis of the impact of preventive services is both methodologically complex and would necessitate considerable resources. For these reasons it is most appropriately to be commissioned by an inter-departmental government group.

For the Housing Corporation

The current review of the Housing Corporation's strategy for older people should incorporate prevention as a key strand and encourage RSLs to work in partnership in developing preventive

strategies. The value of collaboration with other local voluntary agencies in developing these strategies should be made clear.

- All of the Housing Corporation's investment policies should adopt preventive criteria. This should include consideration of prevention in all capital funding activities and a review of the funding mechanisms for aids and adaptations.
- The £10 million available for remodelling sheltered housing is to be welcomed but RSLs should be required to show how prevention has been brought into their development plans. The success of the remodelling programme should be evaluated and if successful, consideration given to increasing the allocation.
- The Housing Corporation performance standards in relation to tenant participation, housing management and community involvement should reflect the benefit of a preventive approach.
- Performance targets on voids which emphasise speed of turnover can mitigate against a client centred approach. Getting the service right to meet an individual's needs is more time consuming in some instances than others and recognition of this needs to be incorporated.

For Local Government

Local Government should take a strategic view of the need for preventive services in their area. This should be encompassed in the framework of a local corporate preventive strategy.

- As part of their strategic role in assessing requirements in their area Local Authorities should collect client and needs data as part of stock condition surveys so that a more comprehensive view of property based and other needs can be taken. This would provide a more holistic view of individual needs, which would encompass both bricks and mortar and support issues. This is particularly important for estimating the preventive needs of older people.
- Accessing adaptations and equipment is key to prevention yet many older people can not get what they need to maintain independent living. Authorities and providers need to audit provision of adaptations, home improvement/repair processes to ensure that resources are targeted effectively and maximum use is made of all housing stock as part of their preventive strategy. Included in this should be a review of application procedures, forms, access to and provision of information to ensure transparency.
- Local Authority preventive strategies should include encouragement for HIAs to help maximise preventive adaptations, repairs and improvements which are not met through the public purse by expanding and developing work in the area of equity release.
- Local Authorities should recognise the part that Handyperson services have to play in prevention and take a strategic view on the distribution and ease of access to such services.

- Evidence from the fieldwork suggests that targeting services only at those needing personal care to prevent their moving unnecessarily into residential care, might miss out on groups of very disabled older people for whom low level preventive services have the same function. Assessment for community care services could bear this in mind when asked to provide help only with housework or similar tasks.
- Present patterns of joint working between local authorities and larger housing providers as “preferred partners” can miss out on small imaginative initiatives and leaves some providers scrabbling for funding to support preventive low cost measures. Local Authorities should identify all potential partners to further a preventive strategy.
- Older people need to be able to find out what their preventive options are. Current provision of information for older people in the community, bearing in mind sight, hearing and mobility impairment, should be audited. Local Authorities should ensure appropriate ways of enabling older people to access information, perhaps through developing partnerships with providers. Included in this needs to be an evaluation and monitoring process which seeks to maintain transparency of eligibility criteria, procedures and forms.

For Housing and Support Providers

Housing and support providers, such as RSLs, HIAs and advice and information services should link prevention firmly in to their strategic decision making.

- Housing design should look to future as well as current needs of occupants and support healthy, active ageing. RSLs need to consider current and likely future tenant profiles in order to identify emerging preventive needs. Reasons for tenants leaving should also be examined to identify potential gaps in preventive support provided by the RSLs. Providers should audit their provision to identify areas of mismatch between provision and residents’ needs in terms of design and services and use this information to inform planning and service delivery.
- To identify the value, cost effectiveness and wider benefits of prevention and savings in other service areas.
- The voice of older people themselves is a crucial aspect of ensuring appropriate preventive approaches. The Tenants’ Charter is one means through which RSLs can take older people’s views on board. It is however vital that the operation of the charter is vigorously monitored and processes reviewed to achieve effective outcomes.
- To promote social inclusion, older people should have an active role in the development of preventive housing and services in their community and in shaping changes in current services. To do this they need an appropriate participation process (language, venues, formats). Providers of housing and services should audit their practices and procedures to optimise opportunities for taking results from consultation through to action.
- The current funding mechanism has led to an uneven distribution of HIAs. Given that HIAs play a significant role in preventive work, this is a major barrier to the development of preventive services.

- Housing and support providers should ensure that staff, including those involved in strategic decision making, service development and those providing a front line service, are aware of current developments and thinking in relation to housing and older people including issues raised by the preventive agenda. Awareness training should be provided where necessary.
- RSLs and other providers should ensure that preventive features are included in design guidance and design briefs, for example, Lifetime Homes. Layout and equipment in areas such as bathrooms and kitchens should incorporate ergonomic features in order to maximise ease of use.

For the Preventative Task Group

Just as the Social Exclusion Unit has raised the profile of exclusion, the Task Group should continue to ensure that the preventive agenda permeates all aspects of social policy in the 21st century.

- There should be greater synergy between prevention and the health and housing agenda.
- Further research is needed to evaluate the effectiveness of preventive measures. A starting point for this will include defining preventive outcomes and a longitudinal study will be necessary to track these outcomes over a period of time.
- Further studies are needed to examine the reasons and routes through which older people enter residential care. The research should try to establish points at which the availability of a preventive service could have avoided such a move.

Chapter Twelve

Summary Checklists

Checklist 1 The Preventive Environment

Does your organisation ensure a supportive environment through design, appropriate adaptations and equipment? Make friends with your local Occupational Therapists and consult the Disabled Living Foundation.

Do you make provision for people with impaired sight and hearing? Periodically consult with clients and residents and specialist sources of advice such as RADAR, RNIB, RNID, and local support groups to keep up to date on available help and developments in technology.

Do you provide housing that is pleasant to live in and has space for different lifestyles ? Do you listen to the occupants ?

Do you remember the preventive dimension of issues such as location, available amenities, daily routines, transport and social networks within housing strategies and consider how you can help support them?

Checklist 2 Responsive Management

Do you have an open and flexible approach to prevention?
Look at what might work and not just on how such needs
have been met in the past.

Do you work with clients and residents to find out
what they see as preventive ?

Have you mapped what is already available to identify gaps
in local provision and avoid duplication ?

Do you act on the information people give you,
by bringing in or developing preventive services
to plug the gaps ?

Checklist 3 Translating a decision into action

Do you plan every part of a proposed service/strategy from training to funding and ensure that policies and procedures are in alignment ?

Do you pilot and evaluate new services with full participation from clients and residents ?

Do you consider what impact the proposed service might have on other internal operational areas ? Think through what else needs to be done to integrate a service with existing arrangements.

Do you consider what provision to protect clients and staff against elder abuse when planning new services ?

Do you check that proposals meet clients/residents needs and redesign them where necessary ?

Do you publicise proposed services to improve take-up and encourage networking? Link into or help develop wider prevention strategies in the locality.

Checklist 4 Evaluation

Do you use the information gathered during the planning stages to set appropriate evaluation criteria, even provisional ones, in consultation with clients ?
(These can include preferred outcomes, staying financially viable/affordable, supporting existing coping strategies. The criteria should not just look at outputs which are easy to measure, but also take in to account perceptions of the preventive impact of services and improvements in quality of life.)

Do you review evaluation criteria at regular intervals with clients? Check whether they need to be changed or enlarged ?

Do you review the preventive services within the widest possible context to avoid complacency and service fossilisation ?
Is it still wanted ? Can anyone else do it better ?
What else needs developing ?

Checklist 5 Partnerships and Collaboration

Do you view residents and clients as partners in prevention ? Keep them involved.

Do you actively seek opportunities to work with other organisations ? Consider sharing training, development, pooling use of equipment and staff.

Do you use local opportunities to promote involvement of older people and enable them to make use of their skills and knowledge, perhaps in intergenerational work ? Keep up to date on national and local initiatives with potential for future partnerships benefiting residents and clients, such as HAZs and Primary Care Groups.

Can you link your provision into larger community initiatives ?

Checklist 6 An Inclusive Community

Do you arrange your working practices to coincide with the definition of a community used by residents and clients ? It can be a geographical area like a street or a town or a group of people joined by common interests, beliefs or activities.

Can you help clients and residents to participate in community affairs ? Offer practical support such as transport, the use of a computer or a meeting place - if this is what they want.

Can you build bridges between your provision and older people living nearby through outreach care and support ? Can you become a local resource for them ?

Do you get involved in housing forums or similar local groups to keep up to date with new initiatives and get a wider perspective on housing in your area ?

Can you maintain/develop your own links with the community around you to pick up on new needs which you can perhaps start to meet ?

Have you considered working with specialist housing providers and sharing expertise to provide equality of access and appropriate provision for all older people ?

**Checklist 7 An Interactive and Effective Approach -
The Viewpoint of Residents and Clients**

Do you view listening to what people want as a starting point rather than starting from what has traditionally been seen as appropriate ?

Do you use the information to design and deliver services people want ? If not they may at best only be "fed and watered". At worst they may decline help and be at risk.

Do you make sure that existing coping strategies and family support are not disturbed ? Where possible support and facilitate them.

Do you build in client and resident participation to keep services focused ?

Are you aware of the interdependency of preventive factors and do you consider the impact of any changes to an individual's personal preventive strategy ?

Checklist 8 What Information ?

Do you map what other agencies can/do provide in advice and information on housing and support options ?
Look for more than leaflets in a display and check accessibility for those with sensory impairments or whose first language is not English.

Are there gaps in this provision ? Check with older people what they would see as useful subject areas to be covered.

Is existing provision one stop in approach or do people have to link up separate pieces of information before they can act on it ?

Checklist 9 Getting the Information Over

Can existing providers of information (Age Concern, LA, CAB) develop their services, through collaborative working or commissioning additional services, to meet identified gaps and demonstrate good practice ?

Where else can the information be made available, e.g. as leaflets, help-lines, signpost publicity to alert older people to competent and updated sources ?
In Post Offices, surgeries, hospitals, tea shops, leisure centres ?

Who is in contact with older people on a regular basis, e.g. carers, wardens, voluntary workers, and can act as information providers or signposts to appropriate sources of information ?

Have you planned and set up a dissemination strategy and do you review it regularly ?

Checklist 10 A Lack of Transparency

Have you audited your provision ? Are your policies and procedures clear ? If not, can you amend them in consultation with residents and clients ?

Do you need to develop/strengthen advocacy support to help residents and clients access services ?

Are there mechanisms/structures for participation ? If not, can you start them?

Can you start the liaison procedures on hospital discharge outlined in Means (1997) ?

Can you work with other agencies to simplify/explain their procedures ? What do their policies say they should do in terms of customer service ?

If not, can you take action which will nudge them into reconsidering their processes ? Publicity through local paper/Ombudsman/MP ? Collaboration with other providers to get the point over ?

Can you take action locally to even out inconsistency in service availability - are agencies and providers aware of sharp differences within small localities ?

Are there legal remedies/campaigns which can support action to even out provision ?

Checklist 11 The Use of Jargon

Are your documents straightforward and written in plain English ? Re-read and audit all your documents, beginning with those which go out to clients and residents and ending with policies and training materials which staff have to understand.

Have you considered asking/paying people not working for you to say what they think they mean ?

Can you hold workshops with residents/clients/staff to agree the complexity/type/amount of information they need ? You may be swamping people with information they don't need.

Have you considered asking clients/staff/residents to re-write material ? Offer prizes for the best entry.

Do you ensure that a solicitor checks rewritten documents, such as tenancy offers, which have legal implications ?

Do you check the vocabulary used to describe situations, processes, people's needs ? Do you use jargon as shorthand ? Is it needed ?

Checklist 12 Stereotypes and Perceptions

Does the design of the built environment assume a lifestyle for older people ? Does it match what they actually do ?

Does your design of services assume how older people spend their day or what support is needed ?

How have you factored preferences/daily routines into assessment procedures ?

Do policies, staff training or daily routines support independence ?

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Appendix One

The Preventative Task Group

Membership

John Belcher	Anchor Trust
Debbie Smith	Anchor Trust
Marie Mulligan	Anchor Trust
Louise Wood	Anchor Trust
Christine Paley	Association of Directors of Social Services
David Browning	Audit Commission
Martin Shreeve OBE	Better Government for Older People
Diana Whitworth	Carers' National Association
Frances Walker	Department of the Environment, Transport & the Regions (observer)
Peter Dunn	Department of Health (observer)
Tessa Harding	Help the Aged
Steve Onger	Housing Corporation (observer)
Angela Sinclair	Islington Pensioners' Forum
Dr Janet Lewis	Joseph Rowntree Foundation
Dorothy Blatcher	Local Government Association
Dr Gerry Bennett	NHS Confederation
Dr Pam Murphy	NHS Executive (observer)
Eileen Waddington	Nuffield Institute for Health
Professor Gerald Wistow	Nuffield Institute for Health

Publications

Promoting Well-being : Developing a preventive approach with older people ([Lewis et al 1999](#)).
This found a number of local authorities had a preventive agenda but also identified tensions between promoting well-being and the service needs of users.

Preventive Strategies for Older People : Mapping the literature on effectiveness and outcomes ([Godfrey M 1999](#)).
This report examines the research evidence on effectiveness and outcomes of preventive services in social care. It found that there was a considerable evidence base about preventive strategies in health and disability but little on prevention in social care in the context of healthy ageing. What there was, was descriptive rather than evaluative with a lack of clarity about outcomes.

Taking Prevention Forward : A Directory of Examples ([Lewis H, Milne A 2000](#)).
This directory provides a series of preventive services and approaches currently operating across England and Scotland.

These publications are available from

**Anchor Trust
Fountain Court
Oxford Spires Business Park
Kidlington
Oxon
OX5 1NZ**

Appendix Two

Topic Guides

The topic guides below were used for qualitative information gathering purposes

Topic guide 2a was used to provide a context for interviews with staff and/or residents/clients, and was completed face to face, over the telephone or by post after discussion.

Topic guides 2b and 2c were used to get information from residents/clients and staff on:

- what residents/clients wanted from preventive services and how far their outcomes were met
- the providers/staff view of preventive services
- key factors underpinning effective prevention
- potential barriers.

Guide 2c was also used in discussions with housing, health and social services staff on prevention during the course of the study.

2a Case Study Profile

Profile of residents/tenants/users.	Give details of age, gender, ethnicity, length of time in present home, level of support (% of residents) (if known).
Profile of housing. What is the tenure ?	Describe the physical layout, adaptations /aids, locality, access.
Activities/contact with community - for schemes.	Are activities inward or outward looking? What examples are there of contact with the community?
Profile of management.	Describe the management style. What information is available on preventive policies ? Has prevention had an impact on performance (turnover, voids) ?
In house services (for schemes).	Describe what is provided for residents.
SSD preventive/support/services.	Describe what residents/clients can access locally from Social Services, (with charges if known).
HA preventive/support/services.	Describe what residents/clients can access locally from local GPs, clinics, community nursing, after hospital care.
Any other preventive services.	Describe any other help available to residents/clients, perhaps from friends, family, neighbours, voluntary groups.
Any joint working.	Describe any instances/projects where you work with other organisations. This could range from occasional liaison to formal partnerships.
Other relevant issues.	e.g. links with wider initiatives such as Better Government for Older People, Health Action Zones ? Please describe.

2b Topics for Discussion - With Residents and Clients

Personal characteristics.	Age, gender, ethnicity, life themes.
What do they see as preventive services ?	What do they think they need - self assessment? Own coping strategies.
Physical environment.	Adaptations - individual/communal. Meaning of home/thoughts on moving. Location, amenities, local networks.
Services/support.	What do they find helpful? What services would they like? Can they change what they get?
Help/support from other people.	Family network/social network. Other informal support.
Support they provide to others.	
Housing/service management and attitudes.	Facilitating services and adaptations. Resident/client participation and consultation. Facilitating contact with community and family.
Advice and information.	Personally received - how useful/did it contribute to preventive aims ? Helpful advice and information not used but known to be available to others/used by someone they knew.
What else would they like to know about?	Any instance where lack of information had hampered choices?
Money.	Personal finances/affordability of current help. Shortfalls hampering choice or availability. Benefit maximisation.
Any other issues.	

2c Topics for Discussion with Staff

Preventive services currently available from all sources.	In house provision, formal provision (Social Services, Health Services, other agencies) and informal support (friends, family).
How people find out about the help they could get.	Sources of advice and information, how useful ? Easy to access ?
Can people change the services they receive ?	What feedback/input do they have ?
How do they access them ?	Formal assessment, third party assessment, self-referral ?
Any charges ?	Are they affordable ? Income from benefits maximised ?
Views on the services.	Feedback - how obtained ? Quality assurance, provision against abuse.
What else might help ?	And who could do it ?
Role of housing management/philosophy	In supporting client.
Collaboration/joint working.	
Operational or other issues.	Which can support prevention or act as barriers.
Future development.	Challenges.
Any other issues.	

Appendix Three

Case studies

Introduction

Case studies on the ten models explored in depth are described as full studies. The six less detailed studies are described as partial studies. All 16 case studies are set out below, providing a context for the case study references included in the main body of the report. They vary slightly in length reflecting the preventive strategies found and amount of information available.

The first five case studies have begun preventive services for older people to help them stay put and promote their inclusion in society, including two who have developed outreach work. The services provided do not include personal care.

The next five case studies (six to ten) have gone on to develop additional services, including personal care to help residents stay as independent as possible. Four also do outreach work in their community.

In the final group of six case studies the thrust of preventive work focuses on the built environment and initiatives supporting engagement with the community. It includes a multidisciplinary Social Services project, two HIAs, a local authority, an RSL and a Housing Action Trust.



Churchfield Court, Liverpool (Anchor Trust)

Contact : The Warden
Churchfield Court
Jones Farm Road
Gateacre
Liverpool
L25 3SR
Tel : 0151 488 6868

Background

Anchor Trust is a charitable trust, registered with the Housing Corporation, providing sheltered housing for rent and for lease, extra care housing and registered residential and nursing care. It also provides community based services such as domiciliary care and Staying Put projects. All residents are older people.

Churchfield Court provides sheltered housing for 49 older people, the majority in their late seventies and eighties. The scheme is in an identifiable area with its own shops, post office, and surgery. Support needs of residents vary, but half have strong family support networks providing low level help. Many residents use the local Age Concern volunteer Good Neighbour scheme for help with shopping and housework, and about a quarter buy in local private help. Three have full care packages from social services.

Preventive Work

Its preventive approach lies in the inclusive strategy developed by the warden to support residents as much as possible through community based resources and enable them to play a part in local life. Residents are on several local committees and strategy groups and are involved in intergenerational work with local schools and organisations. The scheme has close links with community police, other tenants associations and organisations working in the area. It provides a community meeting place for other organisations and hosts a range of activities for residents and local people, including practical help such as shopping trips and adult education sessions. All activities and transport are accessible to people with disabilities.

“We do have fun here - but we also feel useful, not just shut away, you know, like some elderly folk are”

Resident aged 79

The approach helps to improve quality of life for residents and fosters inclusion through participation. The challenge is to maintain the strong community base and level of activity as residents and wardens change.

2 Leicester Quakers Housing Association Ltd (LQHA)

Contact : The Housing Director
Leicester Quaker
Housing Association
28 Queens Road
Leicester
LE2 1WP
Tel: 0116 270 0748

Background

Leicester Quakers Housing Association is a charitable HA registered with the Housing Corporation. It provides sheltered and very sheltered housing and residential care to older people, and also manages local Soroptimist housing. It recently developed specialist accommodation and support for older people with dementia and their carers which is now managed by a separate charity. Half of new residents for its very sheltered housing are nominated by Leicester City Council. Average age of residents is 85 with a third over 90. Two thirds receive attendance allowance and most have support needs.

Preventive Work

Provides very sheltered housing with level access to all flats and to the landscaped garden. Communal areas on site include two laundries, a sun room, a disabled vehicle garage and a WRVS shop. Staff are on site 24 hours a day. Residents can choose from a range of low level preventive services such as pendant alarms, help with bathing in an assisted bathroom, part time handyman, help with forms and bills through the "finance clinic" and lunches. These preventive services are a mix of self funding and are funded by the service charge.

Turnover is low; one of the challenges facing LQHA is to develop outreach work to older people in the nearby community to extend the support they can offer. Another major challenge is developing appropriate accommodation for people from Black and Minority Ethnic groups living nearby.



Contact : Elderly Services
Manager
PCHA
Canterbury House
Canterbury Road
London
NW6 5SQ
Tel : 020 8537 4150

Background

Paddington Churches Housing Association (PCHA) is a charitable RSL registered with the Housing Corporation, managing 21,000 properties across London and in Hertfordshire. 25% of residents are older people, living in PCHA sheltered and general needs housing. 63% of all tenants have lived in their home for over 10 years.

Preventive work

It provides a range of preventive services for its residents. These include outreach support workers for older residents in PCHA housing, a handyman service, occasional decorating service funded by the Knowles Trust for older and disabled tenants. A welfare fund pays for essential items for low income tenants such as furniture, carpets, clothing and telephone installation. Benefits take-up campaigns have worked with older tenants to claim £35,000 in additional benefits; this helps them choose the support they want.

A preventive physical environment is seen as crucial; PCHA has a yearly adaptations budget of £200,000. Local delays in accessing Disabled Facilities Grants mean that all referrals go to PCHA architects department for a speedier response.

4 Notting Hill Housing Trust

Contact : Community Services
Manager
Notting Hill
Housing Trust
Grove House
27 Hammersmith Grove
London W6 0JL
Tel : 020 8357 4582

Background

Notting Hill Housing Trust (NHHT) is a charitable RSL registered with the Housing Corporation, providing and managing housing in central and west London. 30% of residents living in NHHT rented sheltered and general needs housing are older people.

Preventive Work

NHHT is developing its sheltered housing into a preventive community resource for older people in the area, providing facilities for lunch clubs, discussion groups, and open health days. Non-residential scheme managers now have a case load of 35 people, including older people in the nearby community. This part of the job has become a Monday to Friday home support service for NHHT's own tenants, older people on Housing Benefit and those referred by Camden Charities.

The outreach home support includes befriending, advocacy, information on other services, liaison with NHHT, HIAs and other landlords over repairs, adaptations and equipment, help with moving home, and volunteers act as escorts, where needed, for shopping etc. 24 hour emergency cover is also included.

"They've been brilliant, she (Home Support) put this remote thing on so I can open the door without getting up, got me a shower in and helped me sort out when they (hospital) were going to do my operation."

Very disabled older resident describing help received 1998 -1999.



Contact : Senior House
 Manager
 St Monica Home
 Westbury on Trym
 Bristol
 BS9 3UN
 Tel : 0117 949 4871

Background

A registered charity but not registered with the Housing Corporation, providing sheltered housing and registered residential and nursing accommodation on one site. There are 102 residents in the very sheltered housing, average age 80 and this is increasing year by year. Some have complex care packages through social services; others have brought their independent sector care services with them.

Preventive Work

The aim is to provide a home for life, supported by on-site respite and rehabilitation in 92 very sheltered flats with separate bathrooms and kitchens, adapted where necessary using the in house adaptations department. Communal dining and sitting rooms have induction loops. On site 24 hour warden cover and alarm pendants linked into an internal alarm system. In house services include daily lunch, laundry, cleaning, transport, use of the nursing home and health facilities, short term equipment loans and information on benefits. For many residents help with cleaning, laundry and provision of one cooked meal a day plus an appropriate environment is sufficient preventive support.

“Our job is not to make life smooth for residents. That could be patronising. They are adults and used to coping with life’s ups and downs. We provide support if wanted.”

Senior House Warden

Location is in landscaped gardens on the outskirts of Bristol, with croquet, bowls and clock golf. Facilities include a shop, library, studios and a range of classes and activities. The complex has its own chapel, chaplain, organist and daily services.

“It’s a lovely place; I like to keep busy and there is so much going on” Resident

There is an annuity and grant scheme for non residents. This has proved a useful form of preventive support for older people in the community; examples include one-off payments for house repairs, adaptations and washing machines.

The charity is aware that the location of the complex and the wealth of on site facilities could make their provision very inward looking. The challenge is to maintain community links and support residents in keeping social contacts outside the complex alive and healthy.



Contact : The Director
 Inkerman House
 14-18 Nevern Road
 London
 SW5 9PH
 Tel : 020 7370 6778

Background

A charitable housing association, not registered with the Housing Corporation, Inkerman HA provides very sheltered housing for 35 older people aged from the late fifties to late nineties. Two thirds are aged over 80. One quarter need high levels of support, whilst half need some support to live independently.

Preventive Work

It provides 34 fully adapted self-contained flats, 31 of which are wheelchair accessible. Communal areas such the library, dining room, activities room, laundry room and garden are also wheelchair accessible. All flats have an entry-phone and are connected to a central alarm system. Domiciliary services, including low cost equipment is provided through Inkerman Community Support (ICS) to residents and older people living nearby on low incomes. ICS began in 1993 as residents had difficulties in accessing low level preventive services. The aim is not to duplicate existing provision but to identify what is not available and begin to supply it.

ICS provides flexible personal care, and help with a range of practical tasks such as pet-care, cooking, housework, gardening, laundry and handyperson repairs. It helps with benefit maximisation and provides information on local support agencies. Escorts and transport are also provided. People with dementia, as clients and residents, are offered practical support in familiar surroundings.

“Without their help I couldn’t look after my cats and that would be the end. I would be in a home”

Very disabled client in her seventies.

“We have great fun when we go out - they’re like friends”

Client



Flagship Care (formerly
Peddars Way Care) part of
Flagship Housing Group Ltd

Contact: Chief Executive
Flagship Housing
Group Ltd
Station Road
Dereham
Norfolk NR19 1DA
Tel : 01362 698188

Background

Flagship Housing is a charitable RSL registered with the Housing Corporation; as Peddars Way HA it provides housing in the Breckland local authority area of Norfolk. Breckland is predominantly rural, covering about 500 square miles, with many isolated hamlets and some small towns. 27% of the population is over pensionable age, 30% of them live alone and 40% have no car. 35% of Peddars Way residents in Breckland are older people.

Preventive Work

The services provided to people in Peddars Way Housing and in the community by Flagship Care are an advice and information service, provision of community alarms, a home visiting service (HVS) which began in response to needs identified by the information service for outreach warden services and a home care service providing personal care and domestic help. This last service is fairly recent; development was triggered by an awareness that many HVS clients could not access sufficient home care to stay in their community.

All tenures are included. Clients are mainly older people but also include carers, younger people with learning disabilities, mental health problems and physical disabilities. The role of staff is not to take over, but to support the client in the community. Training is given in the importance of maintaining client independence and of letting the client set the pace. Home care assessment and daily records are client held; clients, families and informal carers are encouraged to add their comments.

“So kind and helpful, I couldn’t manage without the help, please keep calling”

Client and resident in her eighties.

The advice and information service works collaboratively with other support agencies, such as Social Services and Age Concern, to provide a one stop mobile information service in an adapted caravan to older people in dispersed communities.



Contact: Chief Executive
Lench's Trust
271 Hagley Road
Birmingham
West Midlands
B16 9NB
Tel : 0121 455 8808

Background

Charitable Trust registered with the Housing Corporation, Lench's Trust has provided almshouse accommodation since 1526. It now has five schemes across Birmingham, housing 205 people including couples. All residents are older people, whose average age is 83 with many in their nineties. The Trust aims to support independent living through a "home for life" philosophy, working in partnerships with families and residents although the increased age of residents means that grandchildren now play a larger part in these partnerships.

Preventive Work

Lench's Trust provides on-site support services across the five sites and is developing partnerships with other almshouses to extend preventive support to older people in the community.

The on-site services include warden services, cleaning, laundry and personal care. Personal care includes assisted bathing and is provided to residents by three full-time and one part-time carer plus a bath nurse. Assessment of needs is through a care manager employed by Lench's Trust. Provision of meals (where needed) across the five sites comes from families, from outside contractors (which residents pay for) and the Rathbone Society (a charity). Services began because the schemes cover five different social service patches and provision of home care services wasn't consistent across all sites.

Current challenges are to build on existing experience of provision for refugees from Montserrat and to develop sensitive provision for older people from Black and Ethnic Minority groups which emphasises inclusivity.



Contact: Director
Abbeyfield Bristol
Society Ltd
Alma Vale Road
Clifton
Bristol
BS8 2HL.
Tel : 0117 973 6997

Background

This is a charitable RSL registered with the Housing Corporation, affiliated to the national Abbeyfield Society and providing very sheltered housing for older people in ten houses in the Bristol area, including an Afro-Caribbean house - Montpellier House. Each house is managed by local volunteers and usually has 8 -10 residents, most are aged between 75 and 94, and 80% are women. The society also runs a registered residential care home.

The Bristol Abbeyfield Society develops training with and for other providers and is a member of the Bristol Supported Housing Forum and the Housing Partnership Forum. It is currently developing an extra care project with Bristol City Council.

Preventive Work

Live-in housekeepers provide 24 hour on-site presence in the very sheltered housing and two meals a day. A separate care company, Abbeyfield Help at Home, has been set up to provide in-house care services and community domiciliary support services. Residents have one hour's care from the Help at Home carer included in their weekly charge.

Help at Home began in 1993 as a response to difficulties being experienced by very sheltered residents in getting help with bathing. Using a "roving care assistant" from the society's registered residential care home to provide help with baths prevented many residents from having to move on. After an initial piloting stage this moved out into the community to support older people in their own homes, with a range of tasks covering personal care, footcare and help with household tasks, such as shopping and cleaning.

Access to good advice and information is seen as key to enabling older people to make decisions. All housing and care options, including those provided by other organisations, and funding routes are discussed with potential residents as part of the application procedure. Advice and information is part of the service for existing residents and clients; more recently it has included a list of reputable tradesmen used by Abbeyfield housing for community clients worried about engaging "cowboys".

"The help (from Help at Home) means I can manage nicely and I don't have to bother my family" Community client aged 79.

"The service you provide makes a very real difference in people's lives" Client's son.

Challenges are to ensure that provision of minority ethnic housing and support is aligned with identified preferences - Montpellier House has long-term voids.



Contact : Community Services
Manager
Accord Housing
Association
35-37 King Street
Darlaston, W. Midlands
WS10 8DD
Tel : 0121 568 6231

Background

A charitable RSL registered with the Housing Corporation, Accord and its subsidiaries provides and manages over 5,000 properties in the Midlands, across a range of urban and rural sites with a strong emphasis on partnership and community based regeneration. Accord provides general needs, sheltered and very sheltered housing, supported housing for residents with special needs plus residential and nursing care. 28% of Accord residents in its rented housing are older people.

Preventive Work

Accord provides a mix of preventive support through very sheltered housing with assisted bathrooms, central alarm systems and lunches to outreach and care services. Outreach offers floating support to vulnerable residents to help retain their tenancies. Depending on what is needed, additional support for residents can come from on-site staff, from outreach workers or, for help with personal care and housework, from Accord Care. This is a separate care company providing personal care and help with practical tasks such as housework, gardening and shopping. It is available to all residents but most clients are older people. The service developed from joint strategic decisions by Accord and local social services.

11

Preventive Adaptations for Older People (PAD)

Contact : PAD Occupational Therapy
Social Services Dept
Medway Street
Radford
Nottingham
NG8 1PN
Tel : 0115 915 5500

Background

A gap in the provision of adaptations for older people who are not substantially or permanently disabled, but who need minor adaptations to enable them to live independently at home was identified. Analysis on the causes of falls in older people attending Accident and Emergency departments suggested common reasons for the environmental falls: visual hazards, changes in ground level, steps, trailing wires, loose mats and slippery surfaces.

A multidisciplinary group (Social Services Occupational Therapy, Housing including Adaptations and Renewal Agency and Queens' Medical Centre Occupational Therapists) decided that small sums spent on adaptations for older people could generate savings to both the NHS and to the City Council. A pilot project (PAD) began in March 1999 to evaluate the cost effectiveness of providing minor adaptations.

Preventive Work

Free minor adaptations available to anyone over 60 living within Nottingham city boundaries, such as :

- grab rails, floor to wall rails, stair rails, half steps
- additional power points to avoid trailing wires, improved lighting/switch positions
- external lighting linked to infra-red sensors, door entry phones
- chair risers, lever tap adapters, long life bulbs
- smoke alarms, carbon monoxide sensors
- lifeline alarms linked via a phone to Nottingham City Council's central control unit (but clients pay a reduced operational charge of £1.50 a week for this item).

Referral is open. Clients do not have to demonstrate need for the adaptation, the intention is that it should be preventive and accessible to all people over 60. However, over a third of those referred had fallen in the past year. Funding is by Nottingham Health Authority through £113,000 "Additional Money for Patient Care this Winter". Further funding will be sought from Modernising Social Services Prevention Grants.

12 Liverpool Housing Action Trust

Contact : Community Care
Manager
Liverpool HAT
Cunard Buildings
Water St
Liverpool
L3 1EG

Background

There are currently five Housing Action Trusts (HATs) set up by the 1988 Housing Act in the country's most disadvantaged housing estates with the aims of :

- improving housing stock by repair or rebuilding
- effectively managing the stock
- encouraging diversity of tenure and ownership
- improving the social, economic and environmental conditions in the HAT area

In October 1993 ownership and management of 35 separate sites in Liverpool, totalling 5,337 units, were transferred from Liverpool City Council to Liverpool HAT, after extensive consultation with residents. 60% of HAT residents in Liverpool are over pensionable age and the number of people over 85 is forecast to rise sharply. This age profile influences the planning and development of housing and related services. Future landlords of the HAT properties are expected to continue the standard of accommodation and services being developed and incorporate high levels of tenant participation and control.

The HAT has a strategy for older people which aims at supporting its own residents and contributing to Liverpool's city-wide provision for older people. Key principles are that older people should have a say in the management of their homes and the sort of services they need, and that such support is best achieved through effective partnerships.

Preventive Work

This case study briefly looks at three preventive strands of the HAT work supporting older people, these are affordable Lifetime Homes, community support services, integration and partnerships.

Affordable Lifetime Homes

All HAT new build and renovated homes are accessible and built to Joseph Rowntree Lifetime Homes design standards, are energy efficient and affordable to heat and "secure

by design" including entry control for flats and maisonettes. Planning includes wider issues such as environmental safety, access to transport and ensuring the housing is attractive and pleasant to live in. Where flats are specifically for older people additional features such as grabrails, shower seats, non-slip finishes, automatic temperature water control and variable height kitchen units are included.

Community Services

These include an outreach warden service provided to existing tenants and more intensive support from a Community Support Team, comprising occupational therapists, social workers and community mental health workers. Older tenants, as they move, can choose from a range of new build two-bedroomed accommodation, such as low rise flats, houses and bungalows, and built to the standards described above. Included also are preventive housing related services, such as a community alarm, help with cleaning and gardening and support from a caretaker or warden. These can be accessed on an "as and when" basis, the cost met by increased service charges eligible for Housing Benefit. Such support services are seen as integral, they aim to remove uncertainty about current or future tenancy support services and how to fund them before moving in.

Running through these initiatives is the recognition that many older people in established communities have already set up informal care or support networks. Thought therefore needs to be given to ways of supporting these when arranging care, allocating properties, or arranging temporary moves while properties are refurbished.

"We've chosen where we want to be - my daughter lives just round the corner, so she can pop in"
Residents in their seventies.

Integration and Partnerships

The HAT sees partnership as vital to ensuring that its work has an enduring impact on the local community and aim at building sustainable communities which benefit all residents. The landlord selection process (for successor landlords who take over when the HAT development is completed) lays emphasis on community support and development, employment creation and tenant empowerment.

Discussions and interviews with staff and residents demonstrated high levels of resident input and empowerment. Older residents were closely involved in the process of refurbishment. Those who chose new build were supported by the HAT during and after the development, including help with moving and getting a new garden started.

There was also a lack of complacency about what had been and could be achieved. Sheffield Hallam University had been commissioned to look at the quality of life in the tower blocks; their report had been published in an accessible leaflet style with "upsides" and "downsides". The issues in the downsides, about delay and the stresses of redevelopment, were being addressed by the HAT.

13 Millennium Mews, Riverside Housing Association

Contact : Project Manager
Riverside HA
46 Wavertree Road
Liverpool
L7 1PH
Tel : 0151 706 6277

Background

Riverside HA is a charitable RSL registered with the Housing Corporation. It provides general needs and sheltered housing in Merseyside, Lancashire, Cheshire, Staffordshire and Leicestershire. 17% of its residents are older people.

Preventive Work

In 1997 Riverside HA responded to concerns of existing tenants about space standards, neighbourhood security, heating and water costs by commissioning the University of Liverpool to review available technologies.

From this came a specific development, the Millennium Mews. This is built on a brownfield site, part of an existing community and comprises 14 houses: 9 x 2 bedroom and 5 x 3 bedroom with high space standards, level access entrances, wheelchair turning spaces, low level switches, wide staircases and corridors, plus toilets and washbasins on the ground and first floor. The two bedroom houses have a downstairs bedroom.

Construction is timber framed and breathes so that moisture inside the house goes to the outside. High levels of insulation reduce noise and total energy costs are estimated at under £8 a week. Solar collectors pre-heat water, windows face the sun and porches reduce draughts; each house has a cost efficient gas boiler and uses recyclable rain water to flush one toilet. Security systems, fire detection, audio, data and TV points are wired in.

The aim was to achieve a mix of ages and household sizes; Liverpool City Council have 50% nomination rights and six of the houses have all residents close to or past retirement age and two have families with at least one member close to or past retirement age. All were interviewed extensively prior to acceptance since they would be an important part of the monitoring process. Those with older people in the household did not want sheltered housing; they wanted to stay part of a mixed age community and take part in the evaluation.

"Just because I am elderly does not mean that I only want to live with elderly people."

14 Portsmouth City Council Housing Dept

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Background

A unitary authority since 1997, Portsmouth has the highest population density outside London with increasing numbers of people over 80 needing support. 40% of its housing stock is pre-1914 and much of this older housing is in disrepair and needs updating. A key element of its housing service strategy is that good quality, affordable and well managed housing should be available across all tenures. Its housing aims are to help all residents and tenants find somewhere to live, meet their housing costs, obtain care and support to remain at home and repair and improve their homes. Behind these aims are more detailed objectives underpinned by high performance targets and reviews.

Preventive Work

This case study focuses on three main housing initiatives which benefit all residents across all tenures. These are : advice and information; care and support and repairs and improvements. Portsmouth's strategy emphasises partnership working and collaborative provision from all sources.

Advice and Information

Key to the effectiveness of a preventive strategy is making sure that people know what is available. For older people this means getting clear and unambiguous information on what accommodation is available, the support they could access and how it would be paid for. Such information was available in a range of formats and languages from points in the city and from the Housing Advice Team based in the civic offices.

Care and Support

This centres around accessible housing, a common social housing register and floating support, irrespective of tenure. It includes ensuring all new build housing commissioned by Portsmouth is built to "lifetime homes" standards. Housing Resettlement Workers help older

people access the right housing, help organise the move and ensure that packages of care and support are in place from the outset.

Other care and support initiatives include grant-aiding independent organisations in 1998 - 1999 with £200,000 towards the costs of the care and support services they provide. The City Council promotes initiatives which increase home security, energy efficiency, and accessible transport.

Repairs and Improvements

Complementing the care and support initiatives is a proactive city council Home Improvement Agency (HIA) working with Care and Repair and other agencies. Care is taken not to duplicate provision, instead the following initiatives dovetail into a city wide preventive strategy. A Handyperson scheme, run under Southern Focus Trust's (SFT) Care and Repair project complements the Homecheck scheme and is funded by the City Council. It offers low cost minor repairs and improvements to older people, disabled people and low income families. Small repairs are done by an Age Concern Handyperson.

Energy Efficiency advice and information target vulnerable households, including older people, and Affordable Warmth grants by the City Council enable older people, disabled and low income households to replace inefficient single point heating. SFT Care and Repair Home Improvement Agency and Portsmouth HIA offer dovetailing services to make the house right for the occupants. A range of funding is used to get the best mix of home improvements, energy efficiency and adaptations to suit the client.

“Since they (Portsmouth HIA) mended the roof and put in (central) heating it's made life easier. Money's not as tight and I feel better, I'm not as cold and my leg's definitely easier.”

Owner occupier client aged 84 living on his own.

High performance targets and streamlined application processes and procedures mean that applications and referrals are turned around quickly. Applicants do not suffer the same degree of delay which afflicts many HIAs.

15 & 16

Staying Put

Background

Set up initially as a pilot project in 1978 by Anchor Trust, Staying Put helps older owner occupiers and private tenants with three major problems they face in obtaining necessary repairs, improvements and adaptations to their home. These are getting sound advice on what needs to be done, choosing a reliable contractor and financing the work.

Staying Put meets these needs through discussing the full range of options available to clients. This advisory service is free. It then helps organise any necessary finance through grants, loans, benefits and charitable sources, and advises on architects, surveyors and contractors. Help is given with obtaining quotes and work is supervised as it progresses. Funding largely comes from comes from DETR subsidies, fee income and Local Authority funding. This funding structure is vulnerable to local budgetary constraints; Supporting People proposes the transfer of the DETR HIA grants (£6.3 million in 1998-99) to local government. It is unclear how this will affect future funding of the sector after 2003-4. This is currently being considered by the Inter-Departmental Review on Funding Supported Housing.

Staying Put works in partnership with relevant agencies such as occupational therapy and housing and social services departments. More recently many projects throughout the country have developed joint projects with other local organisations around broader objectives such as providing a supportive setting for community care services, maximising benefit income, improving home security and energy efficiency and providing handyperson services (focusing on small repairs and minor adaptations).

15 Staying Put Burnley

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Preventive Work

Begun in Burnley in 1992, Staying Put offers clients an holistic repairs, renovation and adaptations service through the local network of contacts and resources it has built up. It puts clients in touch with other preventive agencies, maximises client income and obtains additional finance for essential work from a range of sources. Information on all referrals is kept on a database, to monitor and evaluate work done. A client profile shows 95% are over 60 and 47% are over 75. 59% have long term health problems and 84% have a low income or are on benefits.

Staying Put also runs two projects, on minor adaptations and on energy, which help remedy many of the problems encountered by older people in Burnley living in small terraced houses built on exposed hills. There are few bungalows or adapted properties available.

Minor Adaptations

Originally funded by joint finance these are now referred and funded by Social Services on a spot contract at £90 a job. Minor adaptations are defined as less than four hours work and costing under £150. With input from an occupational therapist the jobs are carried out by a Staying Put technician. Turnaround is quick; urgent works such as hospital discharge adaptations are carried out within three days. Less urgent work takes about 10 days on average. Examples of minor adaptation jobs include grab rails, half steps and outside hand rails, easier to grip handles and controls, removing washbasin legs for a wheelchair user.

"Small outlay - large outcomes , especially when you think how much it costs to keep an elderly person in hospital for want of a grabrail near their toilet and basin."

Occupational therapist.

Home Improvement Plan

This is an Energy Saving Trust scheme run by Staying Put, supported by Age Concern England and Burnley Borough Council. It offers older owner occupiers, (many suffering from

fuel poverty in older houses), a package of measures to keep their home warm and easier to heat, including central heating. The work done can also include energy efficient building work, where window frames are rotten they will be replaced with double glazed frames.

Funding comes from grants and loans raised on the property. 75% of clients are not entitled to benefits or means-tested grants and pay for the work themselves using the equity based loans which Staying Put will help organise. Of the 25% who do receive benefits nearly half have their benefit income increased as a result of the scheme as well as getting grants to cover the cost of the work.

“My bills were more and I wasn’t as warm. I used to have four, no five heaters and fires around the house. And I got the back door step fixed at the same time.”

Client with new central heating and insulation in small terraced cottage on a slope.

An area of work to be developed is that with older people from minority ethnic groups; some live in poor housing, would benefit from the scheme, but are uncertain about using existing funding arrangements. Discussions are ongoing about local credit unions and community loans.

16 Staying Put Bury

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Preventive Work

Beginning as an Adaptations Project in 1995 with funding from Anchor Trust and Social Services, the project initially focused on helping clients with applying for DFGs and facilitating minor adaptations. It became a Staying Put scheme in 1998 with DETR funding. Based in a local resource centre with Bury's Disability Team, Staying Put also works with the Team to provide a unified service for disabled and older people with the aim of "making it easier to stay in your home".

The original adaptations project had been set up partly because 60% of Disabled Facilities Grant applications were not pursued. Considerable amounts of Staying Put staff time is still spent on detailed support work, such as guiding clients through paperwork so that complex renovation and adaptation packages are not jeopardised by failure to fill in a form at the right point in the process. If clients need to move out whilst work is done they have to be found somewhere to live and their fuel and water supplies plus housing benefit need to be stopped and restarted. It is this attention to detail by Staying Put which makes for an effective preventive service for clients where over 80% are over 60, 90% have a long term health problem and over a half are on a low income or depend on benefits. There is now no waiting list for of Disabled Facilities Grants.

"Couldn't have coped with all that correspondence, all those papers without help; I can't hold a pen too well nowadays and I didn't really know what they wanted me to write."

Client in her seventies.

Staying Put in Bury has also developed specific projects such as Home from Hospital. Funding for the project in 1998 came from joint finance from Bury and Rochdale Health Authority and Social Services, with some funding from Lloyds TSB and the Phoenix Trust.

Staying Put has also been contributing to Bury's database on adapted properties and has an input into the five-year Borough wide disability review. There are links with Better Government for Older People's Excellence for Elders surveying older people in an area of central Bury with poor housing and a predominantly Asian population, to get their views on what needs to be done. It also has an input into Bury's Best Value and Health Action Zone bid; older people have an active role in the Health Action Zone work and have identified the need for handyman services. Funding is being sought for this.

Appendix Four

Lifetime Homes Standards

Access

1. Where car-parking is adjacent to the home, it should be capable of enlargement to attain 3.3 metres width.
2. The distance from the car-parking space to the home should be kept to a minimum and should be level or gently sloping.
3. The approach to all entrances should be level or gently sloping. (Gradients for paths should be the same as for public buildings in the Building Regulations.)
4. All entrances should be illuminated and have level access over the threshold and the main entrance should be covered.
5. Where homes are reached by a lift, the lift should be wheelchair accessible.

Inside the home

6. The width of the doorways and hallways should accord with the Access Committee for England's standards.
7. There should be space for the turning of wheelchairs in kitchens, dining areas and sitting rooms, and adequate circulation space for wheelchair users elsewhere.
8. The sitting room (or family room) should be at entrance level.
9. In house of two or more storeys, there should be space on the ground floor that could be used as a convenient bed space.
10. There should be a downstairs toilet which should be wheelchair accessible, with drainage and service provision enabling a shower to be fitted at any time.
11. Walls in bathrooms and toilets should be capable of taking adaptations such as handrails.
12. The design should incorporate provision for a future stairlift and a suitably identified space for potential installation of a through-the-floor lift from the ground to the first floor- for example, to a bedroom next to the bathroom.
13. The bath/bedroom ceiling should be strong enough, or capable of being made strong enough, to support a hoist at a later date. Within the bath/bedroom wall, provision should be made for a future floor-to-ceiling door to connect the two rooms by a hoist.
14. The bathroom layout should be designed to incorporate ease of access, probably from a side approach, to the bath and WC. The wash basin should also be accessible.

Fixtures and fittings

15. Living room window glazing should begin at 800mm or lower, and windows should be easy to open/operate.
16. Switches, sockets and service controls should be at a height usable by all (i.e. between 600mm and 1200mm from the floor).

Preventive Approaches in Housing

An Exploration of Good Practice

Pat Parkinson
Debby Pierpoint

What helps older people stay where they are and enjoy life? What helps delay or avoid the need for more expensive care? This new report looks at the role of housing in effective preventive services. It asks older people and organisations providing housing and services what works - and why.

Using case studies the report describes how appropriate environments, intensive housing management and additional services can work to support older people in a range of settings. Key factors and good practices are identified and discussed and detailed checklists provide starting points for anyone interested in developing a preventive strategy.



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