

Housing Learning & Improvement Network

**DRAFT to be updated in
mid March 2006**

Care Services Improvement Partnership 

Health and Social Care
Change Agent Team

Preventative Care: the Role of Sheltered / Retirement Housing

This paper by the Sussex Gerontology Network at the University of Sussex makes the case for seeing sheltered/retirement housing in the context of the growing interest in the “preventative” agenda. It was prepared as a discussion paper for their workshop in April 2006.

Prepared for the Housing Learning & Improvement Network by
Peter Lloyd from the Sussex Gerontology Network at the University of Sussex

Contents	Page
1. The Issue	1
2. Demographic Change and Ageism	1
3. Quality of Life	2
4. Is Preventative Care Important?	3
5. Preventative Care Defined	4
6. A Check List of Preventative Care Strategies	6
7. Accountability and Evidence	8
8. The Needs of Older People	8
9. What does Sheltered Housing offer?	10
10. How can Sheltered Housing prove its worth?	12
11. To whom should Sheltered Housing be offered?	13
12. Who pays for Preventative Care?	14
13. The Impact of Changes within Sheltered Housing	15
14. Summary and Conclusions	17
References / Useful information	19

Other Housing LIN publications available in this format:

Housing LIN Reports:

Extra Care Housing Training & Workforce Comptencies (main Report and Executive Summary)

Yorkshire & the Humber Region - Extra Care Housing Regional Assessment Study (main Report and Executive Summary)

Factsheet no.1:

Extra Care Housing - What is it?

Factsheet no.2:

Commissioning and Funding Extra Care Housing

Factsheet no.3:

New Provisions for Older People with Learning Disabilities

Factsheet no.4:

Models of Extra Care Housing and Retirement Communities

Factsheet no.5:

Assistive Technology in Extra Care Housing

Factsheet no.6:

Design Principles for Extra Care

Factsheet no.7:

Private Sector Provision of Extra Care Housing

Factsheet no.8:

User Involvement in Extra Care Housing

Factsheet no.9:

Workforce Issues in Extra Care Housing

Factsheet no.10:

Refurbishing or remodelling sheltered housing: a checklist for developiong Extra Care

Factsheet no.11:

An Introduction to Extra Care Housing and Intermediate Care

Factsheet no.12:

An Introduction to Extra Care Housing in Rural Areas

Factsheet no.13:

Eco Housing: Taking Extra Care with environmentally friendly design

Factsheet no 14:

Supporting People with Dementia in Extra Care Housing: an introduction to the the issues

Factsheet no 15:

Extra Care Housing Options for Older People with Functional Mental Health Problems

Factsheet no 16:

Extra Care Housing Models and Older Homeless people

Case Study Report:

Achieving Success in the Development of Extra Care Schemes for Older People

Technical Brief no.1

Care in Extra Care Housing

Technical Brief no.2

Funding Extra Care Housing

Technical Brief no.3

Mixed Tenure in Extra Care Housing

Published by:
Housing Learning & Improvement Network
Health and Social Care Change Agent Team
Department of Health
Wellington House, 2nd Floor
135-155 Waterloo Road
London S1E 8UG

Administration:
Housing LIN, c/o EAC
3rd Floor
London SE1 7TP
020 7820 1682
housinglin@cat.csip.org.uk
www.changeagentteam.org.uk/housing

PREVENTATIVE CARE - THE ROLE OF SHELTERED/RETIREMENT HOUSING

1. The Issue

- 1.1 Good quality sheltered housing can contribute to the delivery of preventative care and support. Government papers indicate a growing understanding of prevention in relation to the provision of health, social care and housing services. For example, the recent Department of Health's White Paper refers to the contribution housing can make to promoting the health and well-being of older and vulnerable adults (1). Furthermore, the report from the Social Exclusion Unit at the Office of the Deputy Prime Minister (ODPM) sets out a vision for actively engaging with older people (2) while the ODPM's Supporting People consultation paper reinforces the links between housing, care and support (3).
- 1.2 But the term preventative care and support for housing providers can sometime remains vague and ambiguous. As a consequence, sheltered housing must clarify the definition and indicate more clearly the role that it performs. It is essential to do this in order to:
- indicate the type of persons who will benefit most from sheltered housing and who should therefore have priority in the allocation process or who want to make a lifestyle choice by moving into sheltered/retirement housing for rent or sale
 - justify the funding sought by sheltered housing - eg: via Supporting People, and to indicate other sources of financial support
- 1.3 To achieve these aims, the individual and organisational outputs and outcomes sought in providing preventative care must be better evidence and, where possible, quantified.

2.0 Demographic Change and Ageism

- 2.1 With increased longevity, more people are living longer - eg: 75+ years and a higher proportion of the total population is in the higher age groups. But what is the effect of this on this for care and support? However, "one must add life to years, not years to life".

Do we therefore experience the same period of high dependency, but postponed to a later decade?

Are some illnesses more prevalent in one's 80's than in one's 70's? The incidence of Alzheimer's, for instance, is said to increase with age

- 2.2 Demographic changes are also leading to changes in social attitudes. For example:
- Declining are the negative images
 - old age is a descent downhill
 - older people are a burden on society
 - Increasing are the positive images
 - older people are entitled to a good quality of life

older age is a period of new opportunities

older people are a resource : they pay taxes, they serve a volunteers

3. Quality of Life

3.1 What is a good quality of life? The many definitions embrace a common set of factors. The following list (reordered) comes from Help the Aged's work on quality of life (4)

- adequate income
- living in a good home in a good neighbourhood and feeling safe
- easy access to affordable transport and services
- good health and functional ability
- psychological and emotional well being
- good social relationships with family, friends and neighbours
- involvement in social and voluntary activities
- pursuing personal hobbies and interests
- feeling valued and respected by others
- a positive outlook
- standards of social comparison and expectations in life

3.2 But can we measure these factors? The answers is yes to a certain extent:

- some can be measured or quantified - eg: quality of housing, size and range of social network, amount of social interaction
- others are highly subjective, reflecting - eg: personality traits, lifestyle, one's ordering of priorities, differences in gender, culture, differences in dependency and stage in the ageing process

3.3 The high degree of interdependence between these factors is self-evident

- Thus poor housing → poor health → lack of social → interaction → depression → poor health

3.4 A closely related concept is social exclusion (as highlighted earlier)

- this is seen as the denial of access to the factors that promote a good quality of life (social exclusion occurs at all ages - but some factors are more pertinent to older age)
- the root cause of social exclusion is generally seen as social inequality : viz low income and its consequences - poor housing, poor life style.

3.5 Sheltered housing cannot remedy low income and its correlates; but it may mitigate some of the consequences of low income, especially enhancing the criteria cited in a good quality of life on the previous page.

4. Is Preventative Care Important?

4.1 It can be argued that preventative care is a pre-requisite for a good quality of life . We all think we know what preventative care is, and we see it as “a good thing”

- “Prevention is better than cure”
- “A stitch in time saves nine” (Help the Aged’s research suggests that “a 6% reduction in dependency and morbidity could reduce publicly funded care costs by as much as £6bn by 2030” (5)

4.2 A report by Anchor Trust, funded by the Housing Corporation, was one of the earliest documents to make the connection between housing and prevention (6).

More recently, a joint Office of the Deputy Prime Minister, Department of Health and Department for Work and Pensions group, the Housing and Older People Development Group’s (HOPDev) recent publication, *Delivering housing for an Ageing Population* states (7) “Increasingly public policy has been moving from focussing support on those with the most complex needs, to an approach that seeks also to maintain and promote people’s independence, health and social inclusion and prevent the need for higher levels of care This growing emphasis on older people’s quality of life increasingly means supporting their physical, mental and emotional health, as well as their access to ordinary facilities”

4.3 But those prescriptions are often contradicted by practice - eg

- in the past decade fewer older people have been receiving home care, though those who do receive it have more hours of support
- the Department of Health Green Paper that preceded the recent White Paper, (8) defines ‘cost neutral’ changes in service provision - ie: though the population ages there will not be increased funding for support
- as highlighted in the joint Association of Directors of Social Services and Local Government Association report, *All our tomorrows: inverting the triangle of care* (9), relatively little funding is allocated specifically to preventative care and such funding is rarely ring-fenced

4.5 Why should this be so?

- Acute illness and premature death arouse public interest and media coverage - eg:
 - a heart attack results in death because services were not available or slow to arrive
 - a terminally ill person is refused an expensive drug which could prolong life by a few months

thus, an extra ten years (perhaps of poor quality of life) added to the life of one person seems to be valued more highly than giving twenty people an extra year of good quality life!

- We still have difficulty in defining the many modes of support and care that might be embraced within preventative care (see below)

- In our evidence led culture, we have difficulty in “proving” the effectiveness of preventative care; treatment of acute illness is usually evident in a short period of time (see below)
- 4.6 Nevertheless , there are repeated calls that the NHS should be a health-creating service, rather than an illness-alleviating one.

5. Preventative Care Defined

- 5.1 So what exactly is Preventative Care? There are countless definitions; although their wording differs, their content is similar.
- 5.2 The definition given by the ADSS (10) in a joint paper with Anchor Trust states:
- “Services which delay or reduce the need for more costly intensive services”
 - “Strategies and approaches which promote the quality of life of older people and engagement with the community”
- 5.3 The following notes rely heavily on Mary Godfrey’s seminal paper (11)
A medical model of preventative care may specify three levels
- “Thus, primary prevention targets specific risk factors to prevent the occurrence of disease or injury. Secondary prevention focusses on the identification and treatment of disease/illness at an early stage. Tertiary prevention is aims at reducing disabilities through, for example, rehabilitation” (M. Godfrey 2001 - p90)
- 5.4 Godfrey continues “Translating these concepts of prevention to the social care arena is not straight forward without a clear theoretical framework that views risk within the broader bio-psycho-social context” (M. Godfrey 2001 - p90)
- 5.5 In their own document the ADSS/Anchor Trust retains the concept of three levels of prevention but includes social housing and environment as well as health and social care factors. It thus requires collaboration between Health and Social Service
- i) Primary prevention thus embraces:
 - decent housing
 - a healthy life style - eg: no drugs, sufficient exercise, good eating habits
 - regular health checks and monitoring
 - good family and neighbourly support
 - engagement in social activities
 - choice and control
 - ii) Secondary prevention focusses on:
 - early detection of illness
 - the provision of low-level services to enable people to manage at home

- iii) Tertiary prevention emphasises:
 - the maintenance of independence and the slowing down of processes of deterioration
 - reducing levels of home care or length of stay in residential care or hospital

5.6 These definitions promote a negative approach to preventative care - one is delaying or avoiding a worse situation

Mary Godfrey advocates a positive approach - building upon the concept of "Successful Ageing" developed by Baltes and Baltes (12)

We all experience throughout our lives, loss and gains and strive to balance them. In older age losses increase in number and intensity:

- loss, through bereavement, of partner, siblings, peers
- loss, through retirement, of job, status, income
- loss through ageing, of physical and mental capacity

- adjusting to these losses is accomplished by various strategies:
 - selection - the restriction of life's domains, avoiding some altogether
 - compensation - the use of alternative means to attain the same goal
 - optimisation - the enrichment of reserves and resources, seeking new opportunities
- The question to be asked, re -preventative care- is thus "What contribution/role do specific services play in optimising gains and compensating for difficult kinds of losses that accompany ageing?"
- Preventative care services would thus include help with:
 - managing the limitation of physical or other abilities
 - addressing the negative impact of significant life changes on social support and social networks
 - sustaining and improving performance in those areas that are valued by the older person
 - developing new strategies to compensate for losses
 - compensation for losses in areas that are less central to the person's self identity
- Primary level strategies would encompass strategies that:
 - enhance opportunities for social contact, expanding networks and support systems
 - stimulating abilities that ageing people seek to sharpen
 - offer the means to pursue valued interests
- Secondary level strategies would embrace services that:
 - optimise residual abilities
 - maintain a familiar environment
 - provide support to enable management of losses
 - support informal care relationships

- Primary level strategies focus on support in anticipation of loss; secondary level on coping with loss

5.7 Mary Godfrey supports this analysis with a discussion of bereavement and the provision of low-intensity domestic help

6. A Check List of Preventative Care Strategies

6.1 As Mary Godfrey argues we should ask not “what is preventative care” but “what purposes does it serve”. Nevertheless, it seems useful to outline the many domains in which preventative care may be located

6.2 Environment

- Location of home - physical attributes : hills, etc
site — distance from services
security : non-violent
- quality of home - space
well heated, damp free
maintenance issues, repairs
daily maintenance, cleaning, gardening
access, stairs, downstairs toilet
accident risks, re falls etc

6.3 Medication

- diagnosis and prescription of preventative medication
- compliance in usage

6.4 Life Style

- maintain physical activity
purposive sport, tennis, swimming
daily tasks in house, shopping
exercise classes, tai chi etc
- maintain mental activity
interests, hobbies, creative tasks
- maintain social activity
network of family and friends
participation in clubs, associations
home visits, befriending etc
- maintain a healthy lifestyle
good eating habits
avoidance of unhealthy habits, smoking, alcohol

6.5 In all these domains:

- enhance choice and control, active rather than passive participation
 - avoid stress:
 - occasioned by severe loss
 - daily hassles (eg: home repairs)
 - fear of insecurity
 - inability to attain goals
- 6.6 Preventative care should not be imposed on older people - it should be sought by them
- they must have knowledge and information about services available
 - they must be able to access them
 - they must be affordable
 - locations of service provision must be accessible
- 6.7 Usage of preventative care should be monitored:
- by family, carers etc
 - by providers of services
 - by 'befrienders' etc
- 6.8 A vast amount of preventative care and support is already provided for older people; we must not under estimate its importance. Providers include:
- The Public Sector
 - The NHS: much medication prescribed is to reduce risks of illness
 - The NHS: health promotion campaigns re alcohol and drug abuse, nutrition and obesity, falls presentation, etc
 - Social Services and NHS domiciliary visits - to enable people to maintain independent living
 - Housing and housing related support or care – extra care, sheltered/retirement housing, home improvement agencies and community alarm services
 - The Informal Sector
 - Six million carers
 - Family and networks of friends, neighbours and the voluntary sector
- 6.9 What is so often under-emphasised are the many processes by which a good quality of social life are promoted - viz good social relationships, involvement in social activities, pursuit of interests etc, as listed above (point 2)
- Many such services are provided:
 - through informal social networks
 - by voluntary agencies, often needing funding to coordinate and facilitate projects

7. Accountability and Evidence

- 7.1 We live in an age when the costs of the care and support that are technologically possible and which we might wish to receive, exceed what we are prepared to pay for, either privately or through taxes. Provision must therefore be “rationed” - a term avoided by politicians
- 7.2 Funders must inevitably seek ‘best value’
- what produces the best results?
 - how might funding be allocated to better effect?
- 7.3 What evidence exists that preventative care is effective, provides valued outcomes? As Mary Godfrey notes “A recent systematic of the literature on prevention in social care found that the evidence base is neither extensive or robust (2001 - citing a 1999 article). This lack of evidence is a major cause of a lack of funding for preventative care
- 7.4 Increasingly very large scale surveys are demonstrating a relationship between preventative care and well being. Thus exercise and physical activity, mental activity (including running a household), religious observance are shown to reduce morbidity and mortality
- 7.5 But in these surveys the outputs and outcomes are very diffused. Medical surveys may demonstrate that a baby aspirin reduces the risk of a heart attack. ‘Exercise’ or ‘mental activity’ covers a host of activities; in the Extend Class is it the gentle exercise or the cup of tea and chat that provides the greatest benefit?
- 7.6 Preventative care is very difficult to evaluate
- some factors (quality of housing) And outcomes (quality of medication) may be quantitatively measured. Others are highly subjective - how happy does one feel? Happier than last year?
 - outcomes are demonstrated far into the future; does preventative care actually result in extra years of good quality life?
 - the factors contributing to a good quality of life are highly interrelated; how does one unscramble them?
 - projects of preventative care are often very small (eg: a lunch club, a befriending scheme); those outcomes which over a short period might be quantified are not statistically significant
 - the small project can therefore quantify outputs (numbers of people/visits involved) but cannot evidence outcomes (better health in the future) save through the citation of the results of large scale surveys cited above; ie: we know/believe that exercise reduces morbidity thus in providing an opportunity for exercise we will reduce morbidity among our participants

8. The Needs of Older People

- 8.1 Most people would prefer to stay in their own home (especially if they are owner occupiers); moving home is traumatic at any age - for older people it is more so when it involves losing family memorabilia, adjustment to a new environment, loss of friends etc. Furthermore, it is government policy that,

within 'community care' people should be enabled and encouraged to live in their own homes, rather than in institutional accommodation

8.2 Some older people however will wish to move:

- to 'downsize' : their home is difficult to manage : too big, stairs, large garden
- to live closer to family or friends
- to live in a more salubrious environment

In each case a move can be made to ordinary housing, not incorporating care and support

8.3 For some older people receiving care and support through domiciliary visits from floating support teams, care workers, etc, a need may arise for:

- more intensive and more co-ordinated support than can effectively be provided by domiciliary visits
- more flexible support, available when called for and not at fixed times, such as telecare (13)
- 24 hour/7 day cover - ie: cover during the night and at weekends

Here a move to accommodation with an on-site care team in extra care sheltered housing, residential care or nursing home is indicated. There is considerable information on housing with care choice in reports from the Department of Health's Learning & Improvement Network (14)

8.4 What risks are experienced by older people who continue to live in their own home?

8.5 Almost one half of people over 80 years live alone; their partner has died; they do not wish to/cannot move in with children. The majority of these are able to continue active and rewarding lives and need little or no support. For others however, while no support may appear to be currently needed, they are "at risk"

- acute events : a fall, heart attack (their personal alarm may not be activated)
- isolation
 - reduced mobility or sensory impairment may deter them from leaving the home;
 - the locality is insecure, violent, hilly, far from shops and services
 - personality factors : shyness, timidity
 - poor social networks, no family living nearby
- Any or all of these factors may lead to depression and poor health, these being highly inter-dependent
- Depression may lead to self-neglect:
 - failure to maintain daily routines : get up, dress, go out
 - failure to eat well
 - failure to take prescribed medication

Each of the above will result in further deterioration of physical and mental health. Thus while many (perhaps most) older people can live active and

fulfilling lives with little or no external support, there remain a considerable number who can be termed vulnerable, at risk, who thus need the care and support that will prevent deterioration in their quality of life.

9. What does Sheltered Housing Offer?

9.1 Bearing in mind the factors which contribute to a good quality of life (paragraph ... above) and the categories of older people classed as vulnerable or at risk, what does sheltered housing offer that is not available to older people who remain in their own home? Why should they move?

9.2 The recent report on the 20/20 Project by EROSH (Emerging Role of Sheltered Housing)(15) explains that sheltered housing offers:

- a decent home
- the services of a scheme manager
- a community of residents
- availability of care and support
- a feeling of security
- the opportunity to retain one's independence

These items are explored in more detail below

9.3 A Decent home embraced here are

- location a pleasant environment, access to shops and services (inner urban schemes may appear less salubrious, but they will be closer to services etc, have better transport links)

 good quality design - space, heating, fittings
 appropriate to older people, mobility access (lift etc)....

 communal facilities - a lounge and other rooms, aundry, assisted bath, electric battery charging
- security – door entry system, alarms

9.4 A Scheme Manager who:

- is involved with the building management of the sheltered/retirement housing scheme
- is involved with the assessment, preparation and maintenance of support plans, monitoring service provision
- monitors resident's well being - daily morning call, regular (quarterly?) formal visits, daily casual interaction
- gives advice, facilitates contact with a wide range of service providers, acts as advocate
- facilitates social activity within the scheme and ensures a harmonious community atmosphere

- 9.5 A Community of Residents: residents in a sheltered scheme live in close proximity one with another; for some, who find social interaction difficult, this may pose a problem; but each resident chooses the degree to which they interact with others
- residents meet each other frequently in moving through the scheme
 - it is easier for residents to form close one-to-one relationships:
 - in providing help and support, helping to get to the coffee morning
 - professional/paid carers are often unable/unwilling to do small domestic tasks - shopping etc - which enhance the quality of life; sheltered scheme residents often help each other in this way
 - in close friendships, a neighbour replacing a lost partner
 - a variety of regular social activities is provided - bingo or cards, fish and chip lunches,, outings, talks by visiting professionals
 - Residents may be mere participants, active helpers or organisers of these events
 - The two themes cited above enable residents to gain a sense of purpose in life
 - in helping another individual
 - in playing a major, and perhaps leadership role in community activities
 - The community of residents is an ideal forum in which new interests may be shared and developed. The scheme manager might act as facilitator in putting residents in contact with organisations which provide support
 - The resident's personal file should include details of past interests and potential new interests
 - Residents in a scheme will be less likely to slide into self neglect
 - they will seek to 'keep up appearances', maintain their status, adhere to the collective norms of the scheme
 - Care and support will be available when needed:
 - either via externally based professionals, contacted through the scheme manager
 - or by an in-house care team, providing much greater flexibility of service delivery (eg: as in an extra care scheme)
 - In all, a scheme promotes a sense of security:
 - one's tenure is safe
 - one is free of routine building maintenance and similar hassles (a regular handy person to do minor work within the flat is an advantage)
 - one has a scheme manager and friends around to help in emergencies (eg: a fall) or to assist with short term care (eg: making a meal)
 - care and support will be available so that one will not have to move on to other accommodation; one has 'a home for life'

The lack of any of these items can lead to a feeling of insecurity, leading to stress, depression and consequent ill health

- 9.6 A caveat : resident involvement in community social activities or in participation in the management of a scheme frequently seems to follow a cyclical pattern:
- by popular acclaim active residents assume leadership roles;
 - but after some time, though still physical able, they experience 'burn out';
 - or their health declines and they cannot commit themselves to regular inputs
 - they are seen by other residents as becoming autocratic; the other residents withdraw support, the leaders' 'burn out' is accentuated since their efforts are not appreciated
 - the organisation of social and communal activity collapses; it falls to the scheme manager to mend the situation, to find new leaders. This is yet another task for which training is advised
- 9.7 Residents very frequently report that their move to sheltered housing gave them "a new lease on life"; we need to explore what this means, what factors are most significant
- 9.8 In discussions about the services offered within sheltered housing the focus is, usually, upon the role of the scheme manager and the provision of care and support. This is due to the fact that such discussions, policy making etc emanate from social services, health and housing professionals. It seems important to stress here, that in the provision of preventative care both the scheme manager and the community of residents are equally significant.
- 9.9 Changes both in the role of the scheme manager and the harmony within the community of residents can vitiate the effectiveness of preventative care

10. How can Sheltered Housing prove its worth?

- 10.1 The paragraphs above indicate the many ways in which sheltered housing provides preventative care; but how might one demonstrate this to the world outside - and in particular to funding agencies?
- 10.2 The difficulties in evidencing the value of sheltered housing are identical to those outlined above (section 7) and do not need repetition
- a scheme is a very small enterprise (30-50 units of accommodation/residents), too small to provide quantitative data of statistical significance. Yet funding is usually bid for by/ allocated to a very small number of schemes
- 10.3 What seems to be needed is a large scale survey in which sheltered housing residents are compared with a sample of people living in their own homes, matched for age, gender, level of dependency
- the results of such a survey can be extrapolated to evidence the outcome within single schemes, provided of course that the scheme is delivering the appropriate outputs - a design which facilitates access, lively social activity etc
- 10.4 What can be measured?
- Outputs are relatively easy to measure and quantify -eg:

the design of the scheme (points for each item)

the activities of the scheme manager, either regular or informal (more paperwork here)

the number of community social activities, the numbers of participants, their leadership roles

the amount of care and support provided to residents and the mode of provision (flexibility etc)

- Outcomes - a better quality of life, reduced morbidity and mortality - are difficult to measure; the following items are suggestions:

Exits from the scheme

by death

by moving onto accommodation providing higher levels of care (could this have been prevented/delayed)

length of residence within the scheme

Intensive support/acute illnesses

numbers of falls, heart attacks etc experienced by residents

management of domiciliary care, home help and/or day care

Individual residents health

levels of medication, visits to GP, hospitalisation

Individual social activity

size of network of friends

number of activities participated in

number of new interests

prominent or leadership roles

10.5 Ultimately one must, perhaps, ask residents if they are happy, satisfied with their lives however ambiguous or misleading the responses might be! Yet there is abundant anecdotal evidence from residents who assert that on entering sheltered housing they have taken on a new lease on life. This evidence must not be ignored

10.6 Surveys of residents will probably be made at regular intervals, to gauge degree of change. We must differentiate

- change between periods before and after entry to a scheme (before could well be a low point - severe illness or bereavement - some later recovery can be expected; but can it be attributed to the scheme?)
- changes year by year after entry to a scheme; one would hope that the health of scheme residents would deteriorate more slowly than that of people living, isolated, in their own homes

11. To whom should Sheltered Housing be offered?

11.1 If we can agree with a definition of the support provided within sheltered housing as preventative care, if we can describe those older people who

benefit most from it, we can begin to define both an allocation process as well as those who make a positive housing with care or support choice.

11.2 Existing allocation procedures are usually based on a points system:

- accommodation is offered to those with most points
- poor quality housing, ill health earn more points

Allocation to those 'in greatest need' thus tends to favour the highly dependent. They certainly have a need for supported housing (by whatever definition) - but is sheltered housing the appropriate solution?

11.3 If our analysis is accepted, priority for entry into sheltered housing should be given to those older people who currently have no, or few, support needs but who are vulnerable and at most risk - through incipient ill health, isolation in its many forms

- The health of these might be expected to deteriorate within sheltered housing (though at a slower rate), so that a scheme will contain residents with a wide spectrum of abilities, from the relatively active to the few who are virtually flat-bound
- early entry to a scheme is recommended since it gives the new entrant a chance to adapt to a new life style. The trauma of a move soon after a crisis may well accelerate a deterioration in health

12. Who pays for Preventative Care?

12.1 In the previous paragraphs we have:

- defined preventative care and the levels at which it may be provided
- shown that sheltered housing can provide many modes of preventative care
- noted that preventative care is under resourced and that there is little or no indication that government funding will, in the near future, be substantially increased

12.2 Where, therefore, should the costs of preventative care within sheltered housing fall?

- on the state
 - benefiting either - all older people
 - or - those deemed eligible for public support (ie: after means testing)
 - either through direct services (salaried care, professionals or workers)
 - or in supporting voluntary organisations (funding the recruitment and coordination of volunteers, their training and expenses etc)
 - or through support provided to individual carers
- on the user of services
 - either - by paying for services actually received
 - or - through a uniform service charge
 - payment only for services received implies the right of a resident to opt out of one or more modes of service provision (eg: the morning call); the risk incurred by the resident is thus increased

the service charge acts as a mode of insurance - when a need arises, support will be provided

if entry into sheltered housing is promoted or advocated for those deemed vulnerable or at risk, then payment of an 'insurance premium' seems a logical consequence

- Many of the costs of preventative care will be met by the voluntary efforts and mutual support of residents
 - in providing support to individual neighbours
 - in their management of collective social activities
- Voluntary support from outside the scheme will come from:
 - family and friends of individual residents
 - volunteers who help with social activities within the scheme

12.3 Within the scheme costing must be calculated

- for the many roles of the scheme manager
- to support, as necessary, the social life of the community of residents

12.4 If a sheltered housing scheme becomes a resource centre for the neighbourhood, then means whereby non-residents contribute to the support received must be explored

12.5 Human nature being what it is, many people will hang on in their own home until a move is forced upon them. Allocation policy must accept, but not promote, such attitudes

13. The Impact of changes within Sheltered Housing

13.1 As we are regularly reminded 'sheltered housing is changing'

- most of the changes have been generated from without - eg:
 - the closure of residential care homes has directed frail and highly dependent older people towards sheltered housing (some observers assert that some of today's entrants to sheltered schemes would have been deemed a decade ago too frail for entry into residential care!)
- the inclusion of sheltered housing within Supporting People was initially resisted by some managing agencies
- the current buzz words - choice, control - emanate from government policy statements

13.2 Some of these changes impact on the way in which preventative care is provided and its effectiveness

- the scheme manager is now a professional, not a 'good neighbour'
 - they are well trained to deal with issues of care and support; this is advantageous to residents
 - but: - increasingly they are non-resident
 - they are absent from the scheme at training courses, team meetings etc

they have far more paperwork to maintain accountability; their offices have computers (they are far less isolated from their managements and peers)

- the inevitable outcome is that scheme managers have far less time to interact with residents
 - collectively: facilitation of communal activities is down graded (and in many cases leads to a decline in these activities)
 - individually: opportunities to learn of a resident's problems (an essential requirement to understanding their support needs), decline. The time spent with the resident who drops by in the scheme manager's office to moan about personal problems may be seen by higher management as unproductive; to the resident it may have great therapeutic value and should be valued as such
- it is frequently asserted that today's entrants to sheltered housing are more frail and dependent than in years past; existing residents too grow older and more dependent. The proportion of highly dependent residents, against the relative active, increases. There are then too few able residents to provide individual support for their neighbours and to play active roles in community activities (and the scheme manager is no longer able/allowed to facilitate these). In consequence the level of social activity falls; the scheme beings to compare unfavourably with the stereotypical residential care home
- Notwithstanding official emphasis on preventative care, Supporting People, faced with budgeting cuts, appears to be trying to restrict its funding to the more dependent older people; that is to those actually receiving care and support
- One consequence of the definition of three levels of preventative care could be the prioritisation of level 3, followed by level 2. (This seems analogous to assessment banding whereby those with the most acute needs receive support whilst those with lesser needs receive little or none)

Preventative care ought, however, to mean the prioritisation of level 1 - those who need little or no support now but who are deemed to be vulnerable, at risk of deterioration and needing considerable support
- It is asserted too that individuals who are homeless and have behavioural problems (frequently due to alcoholism but also to dementia) are allocated accommodation in sheltered housing. Admittedly local authorities have responsibility in housing such people - and a hard-to-let sheltered scheme may seem a solution. But such individuals can easily destroy the harmony within a scheme; residents, instead of participating with enthusiasm in scheme activities, choose to remain within their flats in order to avoid the "difficult" resident. Active residents may also withdraw, or focus upon activities outside the scheme in order to avoid the highly frail and dependent residents

13.3 Pursuant to its policy of livening individuals greater control over services received, Government recently extended its Direct Payments scheme to older people - with minimal success. It is now introducing Individual Budgets:

- an in-house care team within a sheltered scheme provides considerable flexibility and emergency care

- in a newly developed extra care scheme the care team is in place before residents arrive; their entry implies acceptance of the team
- in up-graded schemes the residents may participate in the selection of the team; whilst a few might wish to continue with their earlier care arrangements, case studies suggest a quick recognition of the value of the team and acceptance of its services
- however, promotion of individual choice can threaten the viability of the care team; but residents' control may be exercised collectively

14. Summary and Conclusion/Executive Summary

1. Promoting well-being and quality of life

- Older people are entitled to a good quality of life; this is defined as
 - a decent home and environment
 - good physical and mental health
 - an active and fulfilling social life
 - exercise of choice and control
 - freedom from stress
- 'Preventative Care' embraces the means by which a good quality of life may be achieved; a more positive approach is now advocated - the promotion of successful ageing - rather than the negative prevention or delay of unwelcome conditions

Modes of preventative care range from those:

which reduce morbidity and mortality well into the future

via those:

which slow the deterioration of those classified as vulnerable

to those:

which mitigate the consequences of high dependence and frailty

- Though widely advocated preventative care continues to be under resourced
 - the treatment of acute illness is given priority
 - the, perhaps distant, outcomes of preventative care are difficult to measure
 - it is difficult to assign outcomes - reduced morbidity or mortality - to specific factors in preventative care

2. Person-centred housing, care and support as appropriate

- In analysing the concept of preventative care it will have become clear that sheltered housing provides preventative care to its residents, especially those who are currently able to live independent lives but who may be deemed vulnerable either from risk of acute incidents (eg: heart

attack, falls) or from isolation or who need a more coordinated pattern of care and support

- Sheltered housing provides:
 - a decent, easy to manage home, in a pleasant environment
 - the services of a scheme manager
 - in monitoring the well being of residents
 - in providing advice and advocacy
 - the company of other residents:
 - in facilitating close personal friendships and neighbourly support
 - in providing a range of social activities with the scheme
 - in promoting a sense of status and preventing self-neglect
 - care and support either from a number of external agencies or from an in-house care team (extra care sheltered housing)
 - in all, sheltered housing promotes a sense of security among its residents

3. Cost effective and value for money

- It is essential that sheltered housing should clearly state and promote the preventative care that it offers
 - to justify funding and support
 - to guide the process of allocation of accommodation so that places are offered to those who would benefit most

4. Flexibility in service provision

- Sheltered housing is currently changing in a number of ways; in particular:
 - the 'professional' scheme manager is more expert in monitoring and facilitating the provision of care and support to residents, but is less able to maintain earlier levels of personal interaction with them
 - recent entrants to sheltered housing are more frail than those entering a decade ago; some suffer from behavioural problems; in consequence the harmony of and social activity among the residents is reduced
 - each of these processes may seriously endanger the preventative care that sheltered housing aims to provide

References/Useful information

1. Department of Health (2006). *Our health, our care, our say: communities: a new direction for community services*. London, TSO
2. Office of the Deputy Prime Minister (2006). *A Sure start in later life: ending inequalities for older people*. London, TSO
3. Office of the Deputy Prime Minister (2005) Supporting People.
4. Help the Aged (2004) *Quality of Life in Older Age*. London
5. Help the Aged (2004) *Prevention is better than cure*. London
6. P Parkinson & D Pierpoint (2001). *Preventative approaches in housing: an exploration of good practice*, Oxford, Anchor Trust
7. HOPDEV (2005), *Delivering housing for an ageing population*, London
8. Department of Health (2005). *Independence, Well Being and Choice*. London.
9. ADSS/LGA (2003). *All our tomorrows: inverting the triangle of care*, London
10. G Wistow and H Lewis (1996). *Preventative Services for Older People: Current Approaches and Future Opportunities*. Oxford. ADSS/Anchor Trust
11. M Godfrey (2001). *Preventive strategies for older people: mapping literature on effectiveness and outcomes*. Oxford, Anchor
12. PB Baltes and MM Baltes (1990) *Successful ageing: perspectives from the behavioural sciences*. Cambridge, Cambridge University Press
13. J Porteus and S Brownsell (2000), *Using Telecare: exploring technologies for independent living for older people*. Oxford, Anchor Trust
14. Department of Health (2004). *Extra Care Housing for Older People: an introduction for commissioners*. London. TSO
15. EROSH (2005). *20/20: a vision for housing and care*. Emerging Role of Sheltered Housing Group